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# Not-So-Comprehensive Health Education: Teacher Attitudes Toward Heteronormative Sexuality Education

Sarah Elizabeth Burnham  
*University of South Carolina*

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NOT-SO-COMPEHENSIVE HEALTH EDUCATION: TEACHER ATTITUDES  
TOWARD HETERONORMATIVE SEXUALITY EDUCATION

by

Sarah Elizabeth Burnham

Bachelor of Arts  
University of Colorado, 1993

Master of Arts in Teaching  
Emory University, 2001

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Submitted in Partial Fulfillment of the Requirements

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Accepted by:

Daniella A. Cook, Major Professor

Cathy Brant, Committee Member

Rhonda Jeffries, Committee Member

Robert Johnson, Committee Member

Cheryl L. Addy, Vice Provost and Dean of the Graduate School

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## **Dedication**

This work is dedicated to my former, current, and future students who are queer. You have inspired me, taught me, and shown me patience. You continue to push me to work harder, ask tougher questions, and critically examine myself and the school environment around us. Thank you.

## Acknowledgements

None of this work would have happened without the support of my loving family. For the four years you persevered in my absence, I am extremely grateful. Somehow, I hope to make it up to each of you. Jason, I owe you time to pursue your dreams. I look forward to many great memories in the years to come with you, Isabelle, and Own. For my sweet Gus, I am now your full-time mom. Forever.

I remain in awe of my good fortune of finding such an enthusiastic and encouraging committee. Thank you, Dr. Cook, for reminding me to breathe and set reasonable goals. Thank you for keeping me from going off the rails in doubt. Dr. Brant, you provided a wealth of resources and subject matter expertise which made this journey easier. Dr. Jeffries, your positivity and peacefulness put me at ease, and I instantly knew I was lucky to have you on my side. For you, Dr. Johnson, I am especially grateful. Your survey class gave me the tools I needed to complete this project. Up until that point, everything was an abstract amalgamation of thoughts and possibilities. You helped me organize, shape, and refine my research trajectory. And lastly, even though your name is not on the cover, Dr. Mollie Blackburn, I thank you for being a virtual member of my committee. You kept me on track through my comprehensive exams and ensured I had the foundational knowledge necessary to contextualize this work. I look forward to expressing my thanks in person one day.

## **Abstract**

Drawing upon queer theory, this study investigated health teachers' interactions with the heteronormative sexuality education curriculum as prescribed by the 1988 South Carolina Comprehensive Health Education Act (SC CHEA). A survey composed of Likert-type and open-ended response items measured three constructs: the amount of preparation to teach health education, self-efficacy in teaching sexuality education, and teachers' levels of alignment with, or rejection of, heteronormativity. A convenience sample of middle and high-school teachers in SC public schools responsible for teaching health education yielded 181 responses. Descriptive statistics of the respondents precedes non-parametric analyses of correlations between constructs and among constructs and demographic variables. A significant finding is that many educators lack extensive preparation yet feel confident in their abilities to teach students about sexuality education effectively. In addition, attitudes toward heteronormativity are varied and correlate with gender, religion, and sexuality. Overall, findings indicate the heteronormative ideas and attitudes surrounding gender and sexuality are deeply embedded within the South Carolina sexuality education curriculum.

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## List of Abbreviations

FACS.....	Family and Consumer Science
LGBTQ .....	Lesbian, Gay, Bisexual, Transgender, and Queer
PE.....	Physical Education
QT .....	Queer Theory
SC CHEA.....	South Carolina Comprehensive Health Education Act

## **Chapter One**

### **Introduction**

In 2005 I was a novice teacher, working in a rural middle school teaching science and math. My principal told me after the school year had begun that during my science class I also needed to provide nine weeks of health education, in addition to a year's worth of science instruction. Not only was I concerned about the time constraints, but I also felt unprepared to teach the subject. I had never taken a course in health education or had any health-related professional development. My experience teaching health was limited to serving as a nutrition volunteer in the Peace Corps in West Africa. According to South Carolina guidelines, I was qualified to teach the subject based on my middle-level science certification. I did not feel qualified, but I did feel supported.

I was fortunate to work with adolescents in a small community where I had developed positive relationships with many families during my two years there. Nevertheless, I was anxious and uncomfortable when it came time to teach "reproductive health," the term the South Carolina curriculum uses for sexuality education. I found myself following the script of the book, using fear of sex as a guiding theme and repeating the mantra that sex should only occur within the context of marriage. The assumption was that marriage was between a cisgender man and a cisgender woman.

One day in class, a student said in response to another student's comment, "That's so gay." I paused the conversation and asked him what he meant by that statement. He

struggled for an answer. I asked him if he meant it as an insult and he said, "I guess so." I held my breath for a moment before telling them that one of my closest friends is gay. I told them how I witnessed him struggle with coming out as people he cared for backed away. My friend William is also African American, so I talked about how these markers of his identity often affect how people perceive and treat him. I asked my students if they thought it was important to treat people fairly. As seventh graders, they were particularly attuned to issues of justice and equality. The general agreement in the room indicated they understood the value of fairness. I asked them to reflect on anyone they knew who was gay or lesbian. I was not asking them to share this information, but a couple of students volunteered and mentioned they had a gay or lesbian relative. I mentioned that I had heard a statistic estimating that approximately 5% of the population is gay or lesbian. Several students immediately proclaimed their heterosexuality, and I did not like the direction the class was taking. I quickly wrapped it up with a reminder that all people deserve fair treatment and that hurtful comments were not acceptable in this classroom. A few students nodded while others continued their insistence of heterosexuality.

I had no idea what impact that discussion had on one of my students until five years later. She stopped by the school where I was working to deliver a photo and an invitation to her high school graduation ceremony. The gesture was touching but also surprising. She had been a quiet student with average grades, and we had not kept in touch since I moved schools. I told her I would try to attend the graduation and thanked her for the invitation. A few days later, she sent me a long note through social media explaining how that one class period marked the first time she felt appreciated and welcome in school. She said it helped give her courage to embrace her lesbian identity

and come out to her family. She said that she did not know if she would have made it through school without having had me as her teacher. I was shocked. I barely remembered the class discussion until she reminded me of it. My next thought was wondering how many similar conversations I had missed with other classes and how many of my former students spent time in my room feeling invisible or unsafe. The germination of this study began that day.

## **Background**

Sex education and the inclusion of Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) students are highly controversial topics in contemporary education. There is great variation in how different states in the United States (U.S.) treat both of these concepts. Approaches to sex education include abstinence-only, abstinence-based, comprehensive, and non-existent. Mention of LGBTQ sexuality ranges from prohibited, negative, limited to the context of disease, or to respectful and inclusive. In addition to state policies, much variation occurs in teacher instruction in these areas. Health teachers have a wide range of levels of preparation to teach the subject. Personal beliefs sometimes conflict with professional responsibilities or state mandates, and health teachers display a full spectrum of personal views of people who identify as LGBTQ. A lack of awareness of heteronormativity contributes to its continuation. Regardless of policy, practice, preparation, or belief is the reality of pervasive heteronormativity and its negative effects on individuals and communities. These effects include adverse physical, emotional, and social outcomes for LGBTQ youth. Examining the intersection of teacher preparation, self-efficacy, and personal perspectives can illuminate the path forward to

create more socially just educational environments and provide truly comprehensive sex education which is beneficial to, and inclusive of, all students.

The South Carolina Comprehensive Health Education Act (SC CHEA) of 1988 restricts discussion of “alternate sexual lifestyles” to the context of disease. The statute pathologizes LGBTQ identities and reinforces heteronormativity. Teachers in violation of this statute are subject to termination. Prohibiting inclusion of LGBTQ sexuality information in health classes renders students who are not cisgender and heterosexual invisible or associates them only with risk and disease.

In this study, I will examine three factors which contribute to how health educators teach sex education: the amount of preparation and professional development in health they have, self-efficacy, and their attitudes toward heteronormativity. It is likely that teachers with more professional training to teach sex education will demonstrate greater confidence and competence. It is also likely that the teachers who feel confident and competent will achieve better outcomes. Lastly, it is likely that confident and competent teachers who recognize the heteronormativity embedded in the sexuality education curriculum will seek ways to circumnavigate or confront it in their classrooms. In an ideal scenario, all health teachers would receive adequate training to feel confident and competent in their instruction, and all teachers would also receive training and curricular materials which support the appreciation and inclusion of LGBTQ youth. This study will explore the gap between reality and the ideal regarding the teaching of sexuality education across South Carolina.

## **Operational definitions.**

In this section, I will clarify how I use and make meaning of key terminology for this study. It is important to note that these terms are evolving and what is appropriate today might not be appropriate 10 years from now. According to the American Psychological Association (APA, 1991), the term “homosexuality” has been associated with pathology in the past and can perpetuate negative stereotypes. Language can be ambiguous and is changing over time. Some of the terms I list below may become derogatory or outdated. It is for this reason that I emphasize that this is how I understand and use these terms at this moment in time. Throughout the study, I will use the terms Lesbian, Gay, Bisexual (LGB), Lesbian, Gay, Bisexual, Transgender (LGBT) and Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) as consistent with the literature cited. The following are definitions used by the Human Rights Campaign’s Glossary of Terms (HRC, 2018).

Bisexual refers to “A person emotionally, romantically or sexually attracted to more than one sex, gender or gender identity though not necessarily simultaneously, in the same way or to the same degree.”

Cisgender is “A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.”

Gay refers to “A person who is emotionally, romantically or sexually attracted to members of the same gender.”

Gender Expression is the “External appearance of one's gender identity, usually expressed through behavior, clothing, haircut or voice, and which may or may not

conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.”

Gender Identity is “One’s innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.”

Homophobia is “The fear and hatred of or discomfort with people who are attracted to members of the same sex.”

Lesbian refers to “A woman who is emotionally, romantically or sexually attracted to other women.”

LGBTQ is “An acronym for ‘lesbian, gay, bisexual, transgender and queer’.”

Queer is “A term people often use to express fluid identities and orientations. Often used interchangeably with ‘LGBTQ’.”

Sexual Orientation is “An inherent or immutable enduring emotional, romantic or sexual attraction to other people.”

Transgender is “An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.”

### **Research purpose.**

Not only is there great variation in how states approach LGBTQ inclusion in sexuality education, but there is also great variation in how teachers prepare for and perceive LGBTQ inclusion. A review of the literature shows that while there is an abundance of information on the inclusion of LGBTQ students and issues in the general



school setting, there is far less research regarding LGBTQ students' inclusion or exclusion from sexuality education. The purpose of this study is to examine the relationships among three constructs: preparation to teach sex education, efficacy in teaching sex education, and attitudes toward people who are LGBTQ. Whereas data from each of these constructs can individually indicate areas for improvement in meeting the needs of all students, the intersection of these constructs might inform how to achieve that improvement most effectively. Questions this study will investigate include:

1. How much preparation have teachers had to teach health education?
2. How confident are teachers in their ability to increase student knowledge regarding sexuality?
3. To what extent do teachers' personal beliefs align or conflict with the heteronormativity in the SC sexuality education curriculum?
4. What is the correlation between the constructs described in the first three questions and among these constructs and demographic variables?

The initial part of this study gauges how much preparation teachers have to teach health education, including pre-service coursework as well as ongoing professional development. As in all subject areas, there is a wide range in the amount of content-related preparation teachers have for their subject areas. A 2014 study reported a positive correlation between the amount of formal training in the subjects they teach and teacher confidence (The Organisation for Economic Co-operation and Development, 2014).

While this particular study will not compare the amount of content-related preparation health teachers have as compared with other subject-area educators, it is important to note that teachers are not required to possess health certification to teach health. There are

currently no programs in the state that offer health educator certification. Teachers with no health education preparation are eligible to teach the subject. All teachers who possess certification in physical education (PE), family and consumer science (FACS), and science are eligible to teach health education (M. Lally, personal communication, July 7, 2017). When teachers have adequate subject knowledge, particularly in regards to more sensitive topics, they feel more competent and confident to teach health (Byrne et al., 2012).

The second research question of this study examines how teachers' view their sense of competence, valuation of the information, and ability to effect change in their students' levels of knowledge regarding sexuality education. A way to define self-efficacy is to consider it as a measure of one's confidence to competently produce desired results. From a pilot study I conducted in 2015, many teachers did not feel confident in their ability to meet student needs to provide adequate information for students to make healthy decisions regarding sexual activity. Teachers who feel prepared and confident in their ability to prepare students will likely have the greatest impact on students. This impact can be positive or negative depending on how inclusive and affirming the classroom is concerning race, class, gender, sexual orientation, and other markers of identity.

Finally, the study explores teachers' attitudes toward people who are LGBTQ and policies and curriculum related to people who are LGBTQ. This information informs whether teacher attitudes align or conflict with the prescribed heteronormativity in the SC sex education curriculum. Teachers with positive attitudes toward people with diverse gender and sexual identities face conflict with the heteronormative SC Comprehensive

Health Education Act (SC CHEA) of 1988 and risk termination if they deviate from its restrictions. This study asks teachers to identify conflict they may experience with their personal beliefs and professional obligations.

The results of this study will indicate whether there is a need for similar additional studies on a larger scale. The results will also indicate whether there is a need to change how teachers are prepared to teach sex education, which could impact their sense of self-efficacy. research results will also suggest whether there is an opportunity to incorporate more LGBTQ-inclusive curricula. Specifically, this study will help draw attention to explicit heteronormativity within the 29-year old South Carolina Comprehensive Health Education Act (SC CHEA) of 1988.

### **Organization of the study.**

The remainder of this study is composed of four chapters. Chapter Two provides a review of the related literature, including the context of contemporary sexuality education both in the United States and in South Carolina, pre-service and in-service teacher preparation to teach sexuality education, teacher self-efficacy, and the South Carolina Comprehensive Health Education Act. Chapter Three discusses the methodology of the study. The data are presented and analyzed in relation to the research questions in Chapter Four. Chapter Five presents conclusions and recommendations for future investigation.

## **Chapter Two**

### **Literature Review**

The literature review begins with the political context of heteronormative sexuality education in the United States as well as in South Carolina, followed by the effects of heteronormative curricula. The second section of the literature review explores teacher preparation for teaching health nationally, at the state level, and with regard to LGBTQ inclusion. The literature review concludes with an examination of health teacher self-efficacy in teaching health and self-efficacy in including LGBTQ students in the classroom environment.

#### **The Political Context of Heteronormativity and Its Effects in Schools**

Progress toward greater LGBTQ inclusion in sexuality education is not linear but rather follows the meandering path of public policy as well as popular opinion. Therefore, it is helpful to begin with a with the national perspective before exploring issues at the state level to situate LGBTQ inclusion in legislation and within sexuality education. First, I discuss the current state of LGBTQ issues in politics and public opinion followed by a historical examination of the South Carolina Comprehensive Health Education Act (SC CHEA). This section concludes with literature documenting the effects of heteronormativity on school climate and LGBTQ students.

#### **LGBTQ issues in contemporary U.S. politics**

Recent legislative, judicial, and executive decisions regarding LGBTQ rights demonstrate a wavering level of political support, showing the future is uncertain for

legal protection and equality. The election of President Trump has further threatened progress for LGBTQ rights, demonstrating the highly controversial nature of this topic in the U.S., and the ideological shifts which accompany transitions in government leadership. The progressive push toward rights-based and pleasure positive sexuality education under President Obama is losing traction in the wake of the 2016 election results (Garcia & Fields, 2017).

The U.S. Supreme Court ruling in *Obergefell v. Hodges* granted the right to marry to same-sex couples and mandated that all states recognize same-sex marriages as equal to opposite-sex marriages (135 S. Ct 2584, 2015). The Court's ruling extended the protection of not only liberty interests but also equal dignity to the LGBTQ community (Bird, 2016). To many people, *Obergefell* represented a long-awaited victory in an exhausting chapter in LGBT history (Carpenter, 2017). Whereas this legal right is significant, it is also important to note that legislation does not always result in action. Legislation will be illustrated in greater detail in the section examining the SC CHEA. Also important to note is that legal progress is not uniform; moving forward in some areas but in reverse in others. Shortly after the *Obergefell* ruling, several states sought legislative recourse to restrict LGBTQ rights.

North Carolina's House Bill 2 (H.B. 2) garnered significant attention when Governor Pat McCrory signed it into law on March 23, 2016. The bill, commonly known as the "bathroom bill," eliminated anti-discrimination protections for LGBTQ people and prevented municipalities from enacting anti-discrimination policies. It legislated that individuals could only use restrooms that corresponded with the sex on their birth certificates (N.C. HB 2, 2016). Widely criticized as discriminatory against people who

are transgender, the provision resulted in major sports championships moving out of North Carolina (“Bathroom Bill,” 2016). This highly contentious bill caused a negative economic impact on the state and adversely affected tourism, sports, and entertainment (Berman, 2017). HB 2 also created many legal challenges both federally and privately (Morrill, 2016). North Carolina was not alone in its attempt to restrict transgender people’s access to the facility designated for their gender identities. Lawmakers proposed similar legislation in at least 20 other states, with much of it about school bathrooms (Kralick, 2017). As individual states wrestled with legislative issues about LGBTQ rights, the newly-elected executive branch joined the conversation as well.

With the 2016 election of President Donald Trump and Vice-President Michael Pence, the political climate cooled further toward LGBTQ rights. Trump and Pence won the electoral vote on a ticket that opposed same-sex marriage rights and endorsed conversion therapy for Lesbian, Gay, and Bisexual people (Garcia & Fields, 2017). In July of 2017, President Trump announced via Twitter that transgender people would be no longer able to serve in the military (Hirschfield-Davis & Cooper, 2017). This announcement took many people by surprise and demonstrates how quickly policy can change in a shifting political climate. Two federal judges have since blocked enforcement of the ban (Jarret, 2017). The lack of consensus among federal leaders underscores the conflicting perspectives regarding transgender people and their rights. It also highlights the changing federal and state policies which reflect the ebb and flow of political tides. Similarly shifting opinions are evident in South Carolina in the context of sexuality education.

## **South Carolina Comprehensive Health Education Act**

The South Carolina Comprehensive Health Education Act (SC CHEA) of 1988 mandates that students in South Carolina receive health education in kindergarten through twelfth grade. The SC Code of Laws, Title 59, Section 32 states:

Comprehensive health education" means health education in a school setting that is planned and carried out with the purpose of maintaining, reinforcing, or enhancing the health, health-related skills, and health attitudes and practices of children and youth that are conducive to their good health and that promote wellness, health maintenance, and disease prevention. It includes age-appropriate, sequential instruction in health either as part of existing courses or as a special course.

In grades six through twelve, students must receive education in “reproductive health” with emphasis placed on abstinence until marriage. Based on this stipulation, it might be more accurate to describe the South Carolina sexuality education curriculum as abstinence-based rather than comprehensive. The SC CHEA also stipulates that “The program of instruction provided for in this section may not include a discussion of alternate sexual lifestyles from heterosexual relationships including, but not limited to, homosexual relationships except in the context of instruction concerning sexually transmitted diseases” (S.C. § 59-32-5 *et. seq.*, 1988). Again, the term comprehensive is misleading as this clause pathologizes people with “alternate sexual lifestyles” and excludes all students from medically accurate and comprehensive education.

One of the most contentious issues at the time the Act was written was how to treat “homosexuality.” According to *The State* newspaper, Representative Mike Fair, R-

Greenville, wanted the CHEA to require teachers to say that homosexuality was illegal and immoral (LeBlanc, 1988). He felt the language describing homosexuality as an “alternative lifestyle” was not sufficient. Representative Harriet Keyserling, D-Beaufort, stated that it was not likely that teachers would promote homosexuality (LeBlanc, 1988). The CHEA was considered groundbreaking legislation when it was enacted 30 years ago because it provided specific content outlines for reproductive health as well as time requirements. However, many private citizens, educators, researchers, and health advocates have called for amendments to reflect the current needs of students in SC (Orekoya, White, Samson, & Robillard, 2016; Wiley, Wilson & Zenger, 2013).

Under the SC CHEA, teachers in violation of the state statute are subject to termination. Some teachers are not even aware of this stipulation. Others may not consider it problematic. For teachers who are aware of it, and do find it problematic, how can they address the realities of students who are, or have family members who are LGBTQ? How can they promote student respect for diversity while delivering this curriculum and still meet the needs of all of their students? The concern is especially timely considering *Obergefell v. Hodges*. There is a conflict between this ruling on same-sex marriage and the restrictions imposed on discussions of same-sex relationships in the context of sexuality education. The SC CHEA states that all instruction must be in the context of future family planning within a marriage, but what if the marriage is of a same-sex couple? In the case of LGBTQ students, the SC CHEA does not fulfill its goal to, “provide instruction that will support the development of responsible personal values and behavior and aid in establishing a strong family life for themselves in the future and emphasize the responsibilities of marriage,” (S.C. § 59-32-5 *et. seq.*, 1988). Not only is



the SC CHEA failing to prepare all students for future family life, but it is also failing to prepare them to reduce sexually transmitted infections (STIs) and unintended pregnancies.

The notion that sex only occurs between married men and women is unrealistic in light of the rates of STIs in South Carolina. In the 2015 Sexually Transmitted Diseases Surveillance from the Centers for Disease Control and Prevention, South Carolina ranked seventh in the country for chlamydia and fourth for gonorrhea (CDC, 2016). South Carolina also has the 16<sup>th</sup> highest teen birth rate in the nation (SC Campaign to Prevent Teen Pregnancy, 2017). Based on these statistics, the current curriculum does not adequately inform students of how to reduce the risk of sexually transmitted infections.

In addition to falling short of providing adequate information to prevent sexually transmitted infections and unintended pregnancies, the South Carolina health standards also perpetuate heterosexism through limiting the discussion of “alternate” sexualities to the consequence of disease. The limitation creates connotations of disease associated with non-heterosexual identities. These messages foster an environment which does not acknowledge, let alone value, sexuality or gender diversity. The next section will explore the impact of this hostile environment.

A 2017 study found that 89.5% of South Carolina residents surveyed support teaching comprehensive sexuality education (CSE) in public schools (Kershner, S. H., Corwin, S. J., Prince, M. S., Robillard, A. G., & Oldendick, R. W., 2017). Public support for CSE is evident, but without legislation to implement it, change is unlikely.

State legislators have attempted to amend the South Carolina Comprehensive Health Education Act (SC CHEA) of 1988 without success. In 2013, a bill was

introduced to the SC House of Representatives which required that reproductive health instruction be medically accurate, provided certification requirements for teachers of comprehensive health education, and requested accountability to the department of education to ensure school districts' compliance with the mandate. The bill, H 3435, passed the SC House but died in the SC Senate (SC H 3435, 2014). Private citizens are also trying to challenge the SC CHEA. South Carolina resident Marie-Louise Ramsdale learned of the anti-LGBTQ restriction in the CHEA from a letter sent home by her daughter's high school. In an interview with a local newspaper, Ramsdale stated,

What bothered me is that (the high school), by this letter, is saying that homosexuality is wrong and that it is not an appropriate sexual lifestyle. I'm very concerned about the message it sends to children in the schools who may be gay, not by choice, but by birth. I'm concerned that it promotes homophobia, and I'm equally concerned they're teaching a curriculum that violates the U.S. Constitution (Pan, 2015).

Ramsdale is not the only SC resident who considers the SC CHEA potentially unconstitutional. A task force, led by Columbia attorney Malissa Burnette, launched an investigation into the sexuality education curriculum taught in schools across the state. University of South Carolina constitutional and education law professor Derek Black, who is a member of Burnette's task force, states that the SC CHEA "has probably been unconstitutional since 1988 – not since this summer," referencing the Supreme Court ruling in *Obergefell v. Hodges* (Pan, 2017).

Educators from across the state have also voiced dissatisfaction with the SC CHEA. Following the annual conference for the South Carolina Alliance for the

Advancement of Health Education (SCAAHE) in November 2017, a leading health educator in the state expressed concern that if the SC CHEA were challenged in the current political climate, it could be amended to become even more conservative. Hamill, a professor in the department of physical education, sport and human performance at Winthrop University communicated by email,

As was evident in our discussion, we have much to do in this state with respect to health education. There has been a fear that in revisiting the CHE Act to try to amend it, that more conservative voices would come forward and take away what small gains that have been made (S. Hamill, personal communication, November 14, 2017).

For people who want the SC CHEA amended to become more LGBTQ-inclusive, it is evident that timing their efforts to maximize the likelihood of successful efforts is imperative.

Others have called for amendments to the SC CHEA, as well. In a policy paper for the *American Journal for Public Health*, the authors acknowledge proposed legislation calling for increased oversight of school district compliance with the law, increased training and certification requirements for health educators, as well as the addition of medically accurate and evidence-based information. However, the authors suggest these proposed amendments are insufficient and offer additional recommendations including removal of the restriction of discussion of “alternate sexual lifestyles” from the Act, citing, “The SC Department of Education has a responsibility to meet educational and curriculum standards that address sexual and reproductive health

that is responsive to the needs of *all* [emphasis added] students” (Orekoya, White, Samson, & Robillard, 2016, p. 1952).

In a report assessing the status of the SC CHEA 25 years after its enactment, researchers found that the majority of school districts were not complying with the reproductive health education requirements of the SC CHEA. Findings also indicated that many districts had insufficient or outdated policies regarding reproductive health education. Lastly, the study also revealed that some school districts still use misleading and discriminatory instructional materials and curricula. The authors also provided recommendations for amendments to the SC CHEA to include medically-accurate and evidence-based instruction (Wiley, Wilson, & Zenger, 2013).

As evidenced in the preceding paragraphs, many educators, private citizens, agencies, and lawmakers would like to see the 30-year old SC CHEA amended to become more inclusive and truly comprehensive. The South Carolina legislation reflects a different perspective than the rest of the U.S., by and large. It also fails to meet the mandate that comprehensive health education, “provide instruction that will support the development of responsible personal values and behavior and aid in establishing a strong family life for themselves in the future and emphasize the responsibilities of marriage” (SC CHEA, 1988), as students with LGBTQ identities are excluded from this instruction. The next section will illustrate the effects of heteronormative sexuality education and how states with laws similar to the SC CHEA compare with states with more LGBTQ-inclusive curricula.

### **The impacts of heteronormative school environments.**

Curricula based on heteronormative values, rather than ones which are comprehensive and LGBTQ-inclusive, place students at emotional and physical risk. Hostile school climates affect students' mental health and academic success. (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). School-based supports such as supportive school personnel and gay-straight alliance (GSA) clubs can offset some of the victimization which contributes to lower self-esteem and lower academic outcomes (Kosciw et al., 2016). Previous studies have documented higher rates of substance use, sexual risk behaviors, and suicidal thoughts and attempts in LGBTQ students (Toomey, Ryan, Diaz, Card, & Russell, 2010).

In a 2015 study, 85.2% of LGBTQ students experienced verbal harassment, and 57.6% of LGBTQ students who were harassed did not report the incident, often because they did not expect school intervention to improve the situation. (Kosciw et al., 2016). The national statistics are discouraging, but when examined in states with anti-LGBTQ legislation like South Carolina, the numbers are even more startling. A 2018 study compared eight states that prohibit the positive portrayal of homosexuality in schools to the rest of the country. "No promo homo" laws refer to specific education laws mandating "no promotion of homosexuality." The states defined as "no promo homo" states included Utah, Arizona, Texas, Oklahoma, Louisiana, Mississippi, Alabama, and South Carolina. Utah has since repealed its "no promo homo" law (GLSEN, 2018). The study found that LGBTQ youth in states with "no promo homo" laws experience a more hostile climate, have less access to LGBTQ-inclusive curricula, feel less supported by educators, have lower attendance rates, and have less access to relevant health resources

as compared with other LGBTQ youth (GLSEN 2018). In some cases, there are extreme disparities: Only 29.7% of students in “no promo homo” states have a Gay-Straight Alliance (GSA) or similar club in their schools compared to 58.6% of LGBTQ students from other states. Other support areas found lacking included professional development (PD) for school health professionals. In states without “no promo homo” laws, 14.9% of health professionals reported having had PD related to lesbian, gay, and bisexual issues, as compared with 1.7% in states with “no promo homo laws.” In South Carolina, the “no promo homo” law restricts discussion of homosexuality to the context of disease in health education classes, but other content areas do not limit LGBTQ-inclusion in their curriculum. Unfortunately, many educators may avoid demonstrating support of LGBTQ students in all subject areas for fear of violating the law (GLSEN, 2018). Amending the SC CHEA to become LGBTQ-inclusive could have positive impacts on school climate, beyond just within health education classrooms.

### **The effects of heteronormative sexuality education.**

Historically, sexuality education programs limit the focus to a discussion of reducing sexual risk among heterosexuals (Gupta & Cacchioni, 2013). Assumed heterosexuality permeates sexuality education even when it is not discussed directly (Mayo, 2013). This assumption and privileging heterosexuality marginalizes the specific experiences and health issues of LGB students while reflecting institutional and social intolerance of sexual minorities (Elia & Eliason, 2010a, 2010b; Wilson & Wiley, 2009).

Sexuality education which excludes LGBTQ youth not only perpetuates heteronormativity but also leads to adverse health outcomes. Public policy regarding sexuality education is inconsistent across the U.S. South Carolina is one of 24 states

which mandate both sexuality education and HIV education. Nine states require the inclusion of sexual orientation in instruction in a positive manner. South Carolina, Alabama, and Texas are three of the states that restrict information regarding sexual orientation to negative connotations in sexuality education instruction. Oklahoma and Arizona have anti-LGBTQ restrictions regarding HIV instruction (Guttmacher Institute, 2017). In Alabama, the state code requires, “An emphasis, in a factual manner and from a public health perspective, that homosexuality is not a lifestyle acceptable to the general public and that homosexual conduct is a criminal offense under the laws of the state (AL Code § 16-40A-2, 2016). This state code persists despite the United States Supreme Court decision in *Lawrence v. Texas* which overruled all state sodomy laws 14 years ago (539 U.S. 558, 2003). In contrast, California mandates that sexuality education, “Must encompass the experiences of gay, lesbian, and bisexual students as well as those of their heterosexual classmates and be respectful and inclusive of the experiences of lesbian, gay, and bisexual students” (California Department of Education, 2017). Nationally, a proposed bill in the Senate, The Real Education for Healthy Youth Act of 2017, S. 1653, would provide federal guidance for the respectful inclusion of LGBT students in sexuality education. This bill would withhold federal funds from programs which are, “insensitive and unresponsive to the needs of sexually active youth or lesbian, gay, bisexual, or transgender youth.” This bill, first introduced in 2013, was reintroduced in the House on July 28, 2017, but has not been enacted. Congress provided \$276 million in federal funding for medically accurate and age-appropriate sexuality education and \$85 million for abstinence education programs (SIECUS, 2016). Even with increased funding for better comprehensive sexuality education (CSE), unless teachers recognize

the heteronormativity inside school walls, they are unlikely to confront it. Pre-service teacher education programs can improve LGBTQ awareness and inclusion and help teachers recognize and confront heteronormativity in their classrooms (Kearns, Mitton-Kükner, & Tompkins, 2017, Elsbree & Wong, 2007).

### **Health Teacher Preparation to Teach Sexuality Education**

Well-prepared teachers are critical to effective sexuality education. Teacher training is the most significant factor in determining the comprehensiveness of sexuality education (Hammig, Ogletree, & Wycoff-Horn, 2011). Unfortunately, many middle and high-school health teachers have had little or no training on human sexuality and feel uncomfortable or underprepared to teach sexuality education (Blad, 2014). One topic mentioned during the South Carolina Association for the Advancement of Health Education (SCAAHE) conference was the association's identified need to change requirements to teach health education in SC. The SCAAHE Advocacy Report for November 2017, included notes of recommendations provided to the Education Oversight Committee regarding certification or SC endorsement of teachers providing instruction in health education. The next section will further explore certification, endorsement, and professional development of teachers who are responsible for teaching health, and specifically sexuality, education.

A 2013 national study found that nearly one-third of teachers responsible for teaching sexuality reported receiving no pre-service or in-service training in the subject. The study also found that only 61% of teacher preparation programs require sexuality education courses for health education certification (Eisenberg, Madsen, Oliphant, Sieving, & Resnick, 2013). An amendment proposed in 2016 by the South Carolina state



legislature would have provided certification requirements for teachers of comprehensive health education, pregnancy prevention instruction, and reproductive health (Orekaya, White, Samson, & Robillard, 2016). Unfortunately, the amendment did not pass. The National Teacher Preparation Standards for Sexuality Education, released in 2017, could guide South Carolina institutions of teacher preparation. The goal of the Teacher Preparation Standards is to better equip pre-service teachers to effectively teach sexuality education (Future of Sex Education, 2017). Increased teacher preparation would likely lead to increased teacher self-efficacy.

In the state of South Carolina, teachers with many different areas of certification are eligible to teach health. There is no state college or university in South Carolina which currently offers a teacher preparation program for health certification. Teachers can earn an “add on” certification in health education, requiring 24 hours of college course work (Wiley et al., 2103). The majority of teachers of health education in SC are certified to teach physical education (PE). Data from the South Carolina Department of Education’s (SCDE) 2010-2011 report on CHEA implementation revealed that of the teachers responsible for health education, 30% are certified in PE, 11% in general science, and 6% in family and consumer science. Teachers with dual certification in PE and health accounted for 28% of that group (Beyer, 2011). Some teachers may have had no teacher preparation courses related to health or sexuality education. The SC CHEA requires that local school boards “provide appropriate staff development activities for educational personnel participating in the comprehensive health education program. Local school boards are encouraged to coordinate the activities with the department and institutions of higher learning” (S.C. § 59-32-5 *et. seq.*, 1988). Staff development

activities are infrequent in some counties. From a pilot study conducted by the researcher in 2015, most teachers in the district studied reported having little to no professional development regarding health education.

Implementing a curriculum or program without adequate teacher training often results in ineffective delivery to students. Educators responsible for sexuality education must have confidence in their subject matter knowledge, but also feel comfortable in teaching the curriculum. Teachers who are highly-qualified to teach in a certain subject area are more effective than teachers without preparation for that subject area (Cardina, 2014). One construct this study examines is the relationship of teacher preparation to the sense of self-efficacy in teaching sexuality education.

### **The Impact of Teacher Self-Efficacy on Sexuality Education**

The success of sexuality educators in teaching students to practice healthy behaviors depends on their perceived self-efficacy (Jensen, 2012). According to Jensen, extensive literature exists on the value of self-efficacy of students in sexuality education; however, there is scant current literature on sexuality education teachers' self-efficacy – neither in how they experience it nor how they develop it (2012). An exhaustive search yielded no literature on sexuality teachers' self-efficacy in regards to LGBTQ inclusion. Whereas there is a dearth of recent research regarding sexuality teacher self-efficacy, much exists regarding general education teacher self-efficacy. Some literature points to teacher self-efficacy and LGBTQ-inclusion in other subject areas. The following paragraphs will underscore the necessity of more research in sexuality education teachers' self-efficacy, specifically regarding LGBTQ identities.

Fahlman, Singleton, and Kliber (2002) reported that the amount of teacher health-education preparation significantly impacts teacher's self-efficacy. Self-efficacy is an individual's confidence in their ability to effectively accomplish a task. Bandura's (1977) theory of self-efficacy identifies three critical components for understanding self-efficacy that informs this work: (1) the individual's perception of his or her competence in a certain behavior, (2) the belief that the behavior will produce the desired outcome and, (3) the identified outcome is valuable. (Maddux & Stanley, 1986). Measuring teachers' perceptions of these components can identify their sense of self-efficacy in teaching health and sexuality education. One relationship this study aims to investigate is the correlation between teachers' self-efficacy and their attitudes toward heteronormativity in the health curriculum.

As stated above, the amount of teacher preparation significantly impacts teachers' self-efficacy to effectively teach health (Fahlman, Hall, & Gutuskey, 2013). One study found that the more prepared teachers felt, the more health lessons they taught (Hammig, Ogletree, & Wycoff-Horn, 2011). Another found that teachers who had more preparation in health education felt increased confidence and competence in fulfilling their instructional responsibilities (Jacobs & Wylie, 1995). Self-efficacy reflects a teacher's sense of competence, valuation of the material, and belief in the ability to effect change in students based on that material. When working with a heteronormative curriculum, teachers who identify this curriculum as exclusive and potentially harmful will possibly struggle with self-efficacy. Educators need more than content and pedagogical knowledge to teach about LGBTQ issues and individuals effectively. Teachers must also

possess the belief in their abilities to be competent in these topics (Brant & Tyson, 2016). It is helpful to understand how teachers develop self-efficacy.

There are many means by which teachers can develop a high sense of self-efficacy. One avenue is through teacher education programs (Fletcher & Luft, 2011). Professional development experiences offer other opportunities for teachers to develop confidence and competence in content and pedagogy. PD can also be effective in preparing teachers to confront anti-LGBT bias (Greytak, Kosciw, & Boesen, 2013). Confronting anti-LGBTQ bias is at the heart of queer theory, serves as the theoretical framework for this study and will be discussed in the next chapter.

### **Summary**

Extensive literature confirms the presence of heteronormativity in schools in general, and in sexuality education in particular. Teacher preparation, self-efficacy, and attitude determine the extent to which this heteronormativity will affect individual classrooms and students. Examining the realities of LGBTQ students in schools underscores the urgency of this situation. Changing policies and curriculum alone will not sufficiently erase heteronormativity. Increasing teacher preparation and awareness can be one step in this journey. Building teacher self-efficacy through practical experience, multicultural curriculum educator coursework, and professional development will assist in this process. Examining the intersection of teacher preparation, self-efficacy, and attitudes toward heteronormativity of sexuality teachers will guide the next stage of the research process and inform the study's design.

## **Chapter Three**

### **Research Methods**

#### **Theoretical Framework**

The study, framed in queer theory, allows a multidimensional analysis of existing power structures, binary systems, and assumed norms within the SC CHEA. In this chapter, I discuss Queer Theory and the survey design to explore the utility of pairing of the two.

#### **Queer Theory**

Borne out of queer studies and women's studies, queer theory seeks to deconstruct and dismantle heteronormativity. Heteronormativity is the conforming or reducing to a standard the institutions and practices that privilege heterosexuality. Connell (Rasmussen, Gowlett, & Connell, 2014), a leader at the forefront of queer theory, describes how queer theory and feminist theory overlap and share territory. Connell suggests that queer perspectives run parallel with some feminist positions, at times interacting and at other times combatting (Rasmussen et al., 2014). In contrasting feminist theory with queer theory, McCann (2016) posits that the binary notions of gender have been used historically as an organizing principle of feminist social research. Extending beyond the goal of attaining equal status for people who are LGBTQ, queer theory not only critically examines power structures but also redefines language and epistemological orientations founded on binary systems of gender and sexuality. The SC CHEA is rooted in such binary systems, framing all discussion of sexual relationships

within the confines of traditional gender and sexuality norms. Disrupting these norms, eschewing dichotomies of gender and sexuality, and revealing the prevalence of heteronormativity allows queer theory to illuminate the flaws and inequities in the SC CHEA.

Earles (2016) contends, “For queer theorists, discourse is a complicated network of words, images, and concepts that produce reality and which can generate both emancipatory and/or oppressive power” (p.3). Queer theory challenges even further our notions of how these systems of oppression are deeply embedded and will not improve until we release our current constructs of gender and sexuality. Wilchins acknowledges the progress made by the feminist movement in gaining increased access to equitable work opportunities, for example, but sheds light on the need for growth in our collective understanding of gender (2004). Wilchins also credits Judith Butler as one of the founders of queer theory (2004). McCann describes Butler’s work as “the juncture between postmodernism and feminist approaches emerging during the general postmodern turn in the academy (McCann, 2016, p. 230). Wilchins centralizes queer theory in politics, as evidenced by language, power, identity, and difference (2004). Queer theory requires changing the language and knowledge construction of what gender and sexuality are and why we self-impose these constraints in binary thinking. Queer theory seeks to challenge our dependence on identity markers.

The primary critiques or limitations of queer theory center around how it diverges from feminist theory. The two camps differ in how sex and gender are either naturally occurring or socially constructed (Nagington, 2016). The locus of divergence is how the two approach sex, gender, and sexuality (Jagose, 2009). Butler, as a controversial voice

of queer theory, argues that both sex and gender are social constructions, as the physical characteristics of bodies do not automatically exist in either male or female states (Butler, 1990). Regardless of how feminism and queer theory intersect and conflict, queer theory's reach is significant.

The influence of Queer theory extends across many disciplines, from educational research to philosophy, and even nursing research and practice (Rasmussen, Gowlett, & Connell, 2014, lisahuntur, 2017, & Nagington, 2016). Queer theory contributes to the epistemology of these diverse fields in the practice of identifying and challenging prevailing assumptions of how gender and sexuality influence experiences and identities.

Examination of the complex interactions of language, power, identity, and difference has helped increase our understanding of gender and sexuality in school settings. Building on Wilchins (2004), Murray posits, "Omission of queer issues in education is a heterosexist behavior that reinforces heteronormative values and practices" (2015, p. xiii). Acknowledging this omission is shifting the discussion. Meyer (2010) identifies the necessity of inclusion for student success and states, "In order for BGLQT students, students of BGLQT parents, as well as gender non-conforming youth to have meaningful opportunities for success in schools, information about their lives and their families must be integrated across the curriculum" (Meyer, 2010, p. 12). As educators promote the inclusion of LGBTQ students and issues in our schools, it is important to bear in mind that people hold multiple markers of identity which go beyond gender and sexuality. In seeking to expand our understanding of people beyond these two aspects of identity, it is also useful to expand our construction of knowledge to include methods for collecting and analyzing data that might capture the complexity of identity.

## Potential in Queering Quantitative Methodology

Often, the methods employed in queer research allow researchers to speak with or interact with people. Browne and Nash (2016), suggest that as queer thinking implies fluid and unstable subjects and subjectivities, quantitative questionnaires fixed in time might not easily meld with queer theory. Not all scholars agree. Queer thinking in research challenges researchers to question methodology. In researching queer families, Fish and Russell described using strategies to, “reclaim traditional methods in ways that reflect research practices and epistemologies that might attend to and challenge normativity and privilege” (2018). The authors examine whether it is possible to queer singular methods, solely quantitative or qualitative, or if other possibilities exist to queer methodology (Fish & Russell, 2018). Browne and Nash (2016) stated that,

One could argue that there is, in fact, no ‘queer method’ (that is, ‘methods’ specifically as research techniques), as in the sense that ‘queer’ lives can be addressed through a plethora of methods, and all methods can be put to the task of questioning narratives ( p. 12).

Whereas the survey instrument used in this study reflects a moment fixed in time, the blending of Likert-type items and open-ended response items provides space for new ideas to emerge, especially when coupled with the data and storytelling gathered in the pilot study. In doing so, this work embodies the ways in which queer theory might employ quantitative methodology to attend to and challenge heteronormativity.

The SC CHEA is rooted in binary systems, framing all discussion of sexual relationships within the confines of traditional gender and sexuality norms. Disrupting these norms, eschewing dichotomies of gender and sexuality, and revealing the



prevalence of heteronormativity allows Queer Theory to illuminate the flaws and inequities in the SC CHEA. Using both Likert-type items and open-ended response data allows opportunities to enhance understanding of complex issues in pursuit of a truly comprehensive sexuality education. Conducting this research in the context of queer theory permits inquiry beyond “what is” and challenges the researcher to view the data outside the normative social ordering of subjectivities and identities to imagine “what could be”. The goal of the present study is to not only identify the flaws in the current guidelines and delivery of sexuality education in South Carolina but to also suggest remedies and opportunities for its amelioration. The inspiration for this project began with a pilot study.

## **Research Design**

### **Background Spring 2015 Pilot Study**

During my experience teaching health education in the 2014-2015 school year, I identified the need for more professional development for health education teachers. In discussions with colleagues, I recognized a wide array of teacher attitudes regarding LGBTQ issues. As a result, I conducted a pilot study in the spring of 2015 in preparation for dissertation research to learn more about these teacher attitudes. The survey method was used to mirror the data gathered by a poll conducted in 2005 by Forrest, Oldendick, and Draughon. Their poll used random-digit dialing and phone interviews of registered voters across the state to ascertain their opinions regarding what to include in sexuality education. The pilot study focused specifically on attitudes toward sexual identities and abstinence, as these are potential indicators of teacher alignment, or misalignment, with

the curriculum as written. The pilot study also investigated preparation to teach health education.

Pilot study results indicated that 36% of the teacher respondents reported having no undergraduate coursework or professional development preparation to teach health. In 2013, Wiley, Wilson, and Zenger reported that 86% of South Carolina school districts self-reported providing professional development per the SC CHEA. At the time of the pilot study, it would seem that this was not the case for this particular county, as only 14% reported ever having had SC CHEA-related professional development.

Another area investigated in the pilot study was teachers' attitudes toward heteronormativity in the SC CHEA. For the sake of consistency, the 2005 voter poll used the term "homosexuality," so I used this term in my pilot study as well, despite the fact that this term is now considered outdated and unfavorable. One question in the pilot study assessed how teachers felt about including the topic of "homosexuality" in sexuality education. Nearly 11% thought instruction should treat it as unacceptable, 19% felt that schools should not discuss the topic, 58% thought the discussion should be limited to just facts without judgment, and 11% felt that instruction should present it as acceptable.

The 2005 poll conducted in South Carolina found that 57.6% of the population believed that homosexuality should not be taught or discussed at school (Alton, F. L., Oldendick, R. W., & Daughon, K. A., 2005). Only 30% of the teachers in the pilot study felt that homosexuality should be taught as wrong or not discussed at all in schools.

The pilot study was useful in tailoring the current study to better focus and articulate questions which aim to identify clearer patterns. It confirmed the need for

further investigation of the amount of preparation and professional development teachers have to teach health education, as well as their confidence in their ability to meet student needs and how they feel about LGBTQ inclusion in sexuality education.

### **Research Questions**

The research questions address the issues related to teacher training, self-efficacy, and attitude toward the heteronormative SC CHE curriculum. They are listed below.

1. How much preparation have teachers had to teach health education?
2. What levels of self-efficacy do health teachers report in teaching certain aspects of sexuality education?
3. To what extent do teachers' personal beliefs align or conflict with heteronormativity in the SC sexuality education curriculum?
4. What is the correlation between the constructs described in the first three questions and among these constructs and demographic variables?

These questions are answered using data from an online survey of middle and high-school health teachers.

### **Significance of the Study**

Data from this study identified participants' level of preparation, self-efficacy, and confidence in teaching the curriculum. It also ascertained the degree to which their personal beliefs align or conflict with the heteronormative aspect of the CHEA. These findings could help inform district-level administrators whether more professional development is warranted in not only teaching the sex education curriculum but also in working with LGBTQ students.

Data from this study strongly suggests adjusting the criteria for eligibility to teach health. If respondents showed low levels of self-efficacy correlating to the area of certification, districts could choose to reorganize schedules to restrict the teaching of the subject to the teachers specifically trained in health education. This study also indicated teachers' level of discomfort with teaching sex education. Most importantly, this study demonstrates whether teachers agree or disagree with the heteronormativity embedded in the state sex education curriculum.

This study is also significant in that it utilizes quantitative methodology in the theoretical framework of queer theory. In my literature review, I was unable to locate studies that employed this combination of queer theory with quantitative research design.

### **Data Collection**

Data collection occurred via an online survey between January 23 and February 8, 2018. Recipients received a reminder to complete the survey on January 29. I sent out a second batch of invitations to principals on January 30. I downloaded the results from SurveyMonkey into Microsoft Excel and removed responses from participants not teaching health at the middle school or high-school level. I converted the data from Likert-type responses into point values and then uploaded the data to IBM SPSS. I filtered the open-ended response items onto separate sheets of an Excel file. I describe the analysis of the data later in this chapter.

### **Recruitment of Participants**

The Institutional Review Board (IRB) at the University of South Carolina determined this study qualified for exempt status. This survey utilized snowball sampling, a method frequently employed in qualitative research. Snowball sampling is

defined as a method, “in which researchers ask the participants they have identified to tell their friends and acquaintances about the study” (Emerson, 2015). Through snowball sampling, I asked colleagues to refer me to participants, and then asked participants to forward the survey to other teachers who met the eligibility criteria.

At a conference for the South Carolina Association for the Advancement of Health Education (SCHAAHE), I made connections with several members who offered to assist me in my research. Members of SCAAHE provided me with two email lists. The first was a roster of Physical Education (PE) teachers from across the state who participated in a campaign to implement a physical fitness assessment program. This list included PE teachers from all grade levels. The second list included the email addresses of the principals of all public schools in South Carolina. The cover letter to the principal requested that they forward the survey link to the health teachers in their schools. I filtered out the data from the principals and retained the health teacher responses. I enabled principals to participate so they could preview the survey, but added a question asking if the respondent was an administrator to eliminate these results.

The PE teacher list included 1,447 email addresses but did not identify the grade levels taught by those teachers. The second list included the addresses of 1,258 principals' email address. After filtering out elementary schools, the list contained 521 addresses of middle and high school principals. I used SurveyMonkey to send an email invitation to all the PE teachers. I duplicated the survey and added a question asking whether the respondent was a teacher or administrator and SurveyMonkey sent that survey, along with a web link, to principals. The email message included the request for principals to forward the survey to teachers of health education in their schools.

In total, 1,968 people received email invitations to participate in the survey from SurveyMonkey directly. The survey link was forwarded to many others, as evidenced by the use of the web link, but it is impossible to know how many teachers received the forwarded link from their principals. It is possible that some teachers received the invitation twice. It is likely that many health educators did not receive the invitation from either source.

### **Response Rate**

To disseminate the survey, I used two lists of email addresses of middle and high-school teachers currently teaching health education (the 2017-2018 school year). The first list (1,447 addresses) was physical education (PE) teachers from across the state, at all grade levels. Of those, 606 (41.9%) opened the email, 696 (48.1%) remained unopened, and 138 (9.5%) bounced back. Seven teachers chose to opt-out, effectively blocking the email from SurveyMonkey. Of the 606 teachers who opened the email, 210 elected to respond to the survey, with 74.8% providing complete responses. An additional 50 respondents received an email link, presumably forwarded from a colleague. Of the 260 teachers who began the survey, 40% ( $n = 104$ ) were ineligible because they indicated they are not teaching health at the middle or high-school level this year.

The second email list was middle and high school principals. I requested that they forward the invitation to the health teachers in their buildings. This list generated 50 responses, with 37 of them meeting the eligibility criteria. It is possible that some teachers received the invitation twice. The closest approximation to response rate that I can determine is that from the 1,309 working email addresses from the PE teacher roster,

210 teachers responded to the survey. The rate is equivalent to approximately 16%, but it is important to note that many of the teachers who received the email likely read the invitation letter and knew they were ineligible to participate.

Health education is often provided by content specialists other than just PE teachers, including middle-level science, biology, family and consumer science, and other teachers as well. A report provided by the South Carolina Division of Health and Environmental Control (SC DHEC) indicates that there are 1,691 teachers at the middle and high-school level delivering the health curriculum across the state in 2017-2018 (SC DHEC, 2018). Just over 10.7% of the target population responded to this survey. One important difference between the sample and the target population is that most of the survey respondents are PE teachers, whereas many schools embed health education within other courses, especially at the middle level, such as science or family and consumer science. In many middle schools, the general science teachers provide health education in addition to science within the school year. It is possible that their responses would not follow the patterns identified in the survey respondent data.

### **Respondent Characteristics**

The following paragraphs will provide descriptive statistics of respondents. Of the teachers who responded, 51% ( $n = 92$ ) were teaching in a middle-school setting, 45% ( $n = 82$ ) were in a high-school setting, and 4% ( $n = 7$ ) taught in a combination of elementary, middle, and high schools. The majority of teachers who responded to this survey self-identified as male, heterosexual, white, Christian, and experienced health educators. Further description of the characteristics showing more variance than others follows in later sections.

The first characteristic of note is the years of experience the teachers have teaching health education. As figure 3.1 depicts, this group of respondents is seasoned, with 57.5% ( $n = 101$ ) having 10 or more years' experience. Slightly more than a third have 16 ( $n = 61$ ) or more years' experience. The age of this group reflects that amount of experience, with 56.8% ( $n = 75$ ) of respondents indicating their age to be 41 or older. Only 11% ( $n = 20$ ) are age 30 and younger (see figure 3.2).

The identified gender of respondents of the health survey is markedly different than the SC teacher population as a whole (SCDE, 2017), but similar to the distribution of health and PE teachers across the U.S. in 2011-2102 (NCES, 2013). There was a slightly higher percentage of male-identifying respondents in the survey than female, and four respondents either declined to identify their gender or categorized it as "other." In many schools, there are nearly equal numbers of male and female PE teachers, which might explain this difference. See the table 3.3 for comparison.

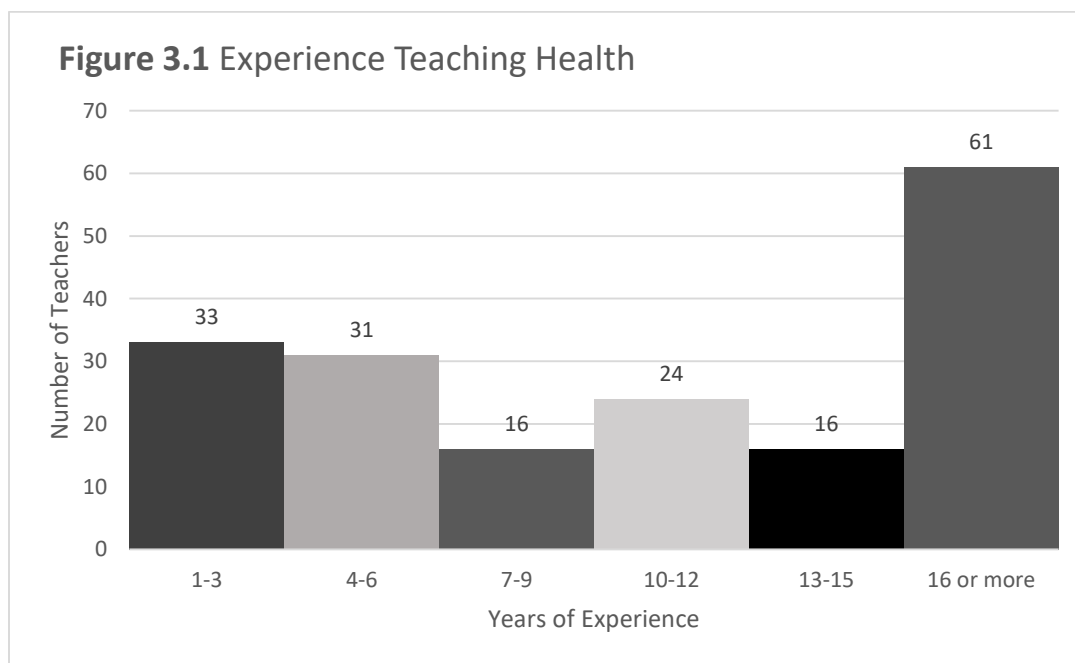


Figure 3.1. Years of Experience Teaching Health



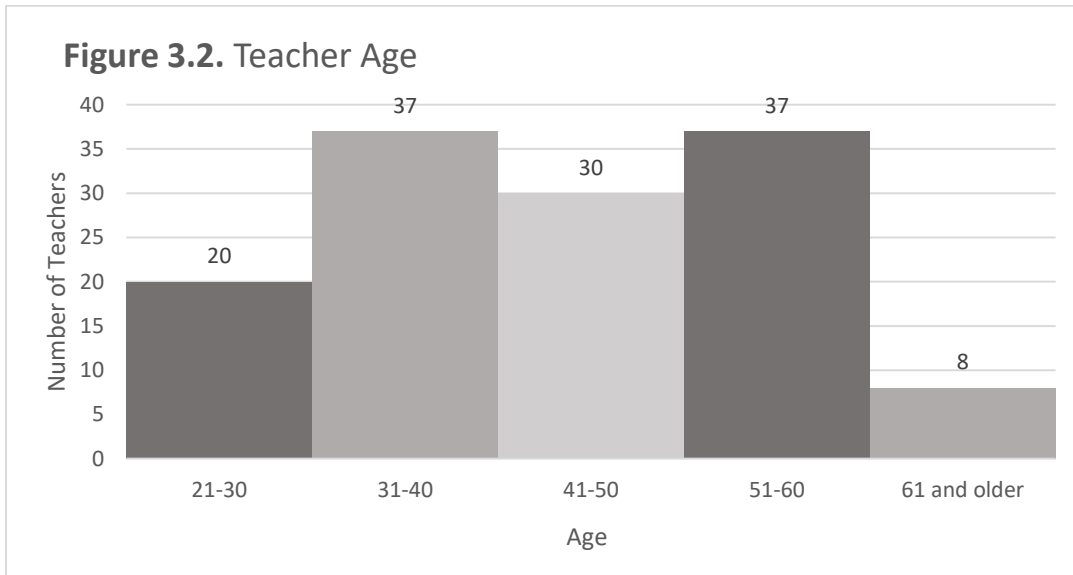


Figure 3.2. Teacher Age

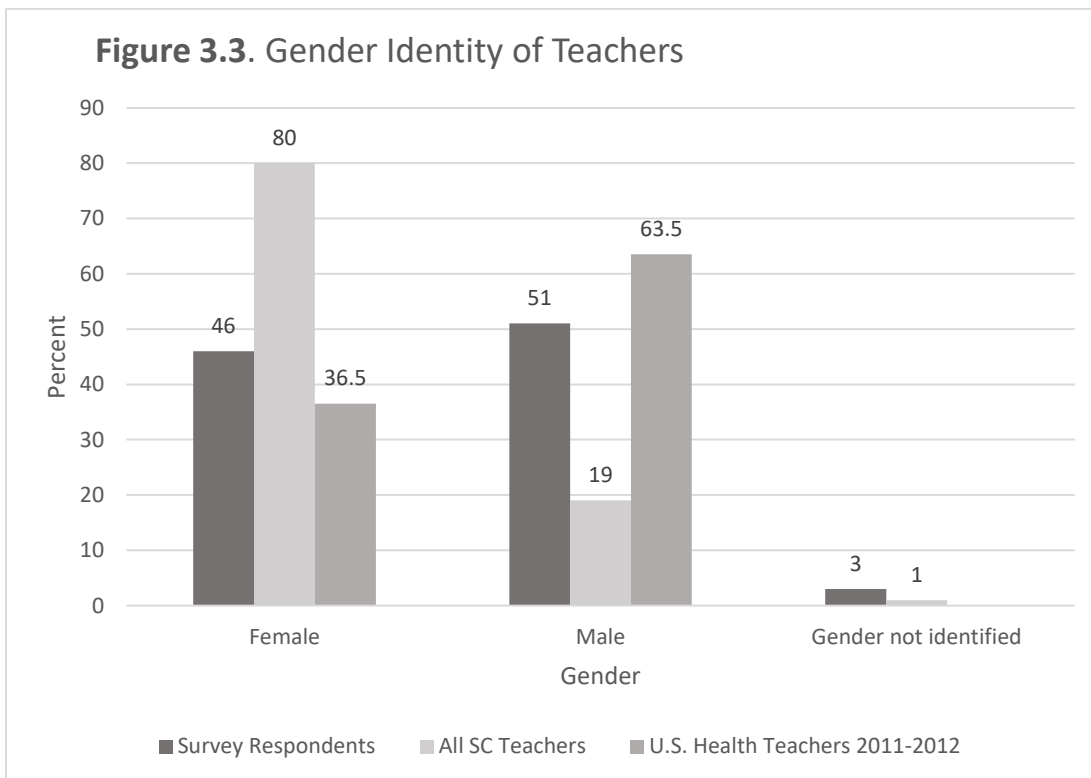


Figure 3.3. Gender Identity of Teachers

## **Summary of Respondent Characteristics**

The 181 respondents represent approximately 10.7% of the teachers responsible for health education in SC public middle and high-schools for the 2017-2018 school year. Many of the respondents are veteran educators, and nearly 57% are 41 years of age or older. Gender characteristics show nearly even numbers of male and female respondents with 61 respondents identifying as female, 67 as male, two as other, and two preferred not to answer. Additional demographic data are explored in correlation to the *Attitude Toward Heteronormativity* subscale in Chapter Four.

## **Instrument**

The survey instrument (see Appendix B) includes questions which combine to form three subscales, measuring respondents' levels of preparation to teach health, self-efficacy, and attitudes toward heteronormativity. The survey also includes demographic questions and open-ended response items. The demographic questions are included to compare the sample population with the target population. The open-ended items allow respondents to report LGBTQ-related comments from students and colleagues, as well as how they responded to these comments. The open-ended items also ask respondents about LGBTQ-supports for students and what, if any, conflict they feel between their personal beliefs and professional obligations. Following the collection of the data, the analysis identified patterns of similarity as well as the wide-ranging discordance among the voices of participants.

The following sections will explain the development of the three subscales. The *Teacher Preparation Subscale* explored first, followed by the *Self-Efficacy Subscale* and, finally, the teacher *Attitude Toward Heteronormativity* subscale. Analysis of the data

from these subscales, in conjunction with the open-response item data, is explored later in the chapter to answer the original research questions

### **Development of the Teacher Preparation Subscale**

Extensive research failed to identify an existing scale to measure teachers' levels of preparation to teach health education. As a result, I developed a scale based on teachers' undergraduate and graduate-level degrees, areas of certification, and Certified and Master Certified Health Education Specialist (CHES and MCHES) credentials. The following paragraphs will explain the point values assigned to different attributes.

The survey included questions asking teachers not only about their majors and areas of concentration for all degree levels but also included questions about the number of health-related courses taken while earning those degrees. The inclusion of this question seemed redundant but helped identify the correlation between various major fields of study and the mean number of health-related courses for respondents. The variable of "health-related coursework" was not defined, leaving respondents to interpret it subjectively. To reduce the effect of this subjectivity, I used the mean number of courses for all respondents indicating a particular major field of study and applied it to assign point values for various major fields of study. The number of courses was multiplied by three to increase differentiation among the scores.

The *Teacher Preparation Subscale* score is the sum of points from undergraduate majors, graduate degrees, areas of teacher certification, and advanced health credentials. The National Commission for Health Education Credentialing (NCHEC) offers Master Certified Health Education Specialist (MCHES) or Certified Health Education Specialist (CHES) credentials to candidates with either a major in health education or at least 25

semester hours of health-education related coursework (NCHEC, 2018). CHES is a voluntary professional certification program that establishes a national standard for health educators. Teachers with CHES or MCHES credentials received an additional 12 points. The sum of the points for educational background, certification, and CHES determined the *Teacher Preparation Subscale* score. The maximum possible score is 87. The table below summarizes the points assigned to the different characteristics including the point values assigned to each characteristic.

Table 3.1

*Point Values Assigned to Characteristics from the Teacher Preparation Subscale*

Characteristic	Points Assigned
<b>Bachelor Major Field of Study</b>	
Health	21
Dual Health/PE	18
Kinesiology, Nutrition, Exercise Science	18
PE, Family & Consumer Science, Sports Med/Management	12
Biology, General Science, Sociology, Elem. Ed.	3
<b>Graduate Major Field of Study</b>	
Health, Public Health	18
Exercise Science with Health Concentration	12
PE, Mental Health, Family & Consumer Sciences	9
Biology, Gen. Science, Sports Med/Management, Counseling	6
<b>Teaching Certification</b>	
Health	12
PE, Middle-Level Science, Biology, Family & Consumer Sci.	3
<b>Certified Health Education Specialist (CHES) Credential</b>	
Regular or Master CHES	12

*Note.* Corresponding point values assigned to various characteristics of the *Teacher Preparation Subscale*.

### **Development of the Self-Efficacy Subscale**

The 2015 pilot study revealed that many teachers did not feel confident in their ability to teach health effectively. This subscale was constructed to measure teachers' self-efficacy in three domains: their valuation of teaching certain concepts, their perceived competence in teaching those subjects, and their ability to increase student knowledge of those concepts. Likert-type items, using a six-point scale, asked respondents to identify their levels of agreement or disagreement with five topics. The topics included pregnancy prevention, sexually transmitted infections (STIs), reproductive anatomy, puberty, and same-sex behaviors in the context of disease. The last topic was specifically constructed to align with the SC CHEA restrictions on discussions of "alternate sexual lifestyles" (SC CHEA, 1988).

### **Development of the Attitude Toward Heteronormativity Subscale**

The third subscale asked respondents to identify their level of agreement or disagreement with 10 items regarding LGBTQ people and issues. For this subscale, 156 respondents responded to all 10 items. The minimum possible score was 10, and the maximum possible score was 60. The first five items related to the LGBTQ-restriction in the SC CHEA and LGBTQ-inclusion in the school setting. The second five items asked respondents about LGBTQ-related topics in general, including same-sex marriage. All items were Likert-type with 6-point anchors. Higher scores indicated more conflict with heteronormativity and lower scores indicated more agreement with it. Four items required reverse coding as they were oppositely worded. An example of this is the item, "Marriage should only be between a man and a woman." In this instance, a response of "strongly agree" would be coded with the lowest point value, one, instead of the highest.

For the six other items, “strongly agree” added six points to the score. Higher scales indicate a greater conflict with heteronormativity and lower scales indicate more agreement with it. Scores on the subscale ranged from 11 to 60, with a mean of 38.33. Cronbach’s Alpha for the reliability of this subscale was 0.870 for the 10 items.

Table 3.2

*Analysis of Items from the Attitude Toward Heteronormativity Subscale*

Subscale Items	Mean	Std. Deviation
I can accept LGBTQ people.	5.16	1.13
I would/do feel comfortable teaching students who are "out" as LGBTQ youth.	4.34	1.63
I have conflicting attitudes or beliefs about LGBTQ people.	4.24	1.65
It is appropriate for middle and high schools to encourage appreciation of individuals with LGBTQ identities.	4.11	1.61
It is important to include examples of LGBTQ people in sex education materials.	3.85	1.71
It is appropriate for middle and high-school students to learn information about individuals who are attracted to persons of the same sex.	3.83	1.67
Sexual identity (for example gay, bisexual) is a choice.	3.47	1.84
The SC CHEA should NOT be amended to remove "alternate sexual lifestyles" restriction.	3.17	1.79
People who are transgender are born that way.	3.11	1.64
Marriage should only be between man and woman.	3.04	2.05

*Note.* Mean and standard deviation of items from heteronormativity subscale responses ( $n = 156$ ).

The statement, “I can accept LGBTQ people had the highest mean score of 5.16 with a standard deviation of 1.13. The item with the lowest mean, of 3.04 and standard deviation of 2.05, was, “Marriage should only be between man and woman.”

The higher standard deviation indicates there was less agreement among the individual scores and more variability. The item which, if eliminated, would most increase the reliability is, “Sexual identity is a choice.” Removing this item would increase the reliability from 0.870 to 0.881. Table 3.2 displays item analysis of the *Attitude Toward Heteronormativity Subscale*.

### **Data Analysis**

Before uploading the data into SPSS, I created a codebook detailing the transcription of the data into numeric form. For the Likert-type items, I assigned points to each anchor. For most items, “Strongly Agree” was assigned one point, except in the case of the four reverse-scored items on the heteronormativity subscale. I created three variables which combined items to form the subscales. For the Teacher Preparation Subscale, scores from educational background, teacher certification, and additional credentialing combined into a single subscale score. Similarly, I combined items to form the *Self-Efficacy Subscale* and *Attitude Toward Heteronormativity subscale*.

Calculating Cronbach’s alpha verified the reliability of each subscale. Descriptive statistics included frequencies, means, and standard deviations for each item. Bivariate Pearson correlation calculations examined relationships between subscales in pairs. Lastly, univariate analysis of each subscale and demographic variables was performed to seek correlations among them. Chapter Four presents the results of these analyses.

I analyzed the open-response data separately then combined the results into the sections in Chapter Four. Open response items #18-21 included multiple questions within a single item. The first item asks if a teacher has heard students make LGBTQ-

positive comments, if so, what they were, and how the teacher responded to the comment. For each item similar to this, I copied responses onto three Excel spreadsheets. The first sheet was coded based on whether or not the teacher had heard such comments. The second sheet grouped responses based on the nature of the comment. The third sheet grouped teachers' responses to the comments when indicated.

I analyzed the first four open-ended items, as well as the remaining open-ended questions, according to this process. Data were color-coded with similar themes and then sorted and resorted as patterns emerged. I performed this process twice for each response and examined the results for consistency. After separately analyzing the open and closed-response data, I synthesized the two in narrative paragraphs in Chapter Four. Pertinent quotes from open-ended responses also appear in Chapter Five to support recommendations for applications and future research.

### **Limitations**

The highly controversial nature of this topic was the primary limitation of this research study. Other limitations included gaining access to participants, the reluctance of participants to respond, and the possibility of participants not responding honestly due to the controversial nature of the topic. The survey begins with less controversial questions regarding educational background and places questions regarding teacher attitude toward the heteronormative curriculum at the end of the survey. This placement was intended to minimize participants' discomfort and to increase the chance that participants will complete the survey they have already begun, despite this discomfort. An additional limitation was that in using this survey method, I was unable to follow up with respondents for clarification on open-ended responses. It is important to note that



data are self-reported. This is particularly relevant for the self-efficacy subscale, and the findings from this subscale will elaborate on this limitation in Chapter Four.

Another limitation to consider is the survey instrument and method of delivery. The survey included original items and items borrowed or adapted from other instruments. The method of distribution could be considered a limitation. I wanted to provide the respondent an opportunity to find a private space in which to complete the questionnaire. As this was an online survey, the respondent needed access to a computer in a location free from close observation. Some teachers may have chosen to complete the survey at home for more privacy, but this could also make the respondent feel more likely to be identifiable. While confidentiality was assured, anonymity was impossible due to the likelihood that some respondents could be identifiable based on unique demographic or education criteria. This fear of identification might have dissuaded respondents from answering any, or some, of the questions.

Gaining approval from various agencies to administer the survey was also a limiting factor. I exercised caution in writing questions that might be considered offensive in language. I removed several items from the draft version to reduce the possibility of offending the persons who would help me access lists of health teachers. When I contacted school district coordinators for health education, all who responded indicated that their districts followed rigorous protocols for allowing research. Based on initial responses, I did not feel confident that approval was likely, so I discontinued pursuit of district permission. The difficulty in gaining access to participants significantly influenced the design of the survey.

## **Scope and Delimitations**

The study's delimitations primarily concern the size and distribution of the population of interest. The email rosters for the survey distribution could not assure that a representative sample of all teachers of health education received an invitation to participate. The sensitive nature of the survey and the difficulty in obtaining access to health teachers made it challenging to obtain a representative sample. However, replication of this study in a stratified random sampling of districts of various sizes and geographic distribution would permit more robust generalization to a population more reflective of the entire state of South Carolina.

The choice to utilize a survey with open and closed-response questions reflects my desire to encourage participation from as many teachers as possible. I assumed that teachers were more likely to respond honestly in a confidential, private setting rather than a public setting such as a focus group or individual interview. The response rate confirmed that I was able to collect more responses this way than by using follow-up interviews.

## **Positionality and the Role of the Researcher**

As a former health educator with the Peace Corps, I identify health education as critically important to overall quality of life. While serving in the Peace Corps, one of my responsibilities included promoting birth-spacing including the use of contraception, to improve the health of women and children. As a result of this experience, I saw the value in health education as it had profound effects on communities. This experience also helped me understand the delicate nature of sexuality education in a conservative Muslim nation where there is little discussion of sexuality.

I possess certification to teach elementary, middle-grades math and middle-grades science and have taught middle school in South Carolina for almost 20 years. During several of those years, I taught health as an embedded course within a regular science class. In effect, this resulted in teaching one year's worth of science in addition to nine weeks of health education during a single school year. I found it difficult to teach either subject well and felt frustrated with the perceived lack of importance assigned to health education.

As a middle-level teacher in a conservative, southern state, I identified parallels between my Peace Corps experience and teaching health. Cultural barriers to medically-accurate information, coupled with obstructions imposed by sexism and heteronormativity, created a sense of moral obligation to respond to this identified need. In conversations with teacher colleagues, I gleaned the sense that LGBTQ students and issues ranked low in importance. I also heard many teachers discuss their unease with teaching sex education and the conflicts they felt between their personal beliefs and the curriculum. Based on these observations, as well as interactions with LGBTQ students, I chose to investigate the teachers' attitudes toward heteronormativity in the sex education curriculum, as well as their attitudes toward implementing the curriculum.

During the 2016-17 academic school year, I served on a local school district's advisory committee to assist in selecting new sexuality education curriculum materials. I attended professional development on implementing the new curriculum as well as several other professional development opportunities provided by the South Carolina Campaign to Prevent Teen Pregnancy (SC Campaign). I also served as a member of the community advisory board for Teen Pregnancy Prevention. These experiences allowed

me to gain insight into multiple perspectives and attitudes toward the importance of sexuality education as well as the valuation of LGBTQ issues in this particular county. My impression was that many teachers and community members were uncomfortable discussing sexuality education and the inclusion of LGBTQ students. In multiple conversations, I heard people express conflict with teaching sexuality education in any way except abstinence-only until marriage. I also heard teachers express anti-LGBTQ sentiment and resistance to changing the curriculum to become more inclusive. Though I am no longer an employee of that school district, nor a member of that community, I sense that teachers in many counties across the state share similar perspectives. My goal in this study is to measure the range and frequencies of perspectives.

### **Validity**

This quantitative study incorporates many open-ended response items to support the findings. Whereas it is not a mixed-methods study, it follows many similar principals in assuring validity. Validity in mixed methods research reflects the quality of inference drawn from the research phase. Tashakkori and Teddlie (2003), contend that two aspects of the research, namely quality of design and rigor of interpretation, determine the quality of inference. The authors propose that the information gathered in mixed methods research is meta-inference. They describe this meta-inference as “an overall conclusion, explanation, or understanding developed through an integration of the inferences obtained from the qualitative and quantitative strands of a mixed-methods study” (Tashakkori & Teddlie, 2003, p. 101). Multiple types of validity will examine the quality of inference drawn from the data.

Content validity analyzes how well an instrument's content measures the construct it is intended to measure (Johnson & Morgan, 2016). An extensive literature review preceded writing the survey scales and interview questions. The literature review provided historical background as well as a contemporary understanding of teacher preparation, teacher self-efficacy, and heteronormativity. Expert review by one of the dissertation committee members was provided for the scale on self-efficacy (C. Brant, personal communication, 2017). The survey questions are written precisely to measure the intended constructs to ensure content validity. Inferences drawn from the survey and data will provide evidence for content validity.

Each of three constructs will be examined independently in the following paragraphs. It is necessary to operationalize each of the three constructs examined in this study before explaining the instrumentation used to gather data.

Teacher preparation to teach health education is the first subscale on the survey. Questions on the subscale asked participants about the number of college courses taken in health education, days of professional development, membership and certification and membership in health education-related professional organization. Operationalizing this construct in a broad frame increased the chances of variability across the data. The variability is desired to allow for more robust discrimination among groups (e.g., Are groups significantly different? How do groups differ?).

The second construct, self-efficacy, is measured primarily in the second subset of questions on the survey in three groups of questions: competence, the value of topic, and ability to affect outcome. These three groups are the foundation of Bandura's theory of

self-efficacy and should evidence construct validity (Bandura, 1977). All three groups of items are Likert-type stems with a six-point scale.

The third construct examines teachers' attitudes toward heteronormativity in two items with five stems each. Item number 16 has five stems which relate to the CHEA Act and LGBTQ inclusion in instruction. Item 17 gauges attitude toward LGBTQ people and rights. The first three stems are similar to items from the LGB-KASH Factor Structure Instrument (Worthington, Dillon, & Becker-Schutte, 2005).

Careful research design with a thorough review of related literature increases the likelihood of construct and convergent validity, but it is the inferences drawn from the data that provide evidence of this validity.

### **Reliability**

The consistency of measures influences the reliability of data. (Trochim & Donnelly, 2008). The estimate is appropriate for a single measurement instrument administered on one occasion. The reliability estimates how well the items from the same construct produce similar results. (Trochim & Donnelly, 2008). For each of the three subscales, I computed Cronbach's alpha to find the mathematical equivalent of all possible split-half estimates of reliability. Results of 0.7 or higher are considered acceptable. Estimating reliability of the open-ended responses is more complicated. Without using interrater reliability measures, it is difficult to assess the reliability of the open-response data. I investigated this consistency by comparing survey data from the first part of the survey with the open-ended items for each survey participant to identify patterns to support reliability.

## **Summary of Research Methods**

Chapter Three outlines the research design and justifies the use of quantitative research framed in queer theory. Results of a pilot study explain the changes to the current study. The significance of the study, research questions, and study context support that this study is relevant because of the lack of similar research. Chapter Three also explains the identification, recruitment, and characteristics of respondents. Also included in this chapter is a description of the development of the survey instrument, followed by expectations for reliability and validity. Chapter Four provides an analysis of the data and discussion of the findings.

## Chapter Four

### Data Analysis

This chapter provides analysis of the data by each research question and discussion of the findings. The chapter concludes with a summary of the analyses.

#### Teacher Preparation Subscale Findings

The first research question asks, “How much preparation have teachers had to teach health education?” Data from the *Teacher Preparation Subscale*, additional survey items, and data from open-ended response items provide insights into this question.

The *Teacher Preparation Subscale* ranges from 0 to 87. The maximum score would indicate the respondent earned a Bachelor’s, Master’s, and Doctor’s degree in health education, possesses health teacher certification and CHES or MCHES credentials. The highest score from any single respondent was 57, which is 65.5% of the maximum possible score.

The survey respondents’ data indicated that 82% (n=181) have undergraduate degrees in PE, health, or both. The data is consistent with the 2013 NCES report, showing 82.9% of health and PE teachers across the US have undergraduate degrees with health and PE as a major field of study. Similarly, 92% of respondents indicated SC teacher certification in PE, which is not surprising as the primary source of recruitment was a roster of PE teachers.

Respondent scores on the *Teacher Preparation Subscale* ranged from zero to 57, with a mean score of 20.6 and standard deviation of 8.6. The Cronbach’s alpha for the



subscale is 0.225, which is quite low. Including more items on this scale could improve this value. Also, the item, “doctoral degree with point values” reduced the reliability of the scale from .295 to 0.225. Only four out of 181 respondents indicated having a doctoral degree, and only two of those were in health-related fields. The candidate with a doctoral degree in health education and promotion received an additional 24 points, with another candidate receiving nine points for a doctoral degree in immunology. The other two doctoral degrees were not related to health and therefore did not add points to the teacher preparation scale. Combining the three degree levels (Bachelor’s, Master’s, and Doctor’s degrees) into a single variable increased Cronbach’s alpha to 0.292. This subscale would benefit from further development.

The mean score of 20.6 is 23.7% of the maximum possible score. If a health teacher has an undergraduate degree in health as well as certification to teach the subject, then that person’s score is 33 on the *Teacher Preparation Subscale*. Only 7.7% of survey respondents had a score of 33 or higher, indicating most teachers delivering the health content do not have degrees or certification in health education. Figure 4.1 shows the distribution of the scores. It is important to note there is a 15-point difference between the highest (57) and next-highest (42) score.

An open-ended response item, not included as part of the *Teacher Preparation Subscale* score, confirms the lack of preparation. The item asks, “Throughout your career, approximately how many days of district-provided professional development have you received to teach health, including instructions on Erin’s Law and school-approved curriculum?” Per the SC CHEA, districts are required to provide professional

development (PD) opportunities to health educators. There are no specific guidelines for the nature, frequency, duration, or accountability for this mandate.

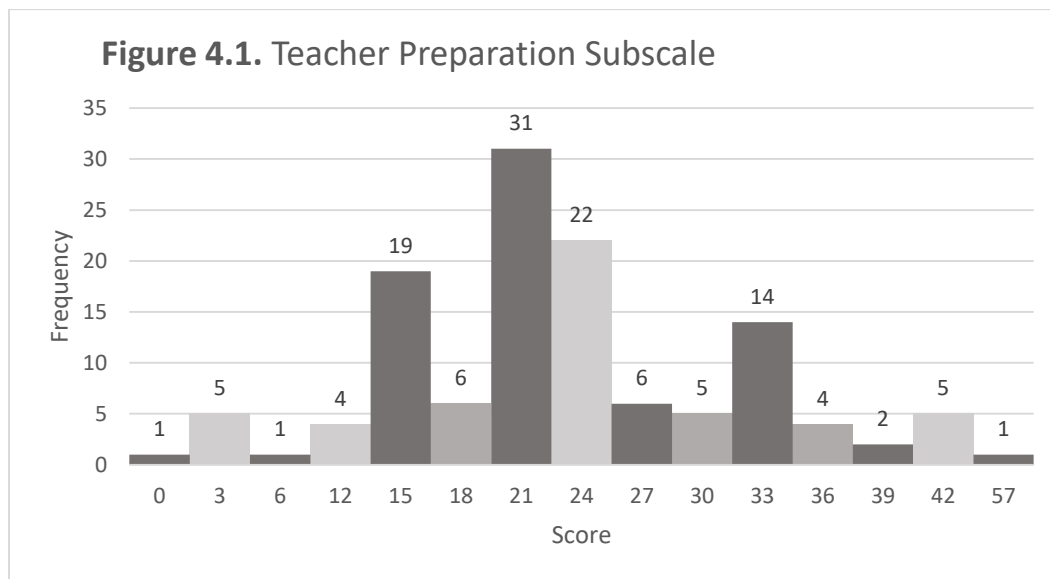
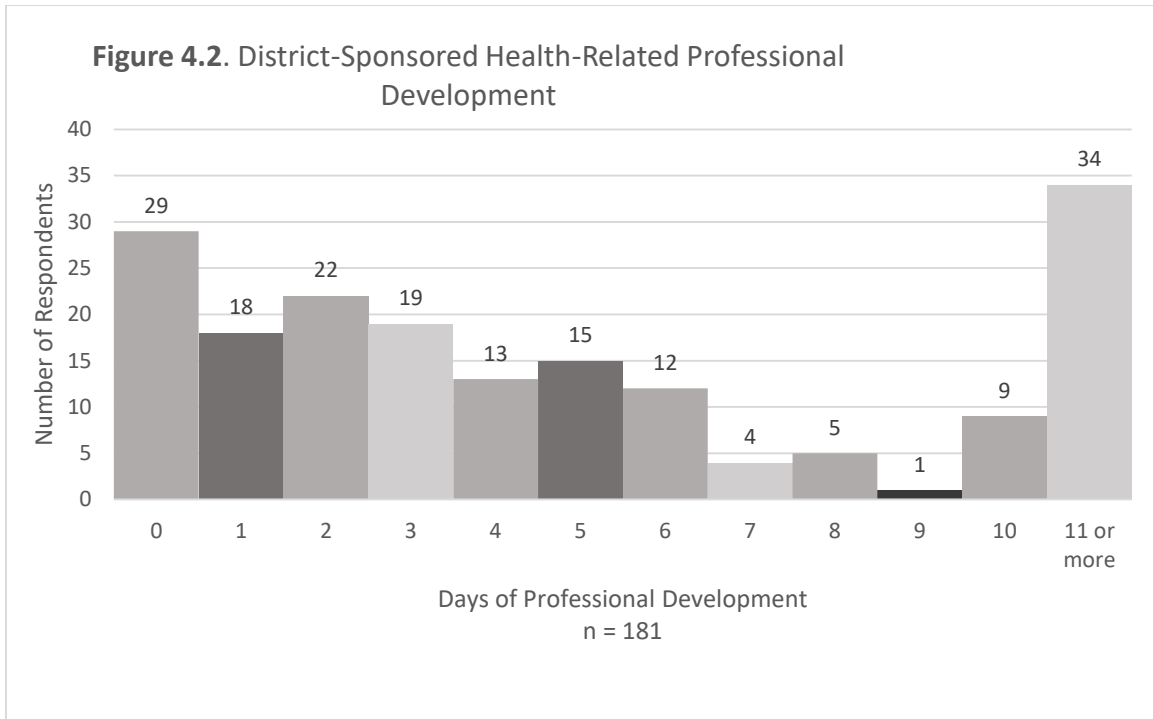


Figure 4.1. Teacher Preparation Subscale

Slightly more than one-third (n=61) of the respondents have 16 or more years of experience teaching health education. According to the response data, 34 teachers indicated having 11 or more days of PD. Even if districts were providing only one day per year of PD for health teachers, the number of respondents indicating 11 or more days of PD should be nearly double. One interesting finding was the number of respondents indicating that they have had no health-education professional development. Of the 181 respondents, 29 indicated having zero days of PD for health education. Figure 4.2 shows the results from this question. Not only do many teachers show minimal preparation to teach health education before they enter the classroom, but many also do not receive health-related professional development, either. Respondents indicated a wide range of responses to the number of days of health-related PD (see Figure 4.2).



*Figure 4.2. District-Sponsored Health-Related Professional Development*

As mentioned in Chapter Two, no colleges or universities in SC offer programs leading to teacher certification in health (SCDE, 2018). It is possible to obtain an “add-on” certification with 24 hours of coursework. One respondent, out of the 181, indicated this path. Only 2.2% ( $n=4$ ) respondents hold undergraduate degrees in health education. An additional 17.7% ( $n = 33$ ) earned dual degrees in PE and health. More than 80% of survey respondents are teaching health without undergraduate degrees in health education. In contrast, in 2011-2012, 78.3% of science teachers held undergraduate degrees in science (NCES, 2013). Certification requirements for teaching health are markedly different than from other subjects. This disparity indicates the lack of importance assigned to health education in SC. One respondent wrote,

Health is the most unappreciated and underrated subject in SC public schools.

Proper health instruction should be the most important thing because if students

are NOT mentally and physically healthy, they will not learn at their peak potential. The law requirement for health instruction in elementary schools is not being followed and most districts have no staff development for teaching health. Laws must be changed and FOLLOWED and districts must be punished if proper health instruction is not provided.

It would seem likely that if health education were a priority, more teachers would demonstrate greater amounts of preparation, including advanced degrees. Four respondents indicated Master's degrees in health education, one in public health, one in clinical mental health, and two with a combination of health and exercise science. Out of 181 respondents, 4.4% hold graduate degrees in health education or health-related fields. Only one respondent from the survey indicated a doctoral degree in health.

Another indicator of teacher preparation is CHES or MCHES certification. Of the 181 respondents, 6.7% ( $n = 12$ ) indicated possession of this credential. Similarly, The National Board for Professional Teaching Standards (NBPTS) offers National Board Certification (NBC) in many different subject areas, including health education (NBPTS, 2018). South Carolina ranks second in the nation for percentage of teachers with NBC. Of the teacher population, 17.96% ( $n = 9,028$ ) have NBC. Of these, only six (0.00066%) have NBC in health education (NBPTS, 2018).

Responses from the open-ended survey items also indicate the lack of preparation for many teachers of health education. When asked about conflicts with the content, one teacher wrote, "No. I am just not totally qualified to teach the material. Just do the best I can."

The survey respondents, who account for approximately 10.7% of the target population, do not indicate robust preparation to teach health education. Of the respondents, 47% scored 15 or fewer points. A Bachelor's degree in PE with PE certification is equal to 15 points. One respondent scored 0 points, listing an undergraduate degree and certification in art, but currently teaching health education in a middle school. The respondent with the highest score indicated a Bachelor's degree in PE, a Master's degree in Health Education, PE certification, Health Certification, and CHES credential, with a *Teacher Preparation Subscale* score of 57. The next highest score was 42, less than half the maximum *Teacher Preparation Subscale* score. From this analysis, the survey respondents do not demonstrate extensive preparation to teach general health, let alone sexuality education. The next section will analyze how these teachers and their self-efficacy in teaching health education.

### **Teachers' Levels of Self-Efficacy Findings**

Whereas the first research question analyzed teacher preparation for health education at large, the second question focuses on one particular aspect of health education. Research question two asks, "What levels of self-efficacy do health teachers report in teaching certain aspects of sexuality education?" Three constructs determined self-efficacy: valuation of the material, the sense of competence in educating students, and their ability to affect student knowledge. The three identified constructs emanate from Bandura's theory of self-efficacy (Bandura, 1977). The *Self-Efficacy Subscale I* created uses Likert-type items on a six-point scale. Respondents were asked to rate five topics' importance in teaching, their competence in teaching it, and how much their students' knowledge levels would change as a result of their instruction.

From the 176 responses, scores on this subscale ranged from 15 to 90, with a mean of 76.15, or 84.5% of the maximum score. The Cronbach's alpha reliability statistic for this subscale was 0.94, an indication that the items were measuring the same construct. The three items related to same-sex behaviors showed the lowest means and highest standard deviations. The item with the lowest mean score, 3.82, was the last, "As a result of my instruction, my students will know more about same-sex behaviors in the context of disease prevention." This item had the highest standard deviation, 1.88, indicating that scores were wide-ranging and more spread out. The item with the highest mean, 5.69, was "It is important to teach students about sexually transmitted diseases." This item had the lowest standard deviation, indicating the scores had less variability and fewer extremes. Table 4.1 displays statistics from individual items.

Table 4.1

*Self-Efficacy Subscale Item Analysis*

Self-Efficacy Subscale Item	Mean	Std. Deviation
It is important to teach students about sexually transmitted diseases	5.69	0.77
It is important to teach students about pregnancy prevention	5.60	0.82
It is important to teach students about puberty	5.45	0.85
It is important to teach students about reproductive anatomy	5.44	0.92
I feel competent educating students about reproductive anatomy	5.20	1.21
I feel competent educating students about puberty	5.20	1.21
As a result of my instruction, my students will know more about sexually transmitted diseases	5.18	1.15
I feel competent educating students about sexually transmitted diseases	5.15	1.24
I feel competent educating students about pregnancy prevention	5.14	1.26
As a result of my instruction, my students will know more about puberty	5.10	1.17
As a result of my instruction, my students will know more about pregnancy prevention	5.05	1.30

As a result of my instruction, my students will know more about reproductive anatomy	5.04	1.25
It is important to teach students about same-sex behaviors in the context of disease prevention	4.86	1.50
I feel competent educating students about same-sex behaviors in the context of disease prevention	4.22	1.80
As a result of my instruction, my students will know more about same-sex behaviors in the context of disease prevention	3.82	1.88

Note. Mean and standard deviation for the 15 items on the self-efficacy subscale ( $n = 176$ ).

Despite the lack of preparation indicated by the *Teacher Preparation Subscale*, many teachers demonstrated high levels of self-efficacy. It is important to note that these measures are self-reported. The lowest score possible is 15, and the highest is 90.

Teacher scores ranged from 15 to 90, with a mean of 76.15. Distribution of the scores is shown in Figure 4.3.

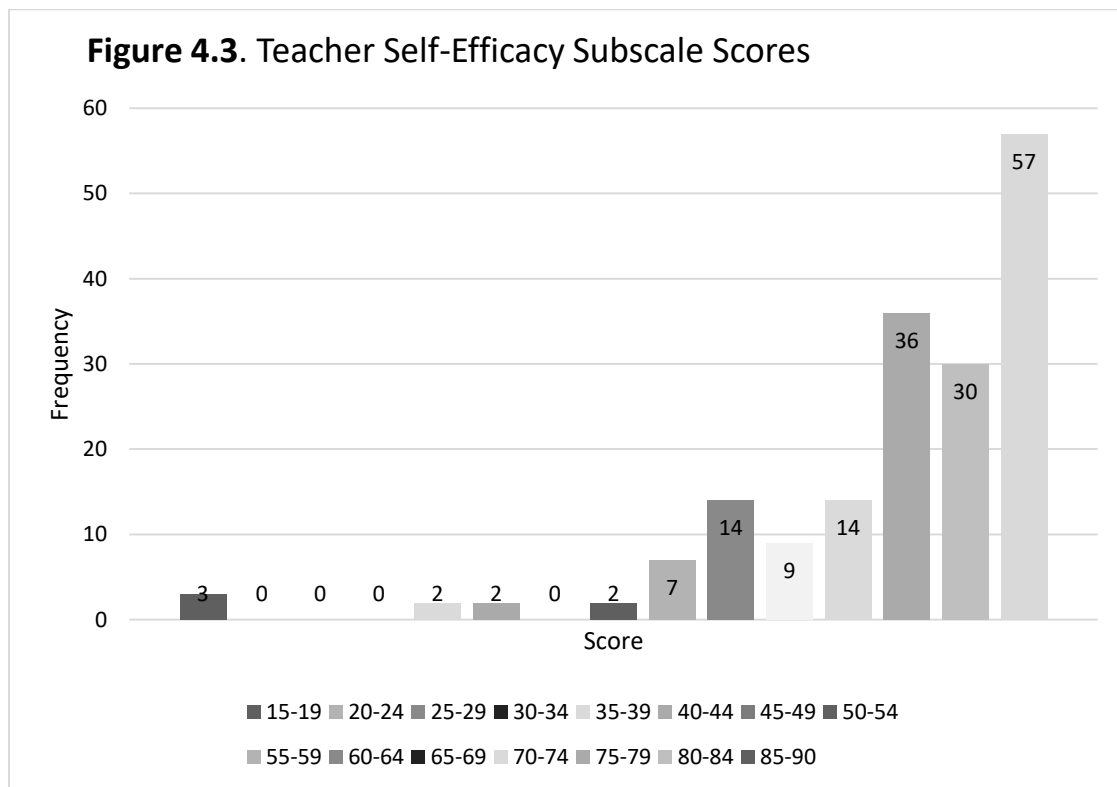
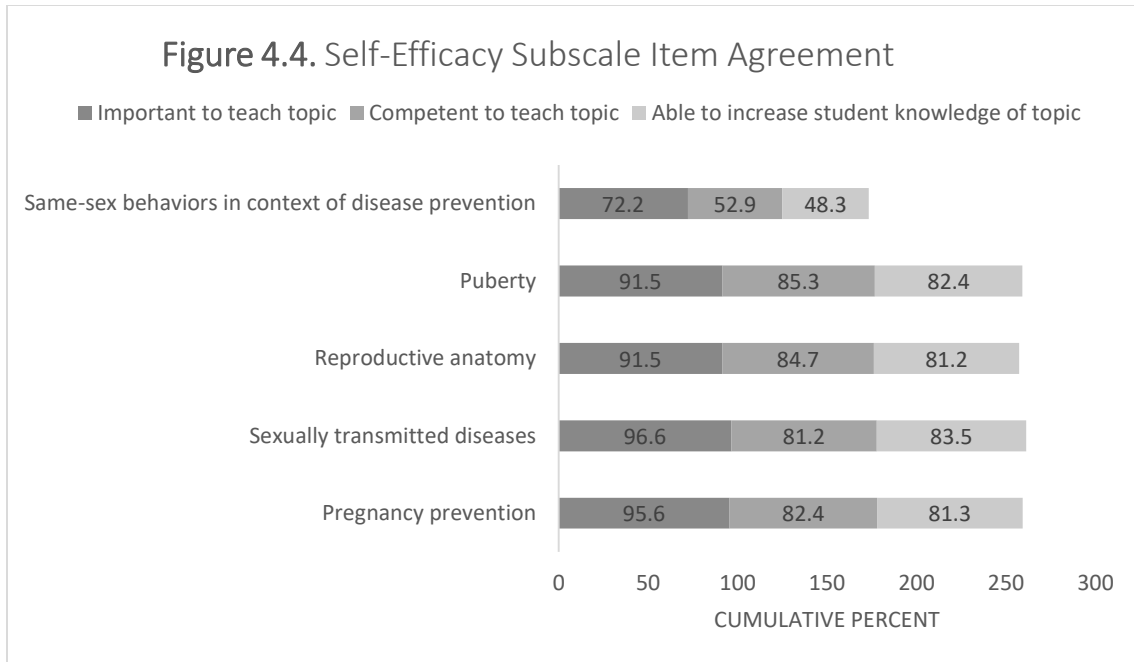


Figure 4.3. Teacher Self-Efficacy Subscale Score Distribution



*Figure 4.4. Respondents Who Agree or Strongly Agree with Self-Efficacy Subscale Topics*

The items on the *Self-Efficacy Subscale* are focused on aspects of sexual health, such as reproductive anatomy and sexually transmitted infections. The three items related to same-sex behaviors showed the lowest means and highest standard deviations. The item with the lowest mean score, 3.82, was the last, “As a result of my instruction, my students will know more about same-sex behaviors in the context of disease prevention.” The item with the highest mean and lowest standard deviation was, “It is important to teach about sexually transmitted diseases,” with a mean score of 5.69. The two items that showed the lowest inter-item correlation were, “It is important to teach reproductive anatomy” and “As a result of my instruction, my students will know more about same-sex behaviors in the context of disease prevention.” The inter-item correlation for these two items was 0.189. The two items with the highest inter-item correlation, of 0.953,



were “I feel competent educating students about sexually transmitted diseases,” and “I feel competent educating students about puberty.”

The greatest gap is with teaching same-sex behaviors in the context of disease prevention. Just over 72% of teachers ranked this as important to teach, but only 52.9% indicated confidence in teaching the topic, a difference of 19.1%. Although teaching students about the ways sexually-transmitted infections are transmitted through same-sex behavior is permissible according to the SC CHEA, the data reveal that nearly half of the respondents do not feel competent to teach this content. Some respondents indicated in their open-ended responses that the topic of same-sex behavior was forbidden in their district, despite the SC CHEA mandate that discussion of “alternate sexual lifestyles” is permitted but restricted to the context of disease prevention (SC CHEA, 1988). One respondent wrote, “I feel that we should be allowed to teach comp. health to all students. We should be allowed to discuss alternate lifestyles and birth control.” Whereas school districts are permitted to exclude birth control from middle school health classes, “pregnancy prevention,” which includes methods of birth control, is required in high school classes (SC CHEA, 1988). The teacher from this district either misunderstands the local directives or the district is not in compliance with the law. Chapter Five will explore the opportunities for increasing teacher effectiveness in further detail.

### **Attitudes Toward Heteronormative Subscale Findings**

Research question 3 asks, “To what extent do teachers’ personal beliefs align or conflict with heteronormativity in the SC sexuality education curriculum?” The *Attitude Toward Heteronormativity* was the instrument used to assess teachers’ alignment with, or rejection of, heteronormativity. The minimum possible score was 10, and the maximum

possible score was 60. Respondents' scores ranged from 11 to 60. The mean score was 38.33 with a standard deviation of 11.46. Figure 4.5 shows the distribution of the scores.

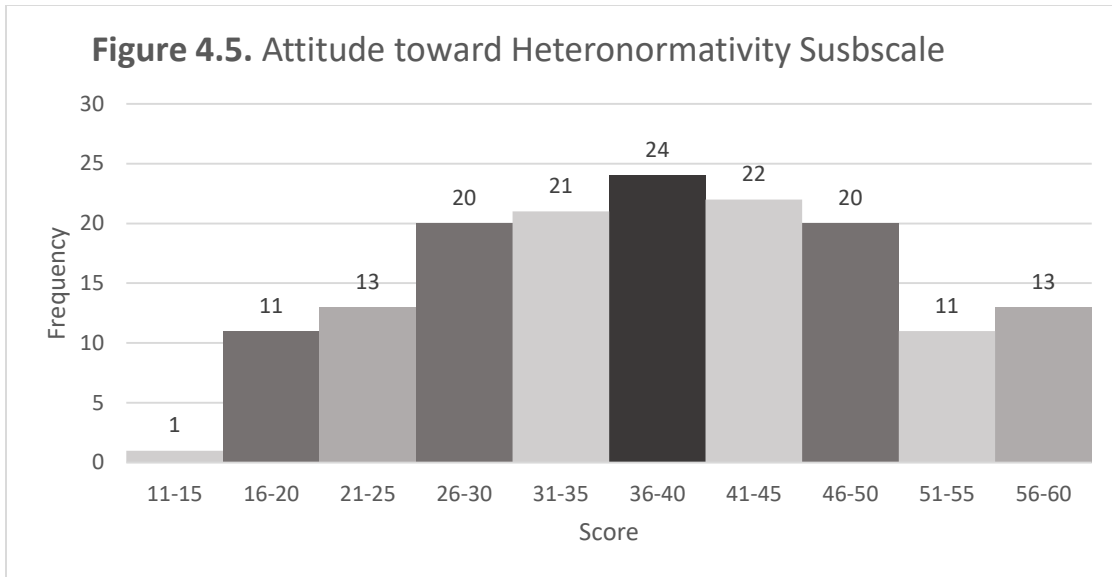
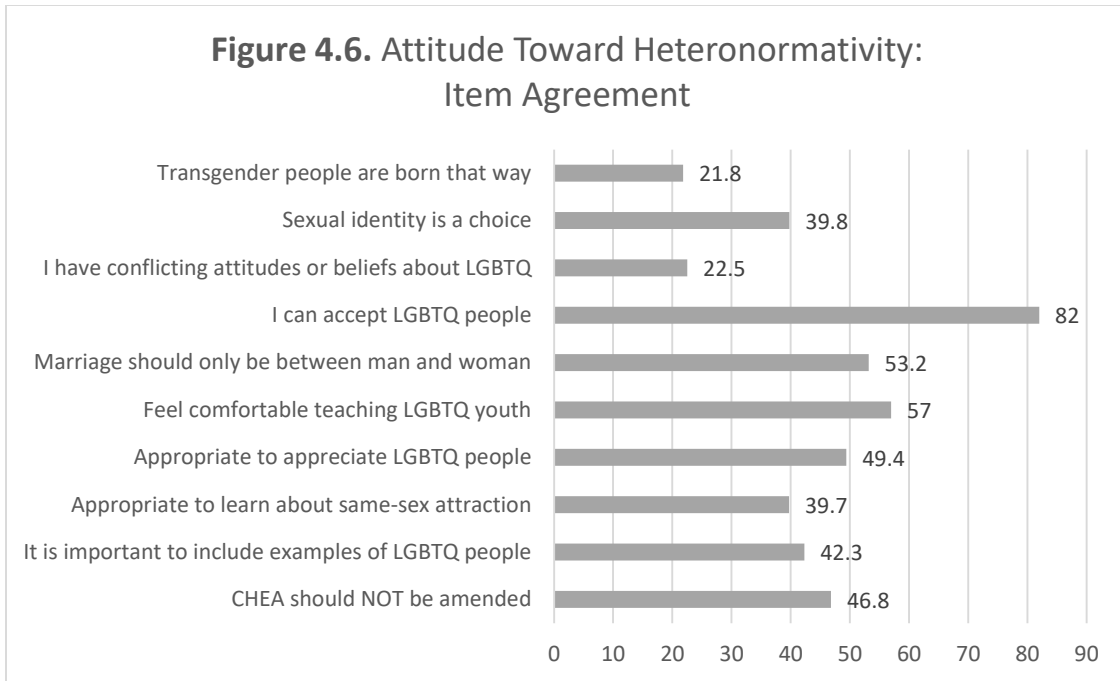


Figure 4.5. Attitude Toward Heteronormativity Subscale Score Distribution

Of the ten items on the *Attitude Toward Heteronormativity* subscale, the percent of respondents who agree or strongly agree with items ranged from 21.8% to 82%. Four of the items were oppositely-worded, and for those items, strong agreement would indicate more alignment with heteronormativity. These items include, “Sexual identity is a choice,” “I have conflicting feelings about LGBTQ people,” “Marriage should only be between a man and a woman,” and “The CHEA should NOT be amended.” For the other six items, the higher agreement indicates less alignment with heteronormativity and a more positive attitude toward people who are LGBTQ. Figure 4.6 shows the percentage of respondents who indicated they agree or strongly agree with the individual items.

Despite 39.8% of respondents indicating they felt strongly that sexual identity is a choice, 49.4% of them indicated they felt that it is appropriate for middle and high-school



*Figure 4.6. Attitude Toward Heteronormativity: Percent Who Agree or Strongly Agree* schools to encourage appreciation of individuals with LGBTQ identities. This demonstrates that many teachers recognize the importance of inclusive instruction despite personal beliefs which do not fully support LGBTQ identities. This finding is echoed in the percentage of teachers who indicated that they felt strongly that transgender identity is a choice. Only 21.8% of respondents either agree or strongly agree that people who are transgender are born that way, yet nearly half indicated that it is important to include the positive portrayal of LGBTQ students in the schools. The teachers' responses are slightly less inclusive than those of the general public, as indicated by the 2009 study conducted by Alton, Valois, Oldendick, & Drake on public opinion of school-based sexuality education in SC. In the Alton et al. study, 42.4% of respondents indicated that they felt it was appropriate to include the topic of homosexuality in sexuality education (2009). Of the survey respondents, 39.7% indicated they agree or strongly agree that the topic was appropriate for inclusion.

Whereas 82% of respondents either agree or strongly agree with the statement, “I can accept LGBTQ people, only 57% of them felt the same way about the statement, “I would/do feel comfortable teaching students who are ‘out’ as LGBTQ youth.” If teachers accept LGBTQ people, then why would they feel uncomfortable teaching LGBTQ youth? One possibility is that they have not had adequate training in meeting the needs of this population. Of 179 respondents, 136 reported having no LGBTQ-awareness training. As many of the respondents are older and attended teacher-preparation programs at a time when multicultural education was less common, it is less likely that they received LGBTQ-awareness training as part of their college coursework. Respondents indicated that in some school districts, school boards prohibit any discussion of LGBTQ people or issues, so it is unlikely they would receive PD on the topic. One participant stated, “My district has told me that I cannot teach anything about homosexuals besides refer to it as alternative lifestyle.” Of the respondents to this question, 76% indicate having no LGBTQ-training. Figure 4.7 further illustrates this point.

Open-ended response data demonstrate the lack of LGBTQ-training for teachers of health education. As noted in Figure 4.7, 76% of respondents reported having no training to support LGBTQ students. One respondent indicated the professional development experience as, “We had a lawyer come and talk rules to us – 30 minutes.” Another stated, regarding professional development (PD), “Nothing. We NEED it.” A third respondent indicated that PD was a new experience: “For the first time this year, we had a 45-minute professional development on transgender students given by our district lead school counselor.”

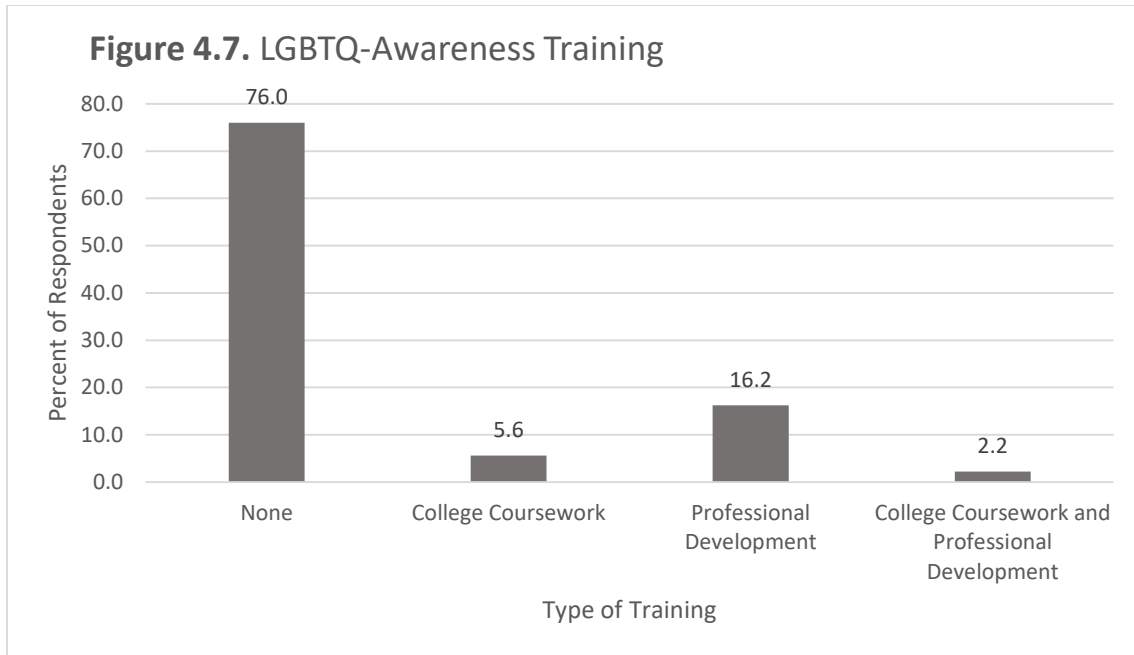


Figure 4.7. LGBTQ-Awareness Training

Of the respondents, 23.7% indicated they slightly disagreed, disagreed, or strongly disagreed with feeling comfortable teaching LGBTQ youth. If they do not feel comfortable teaching LGBTQ youth, it is unlikely that they will seek ways to make their classrooms more welcoming and appreciative of their identities. This is an area of opportunity for professional development and increased teacher preparation. I will further explore this issue in Chapter Five.

Another item that demonstrates a conflict with the full support of LGBTQ people was the item, “Marriage should only be between a man and a woman.” Of the 124 teachers who responded to the item, 53.2% indicated that they agree or strongly agree with this statement. In contrast, a 2017 poll indicated that only 32% of Americans oppose same-sex marriage (Pew Research Center, 2017). For SC teachers who oppose same-sex marriage, it is likely that they would not see the need to amend the SC CHEA to eliminate the “alternate sexual lifestyles” restriction. A Pearson correlation of .516,

significant at the 0.01 level, is shown between the items regarding same-sex marriage and amending the SC CHEA. Teachers who oppose same-sex marriage were more likely to show support for leaving the SC CHEA as is.

An open-ended item on the survey allowed respondents to further clarify their attitudes toward the heteronormativity within the SC CHEA. The item asked respondents, “Do you feel conflicts between your personal beliefs and your professional obligations regarding health education? If so, what are they and how do you address them.” Of the 181 survey respondents, 102 chose to answer this question. From those responses, 62.7% indicated having no conflict. For teachers who do not find heteronormativity problematic, the curriculum as written should be agreeable as it prevents positive portrayal of LGBTQ identity within health classes. For the teachers who indicated conflict, 22.5% responded that they would like to see the SC CHEA become more conservative, and 12.7% would like it to become less conservative.

Some teachers attributed the lack of conflict to their ability to separate personal beliefs from professional obligations. One respondent stated, “My personal beliefs are not important!! My job is to teach all students about pregnancy prevention, disease prevention, and building responsible relationships.” Another also expressed no conflict by writing, “No. I understand it is my job to instruct and inform them so I do not bring my personal beliefs into my classroom environment.”

Of the 22.5% of teachers indicating that they would like to see the curriculum become more conservative, their religious beliefs shaped their positions. One teacher indicated a conflict, saying, “Yes. I am a strong Christian and I feel it is my responsibility to share love and faith with all people. Anything less is not really sharing God.” Another

stated, “I think LGBTQ is a sin based on my religion. I think Transgender people have a mental disorder based on suicide rates. I don’t let the kids know my personal beliefs and I teach according to the law and standards. I also keep things as gender neutral as I can.” It is evident that this teacher struggles with the conflict but tries to approach the responsibility of teaching inclusively. Other teachers in the survey responded that they experienced conflict with the restrictive limits of the SC CHEA.

Several teachers reported wanting the SC CHEA to be less restrictive and for sexuality education to be more comprehensive and inclusive. One stated, “The biggest conflict I have is that we are so limited in what we are ‘allowed’ to say and talk about. I feel this is such a huge injustice to my students.” Another respondent echoed this sentiment and also acknowledged the risk of not adhering to the SC CHEA guidelines. The teacher wrote,

We have an older and very conservative school district and board. Ultimately, I can only retain my job by teaching only what has been approved to teach.

Although I struggle with this because I know my students need more up-to-date education, I can not be effective at all if I am not here to teach.

The teacher describes the dangerous tight-rope walk many teachers must take if they want to teach sexuality education in a more progressive manner. Lastly, one respondent described frustration with both the delivery and the content of health education by stating, “Yes. I feel that we should cover more material and that anyone in a health classroom should be required to have a degree in health education, not just PE. There is a clear disconnect between what we are allowed to discuss in a classroom (specifically dealing with reproductive health) and the law.” The teacher highlights the fact that teaching

health education does not require a degree in the subject. Also, the statement indicates that aspects of health education relating to reproductive health could conflict with the law. One interpretation of this statement is that some educators are not teaching the required content, which is possible due to limited accountability required of districts to monitor and report CHEA instruction. Another possible interpretation of this statement is that the SC CHEA reflects a time when same-sex marriage was not legal. Framing “reproductive health” in the context of future family planning within marriage but restricting discussion of same-sex sexual activity to the context of disease prevention pinpoints a contradiction within the SC CHEA.

### **Existence of Wide Ranging and Conflicting Attitudes**

Other questions from the open-ended items exemplify the wide range of attitudes toward heteronormativity in schools. Four questions asked the respondents whether they had ever heard positive or negative comments regarding LGBTQ people from students or colleagues, and how they responded to the comments. The analysis suggests the existence of wide ranging and often conflicting attitudes from respondents.

*LGBTQ-Positive Statements from Students.* The first question asked if teachers had ever heard students make LGBTQ-positive comments, and, if so, how they responded. Of the 98 respondents, 33% reported having heard positive comments and 67% responded that they had not heard positive comments. Examples of positive comments, as provided by respondents, included, “Everyone is different and should be accepted,” and “It’s their choice, not my thing, but cool for them.” Of the 18 teachers who indicated how they responded to LGBTQ-positive comments from students, 12 indicated that they acknowledged or affirmed the positive comment, with statements such



as, “I agree” or “Everyone is different and different is what makes us great as a community.” Six of the 18 teachers who identified how they reacted to positive comments indicated that they ignored it. One respondent said, “I did not respond, since it goes against the policy in (*name of county redacted*) County to discuss such topics with students.” Another stated, “Did not respond- just walked away.” It is possible that the teacher who wrote this does not feel comfortable discussing any sort of LGBTQ topic at school because the climate does not support any such conversation.

*LGBTQ-Negative Statements from Students.* Another item asked respondents whether they had heard LGBTQ-negative statements from students and how they reacted to them. Of the 104 who answered this question, 66 can recall hearing students making negative comments. Two respondents wrote that the subject was off limits, and 36 do not recall hearing negative comments from students.

The types of LGBTQ-negative comments followed five general themes. The most common theme (38.7%) was using terms such as “gay” as an insult, usually in a teasing manner. Another theme was deliberately hurtful language or slurs, such as calling a student “faggot” or “dyke.” This type of comment accounted for 25% of the responses provided. Comments associating LGBTQ-status with fear, difference, or confusion accounted for almost 16% of the total. Student-specific comments made up 11% of the comments and associating LGBTQ sexuality and gender identity with sin or against religion accounted for 9%.

Some of the respondents’ replies include, “Students calling each other ‘gay’ as a form of teasing almost daily,” and “The usual derogatory terms, ‘queer,’ ‘faggot,’ etc.” and “They are weird and make me feel uncomfortable.” Teachers identified three

primary strategies for responding to these situations: explaining why the comment was inappropriate (21%), encouraging respect or tolerance (36%), and treating the situation as a discipline issue (36%). Eight percent of the responses were not categorized.

Examples of teacher responses included, “Even if you don’t agree with others’ choices it does not make them any less of a person who needs to be treated with respect,” and, “They said they are going to hell and I corrected them by saying no sin is greater than another one.” Another teacher wrote, “Yes, students use homosexual slurs. I tell all students not to use inappropriate language.”

From the two questions asking if respondents had heard LGBTQ-negative questions, responses indicate that LGBTQ-negative comments are approximately twice as common as LGBTQ-positive comments. Teacher response to negative comments is more common than with positive comments. Many teachers indicated responses to negative comments which encourage tolerance or respect but fall short of affirmation and appreciation. Similar patterns are evident with LGBTQ-related comments from colleagues.

*LGBTQ-Positive Comments from Colleagues.* From the 97 responses asking teachers whether they had heard colleagues make LGBTQ-positive comments, 66% do not recall ever hearing any. One respondent indicated a positive comment as, “Yes, faculty members have had civil talks about LGBTQ training.” Another stated that the positive comments were, “Not very often, did not respond – just walked away.” Again, this echoes the LGBTQ-positive comment mentioned above from a student with the teacher ignoring the comment and avoiding the discussion.

*LGBTQ-Negative Comments from Colleagues.* There were approximately equal numbers (67%) of respondents who indicated that they had not heard LGBTQ-negative comments from peers. Fifteen percent responded that they did not remember or wrote “N/A.” An additional 18% stated that they had heard LGBTQ-negative comments from colleagues. Examples included, “Gay slurs. I tend to ignore ignorant people,” and “Yes, I just said I would appreciate it if they didn’t talk that way about people.” Another teacher wrote, “Yes. Mainly from my fellow male PE teachers. They know how I feel about it at this point and avoid doing it around me now. But I do still hear comments from them when they don’t notice I am there.” For the teachers who indicated that they had not heard LGBTQ-negative comments from colleagues, their responses include, “No, the folks I work with love all students and behave professionally – at least around me,” and “Not something that’s talked about much.”

*Analysis of LGBTQ-positive and negative comments.* From the data described in the preceding paragraphs, respondents were more likely to hear both LGBTQ- negative and LGBTQ-positive comments from students than from colleagues which is not surprising given that teachers spend more time conversing with students than with other teachers. Respondents indicated they were more likely to intervene with negative comments from students than from colleagues. The frequency and response to these comments demonstrate a wide range of teacher attitudes toward heteronormativity, as shown in the *Teacher Preparation Subscale* scores as well.

### **Correlations Among Subscales and Demographic Data**

Research question four looked to identify correlations among the three subscales as well as between individual subscales and demographic variables. It is important to

note that inferential statistics are provided but should be interpreted with caution. Generalization to the target population from this convenience sample is not appropriate; however, inferential statistics are provided for reference.

#### ***Distribution of subscale scores.***

Analyzing the scales for normal distribution using Shapiro-Wilk tests revealed that all three lacked normal distributions. The  $p$ -values for the TPH, *Self-Efficacy Subscale*, and *Attitude Toward Heteronormativity* subscales were .000, .000, and .049, respectively.

#### ***Correlation between subscales.***

Subsequently, Spearman's rank-order correlation tests were performed to assess the relationships between the subscales. Two of the three subscales demonstrated positive correlations. The following paragraphs describe the procedures and analysis of results.

There was a weak positive correlation between scores on the TPH and *Self-Efficacy Subscale*,  $r_s (179) = .155$ ,  $p < .05$ . Teachers with more preparation to teach health demonstrated slightly higher self-efficacy than those with less.

No correlation was shown between scores on the TPH and *Attitude Toward Heteronormativity* subscales,  $r_s (179) = -.014$ ,  $p = .861$ . The amount of preparation to teach health does not show correlation with teachers' attitudes toward heteronormativity.

There was a positive correlation between scores on the *Attitude Toward Heteronormativity* and *Self-Efficacy Subscale*,  $r_s (179) = .215$ ,  $p < .01$ . Teachers who were more likely to reject heteronormativity were more likely to demonstrate higher self-efficacy. This could be attributed to the inclusion on the *Self-Efficacy Subscale* regarding

same-sex behaviors in the context of disease-prevention. It is plausible that teachers with more positive attitudes toward LGBTQ people and issues would feel this topic was valuable, they were competent to teach it, and that their students would be more knowledgeable of the topic as a result of their instruction. For teachers who align with heteronormativity, it is possible they avoid this topic completely, despite the SC CHEA expressly allowing this discussion within the context of disease-prevention.

### ***Correlations between subscale scores and demographic variables.***

The lack of normal distribution indicated that non-parametric statistical analysis was appropriate. Kruskal-Wallis H tests were conducted to determine if there were differences in subscale scores and each of the demographic variables. Each subscale was analyzed for its relationship with the categories of age, gender, race, religion, and sexuality.

Both the TPH and *Self-Efficacy Subscale* produced p-values greater than .05 for all five demographic categories, indicating no statistically significant differences between groups for the five demographic categories and the two subscales. However, three of the five demographic variables demonstrated statistically significant differences with the *Attitude Toward Heteronormativity* subscale.

A Kruskal-Wallis test was conducted to determine if there were differences in *Attitude Toward Heteronormativity* scores between genders: “female” ( $n = 61$ ), “male” ( $n = 67$ ), “other” ( $n = 2$ ), and “prefer not to answer” ( $n = 2$ ). Distributions of *Attitude Toward Heteronormativity* scores were similar for all groups, as assessed by visual inspection of a boxplot. Median *Attitude Toward Heteronormativity* scores were statistically significantly different between the different genders,  $\chi^2(3) = 25.869, p <$

.001. Subsequently, pairwise comparisons were performed using Dunn's procedure with a Bonferroni correction for multiple comparisons. Adjusted p-values are presented. This post hoc analysis revealed statistically significant differences in the *Attitude Toward Heteronormativity* subscale scores between male (Mdn = 35.00) and female (Mdn = 45.00), ( $p < .001$ ) respondents but not between respondents selecting "other" or "prefer not to answer" or any other group combination. Respondents identifying as female were more likely to reject heteronormativity than male respondents.

Using the same procedures, a Kruskal-Wallis H test was conducted to determine if there were differences in *Attitude Toward Heteronormativity* scores between respondents with different religious beliefs: "Christianity" ( $n = 119$ ), "Buddhism" ( $n = 2$ ), "Judaism" ( $n = 1$ ), and "None" ( $n = 10$ ). Median *Attitude Toward Heteronormativity* scores were statistically significantly different between the different religions,  $\chi^2(3) = 8.780, p = .032$ . Pairwise comparisons revealed significant differences in the *Attitude Toward Heteronormativity* subscale scores between participants identifying Christianity as their primary religion, (Mdn = 38.00) and those who indicated having no religion (Mdn = 46.50), Respondents identifying as Christian were more likely to align with heteronormativity than respondents indicating no religious beliefs.

The same procedures revealed statistically significant differences in the *Attitude Toward Heteronormativity* scores between categories of identified sexuality: "Bisexual" ( $n = 1$ ), "Heterosexual" ( $n = 108$ ), "Lesbian" ( $n = 5$ ), "Prefer not to answer" ( $n = 15$ ), and "Other" ( $n = 3$ ). Median *Attitude Toward Heteronormativity* scores were statistically significantly different between the different sexualities,  $\chi^2(4) = 12.688, p = .013$ .

Pairwise comparisons revealed statistically significant differences in the *Attitude Toward*

*Heteronormativity* subscale scores between participants identifying as Lesbian (Mdn = 52.00) and heterosexual (Mdn = 37.50). Unsurprisingly, Lesbian respondents were more likely to reject heteronormativity than heterosexual respondents.

### **Summary of Data Analysis**

The three subscales each provided valuable information, supported by the data in the open-ended response items. Data indicated that most teachers lack significant preparation to teach health and sexuality education. Despite this lack of preparation, many show high levels of self-efficacy. This surprising finding is significant and warrants further exploration. How can teachers feel confident when they lack preparation? Lastly, attitudes toward heteronormativity indicate great room for improvement and a lack of LGBTQ-awareness training.

Statistical analysis of quantitative data showed positive correlations between preparation to teach and self-efficacy, as well as with attitude toward heteronormativity and self-efficacy. The only subscale demonstrating correlation with demographic variables was the *Attitude Toward Heteronormativity*. Respondents who are Christian, male, and heterosexual were most likely to align with heteronormativity. Chapter Five will further explore the implications of these findings as well as suggestions for future research.

## Chapter Five

### Implications and Conclusions

This chapter presents the summary findings and their corresponding implications, along with recommendations for change in policy and practice. The literature review and survey results provide support for these recommendations. Additionally, national resources and policy from other states suggest methods for improving the implementation of anti-heteronormative sexuality education. The chapter concludes with recommendations for amending the SC CHEA.

### Implications and Recommendations

This section will examine the implications of the findings from the survey and provide corresponding recommendations for each of the three constructs. Analysis of open and closed-response item data supports the proposed changes for each construct. The *Teacher Preparation Subscale* and several open-ended response items from the survey indicate inconsistent and often inadequate educator preparation to teach health and sexuality education. This section of the chapter will justify the need for changes in teacher preparation programs, increased professional development opportunities, and state-mandated teacher certification requirements necessary to address this deficiency.

The respondents to this survey reflect approximately 11% of the educators currently teaching health in public middle and high schools across the state. As detailed in Chapter Four, respondents' mean score on the *Teacher Preparation Subscale* was 20.6, equivalent to 23.7% of the maximum possible score. Less than 8% of respondents'



scores corresponded to an undergraduate degree in health with health education certification. This would not be acceptable for any other subject area such as math or language arts. The respondent data shows a significant lack of pre-teaching preparation for health instruction. The lack of health teacher preparation in SC is similar to patterns found in a 2014 national study (Rhodes, Jozkowski, Hammig, Ogletree, & Fogarty, 2014). The national study found 62.4% of individuals teaching health education in public secondary schools insufficiently prepared in the field. The authors suggested that their findings demonstrate the need for exclusively professionally-prepared health teachers teaching classes that are not embedded within other classes (Rhodes et al., 2014).

As mentioned in previous chapters, South Carolina currently has no teacher preparation programs that lead to health education certification. Without this opportunity, there is no way to prepare future educators to enter the classroom fully prepared to teach the subject. An obvious remedy to this situation is to require state universities with teacher preparation programs to offer this path to certification. If enrollment rates were low, the state could actively recruit future health educators. However, implementation of health teacher preparation programs is likely to take years to accomplish.

One opportunity to improve this situation would be for the SC State Department of Education to require the “add-on” certification for health education. An existing model of increasing certification requirements is the Read to Succeed (R2S) initiative in South Carolina. According to the SCDE website, “The goal of the R2S Act is to ensure that every educator at every grade level in every school and subject area is committed and able to support the reading development of the South Carolina students they serve

(SCDE, 2018). Through the Read to Succeed initiative, all SC teachers are required to complete literacy coursework before their next certification cycle. The state could mandate similar coursework for teachers of health education.

Currently, the add-on health certification requires 24 hours of coursework, including courses in anatomy and physiology, first aid, and a course called, “School Health Program” (SCDE, 2018). I was unable to find a university in South Carolina currently offering a course with a similar title. Rather than requiring the complete requirements for add-on certification, the state could mandate a 12-credit-hour program focusing entirely on school-based health education. A series of four courses would provide educators a basic foundation to enhance the content and pedagogical knowledge in health education.

In conjunction with additional coursework, health educators would benefit from ongoing professional development. Survey respondents indicated a median of four days of health-related professional development throughout their teaching careers. The SC CHEA mandates teachers receive “appropriate staff development activities for personnel participating in the comprehensive health education program” (CHEA, 1988). However, there is no guidance provided regarding the nature, duration, or frequency of this staff development. Advocates for Youth, a national agency dedicated to young people’s sexual health, offers professional development programs tailored to many topics, including comprehensive sexuality education (Advocates for Youth, 2018). The American School Health Association (ASHA) offers online professional development opportunities including self-study and webinars (ASHA, 2018). Combining teacher preparation programs with additional opportunities for professional development could

substantially improve educators' preparation to teach health education. Professional development for teachers already teaching health offers a faster way to improve teacher preparation.

Survey respondents frequently indicated a desire for increased preparation. One respondent stated that there is, "very little professional education or in-services provided." Another teacher stated, "Most teachers, including myself, that I have come across who teach health are NOT trained or qualified to do so." Another educator replied, "There needs [sic] to be certified health teachers teaching health in school. Just like any subject. You should be qualified to teach your subject." These comments confirm the lack of preparation and the teachers' sense of under preparedness to effectively teach the subject.

The lack of preparation does not correlate with respondents' self-reported self-efficacy. Responses from the Likert-type items on the *Self-Efficacy Subscale* demonstrated higher self-efficacy than the open-ended responses which required more time and reflection. The *Self-Efficacy Subscale* scores indicated that most respondents felt confident in their instruction, but open-ended responses showed some insecurity. One respondent indicated, "I would like more training and clarification on what should be taught." Another teacher replied, "We are not meeting the needs of students." Comments like these indicate that some teachers lack confidence in their abilities to teach students health education effectively. Also indicated in the open-ended responses was the controversy regarding the content to be included in health education.

The *Attitude Toward Heteronormativity* subscale indicated that health teachers show a wide range of attitudes toward LGBTQ topics. Whereas 82% of respondents

indicated they accept LGBTQ people, only 57% said they felt comfortable teaching students who are “out” as LGBTQ youth. Teachers who do not feel comfortable serving students with LGBTQ identities are unlikely to find ways to meet their health education needs. Many expressed strong oppositions to LGBTQ-inclusivity. Statements included, “LGBTQ choices and relationships should not be taught in a public, education classroom” and “I believe that same-sex relationships are a choice and are not normal.” Others indicated that their religious beliefs do not support LGBTQ identities in statements such as, “I think LGBTQ is a sin based on my religion,” and “God created Adam and Eve, not Adam and Steve.” When asked how they could change their instruction to be more LGBTQ-inclusive if the CHEA permitted it, some teachers replied that they would refuse, stating, “I wouldn’t teach it” and, “I don’t believe this should be taught.” From the teachers’ responses, it is apparent that many teachers would benefit from LGBTQ-sensitivity training.

It is unconstitutional to ask teachers to change their religious beliefs. However, they do have a professional obligation to educate all students in their classrooms in a respectful manner. In addition to professional development to support health curriculum knowledge, school districts could offer LGBTQ-sensitivity training to address the conflict. A Queer Endeavor, housed in the University of Colorado at Boulder School of Education, is an initiative dedicated to supporting teachers with issues related to gender and sexual diversity. A Queer Endeavor offers professional development opportunities to help schools create cultures that are not only safe but affirming of diversity (A Queer Endeavor, 2018). Professional development of this nature could help reduce the effects of the heteronormative curriculum.

The survey data also indicated that many teachers are fearful of any discussion related to LGBTQ issues, even outside of the health classroom. Some mentioned that their school district expressly forbids any discussion of LGBTQ issues, not just inside health classrooms. One respondent stated, “I do not discuss anything to do with LGBTQ b/c I do not want to lose my job.” A 2018 report demonstrated that students in states, like South Carolina, with LGBTQ-restrictive sexuality education curricula face more hostile environments in the general school environment than students in other states. Teachers in these “no promo homo” states are also less likely to incorporate LGBTQ topics into the curriculum (GLSEN 2018). Amending the SC CHEA to remove the “no promo homo” clause could have a positive effect beyond health classrooms and increase teacher confidence in making their classrooms more LGBTQ-inclusive.

Many respondents in the survey expressed frustration with the limitations imposed by the SC CHEA. One respondent stated, “SC laws on sexuality education need to be changed to include everyone – not just the legislators’ beliefs.” Another teacher echoed this by writing, “The CHE Act is outdated. It needs to be rewritten to reflect today’s society. I need to be able to discuss any issues my students face, instead of turning away from discussions about LGBTQ youth.” Another teacher wrote, “LGBTQ students need to be included, but with education, that benefits them. Obviously, our archaic current curriculum teaches as if they do not exist.” Until the SC CHEA is amended, LGBTQ identities in health classes will remain invisible at best, and stigmatized, at worst. Educational policy shows great variation across the country. California enacted the Healthy Youth Act in 2015 “to provide pupils with the knowledge and skills they need to develop healthy attitudes concerning adolescent growth and

development, body image, gender, sexual orientation, marriage, and family” (California Healthy Youth Act, 2015). Other states have similar provisions requiring the respectful inclusion of sexual and gender identity diversity in sexuality education, including Colorado, Delaware, Iowa, New Jersey, New Mexico, Oregon, Rhode Island, and Washington (Guttmacher Institute, 2018). South Carolina legislators could look to these states for guidance in amending the SC CHEA.

### **Suggestions for Future Research**

This study did not intend to answer all research questions definitively. Rather, it sought to provide a data for a robust beginning of questions related to heteronormativity in the sexuality education curriculum in South Carolina. The data strongly suggest several lines of inquiry warranting further exploration.

In this study, questions about teachers’ attitudes toward heteronormativity were answered more thoroughly than the others. One avenue for possible further investigation would be the single open-ended item asking teachers if they felt a conflict between personal beliefs and professional obligations. Many teachers provided lengthy responses with rich detail. Having a greater understanding of how teachers approach conflict with the curriculum they feel is either too liberal or too conservative would help pinpoint the best approach to tailoring professional development to meet their needs.

Future research could delve into how teachers navigate conflicts between personal beliefs and professional obligations. The Kruskal-Wallis H test results indicated that teachers reporting Christianity as their primary religion demonstrated lower scores on the *Attitude Toward Heteronormativity* subscale and more alignment with heteronormativity. The issue is complex, as it is the intersection of religious freedom and civil rights.

Several respondents indicated that their religious beliefs do not preclude them from teaching effectively and inclusively. A qualitative study investigating how teachers navigate this situation could identify effective teacher-preparation and professional development strategies to assist teachers facing this conflict.

An alternate question, originally included in the survey but eliminated due to length, asked respondents if they wanted to teach health or if they would rather not. In retrospect, that question could have redirected suggestions for remediation. If many of the teachers who are teaching health do not want to teach it, it would make sense to find out who does want to teach it, as these are the educators who will likely be most effective.

Another intriguing finding was the high level of self-efficacy reported by teachers, despite minimal preparation to teach health education. One possible explanation is that many of the respondents are seasoned educators and with that experience comes confidence. An additional possibility is that self-efficacy is not an accurate predictor of classroom outcomes. Teachers might feel that they are capable of effectively providing health education but not be effective. Unlike most other subjects, health education is not subject to state standardized assessments. There is no benchmark data to measure student learning, making it hard to gauge whether students are learning the material. South Carolina's teen pregnancy and STI rates are worse than most of the rest of the country. The state ranks seventh in the nation for chlamydial infections and fourth in the nation for gonorrheal infections (CDC, 2015). South Carolina has the 16<sup>th</sup> highest teen birth rate in the nation (SC Campaign, 2017). These statistics would indicate that SC sexuality education teachers are not exceptionally effective. One avenue for

future research could investigate the efficacy of health educators in reducing rates of STIs and teen pregnancy.

Another unanswered question not included in this study is the course structure of health education. Many students in South Carolina receive health education instruction embedded within other courses such as science or PE. Some schools provide health education as a stand-alone course. Comparing outcomes of these different methods of delivery could also tailor suggestions for improving youth health outcomes. If stand-alone courses demonstrate better outcomes than those embedding health in other courses, then legislation could mandate that the course structure change to reflect that.

An additional area for improvement is measurement and data collection in sexuality education research. The three subscales used in the study were self-created. Development of survey instruments that demonstrate reliability and validity in measuring teacher preparation and attitude toward heteronormative sexuality education would likely produce clearer correlations among the constructs. Using benchmark assessment data and teacher observation could provide a more accurate measure of teacher efficacy instead of teacher-reported self-efficacy. These refinements in instrumentation and data collection could produce more robust conclusions. Greater availability of data regarding the efficacy of sexuality education could justify policy change.

## **Conclusion**

This study focused on how health teachers interact with the heteronormative curriculum as prescribed by the SC CHEA. Results demonstrated that many teachers lack adequate preparation yet feel confident in their ability to educate students about sexuality education effectively. The study examined the various attitudes of respondents



toward heteronormativity. Some teachers revealed intense conflict with LGBTQ identities while others wrestled with the constraints of an exclusionary system of instruction. Open and closed-response data reflected and echoed each other, providing confidence in the findings. Pervasive heteronormativity exists not only within the health and sexuality curriculum in South Carolina but also within many of the teachers responsible for its delivery. Amending legislation will not provide complete resolution of this issue. Wholesale changes to teacher preparation, requirements for certification and instruction, and extensive professional development opportunities could improve the ability of teachers to meet the needs of all of the students in their classrooms. Until educators fully embrace LGBTQ identities, however, instruction will never move beyond tolerance. Affirmation and appreciation are possible when envisaged through the lens of queer theory, shedding attachment to binary notions of gender and sexuality and normative practices, but the process requires deliberate effort to move away from what is familiar. In the context of a shifting political climate, some hold hope of simply not regressing to even more oppressive circumstances. As states across the US ride the current and move forward to more LGBTQ-inclusive curricula, the SC CHEA anchors us to 1988 and heteronormative sexuality education. As educators and communities seek to provide inclusive environments for LGBTQ students and families, advocacy for legislative and institutional change remain priorities.

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## Appendix A

### Middle and High-School Health Educators–Preparation and Attitudes

#### Section One (Preparation to Teach Health Scale)

1. Are you teaching health in a public middle or high school for the 2017-2018 school year? Y/N
2. What grade levels do you teach this year (2018-2018 school year)? Check all that apply.
3. What was your undergraduate major in college?
4. How many years, including 2017-2018, have you taught health education in public middle or high schools?
5. Do you have a Master's degree? If so, please list.
6. Do you have a Master's degree? If so, please list.
7. Approximately how many undergraduate or graduate-level health education courses have you taken?
8. In what areas are currently certified to teach in South Carolina?
9. Throughout your teaching career, approximately how many days of district-provided professional development have you received to teach health, including instruction on Erin's Lay and school-approved health curriculum?
10. What type of training, if any, have you had on the inclusion of Lesbian, Gay, Bisexual, Transgender, and Queer (LTBTQ) middle and high-school students?
11. Do you have Certified Health Education Specialist (CHES) or Master Certified Health Education Specialist (MCHES) certification?
12. Are you currently a member or the South Carolina Association for the Advancement of Education (SCAAHE)?

## Section Two - Teacher Self-Efficacy Subscale

6-point scale:

1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Agree, 6 = Strongly Agree

**To what extent do you agree with the following statements? (6-point scale)**

13. It is **important** to teach students about:

- Pregnancy prevention
- Sexually transmitted infections
- Reproductive anatomy
- Puberty
- Same-sex behaviors in the context of disease-prevention

14. I feel **competent** education students about:

- Pregnancy prevention
- Sexually transmitted infections
- Reproductive anatomy
- Puberty
- Same-sex behaviors in the context of disease-prevention

15. **As a result of my instruction**, my students will know more about:

- Pregnancy prevention
- Sexually transmitted infections
- Reproductive anatomy
- Puberty
- Same-sex behaviors in the context of disease-prevention

### Section Three – Attitudes Toward Heteronormativity Subscale

The next section asks questions that relate to one regulation within the South Carolina Comprehensive Health Education (SC CHE) Act of 1988 which states, “The program of instruction provided for in this section may not include a discussion of alternate sexual lifestyles from heterosexual relationships including, but not limited to, homosexual relationships except in the context of instruction concerning sexually transmitted diseases.”

#### 16. To what extent do you agree with the following statements? (6-point scale)

- *The above statement should remain in the state regulations.*
- It is important to include examples of LGBTQ people in sex education curriculum materials.
- It is appropriate for middle and high-school students to learn information about individuals who are attracted to persons of the same sex.
- It is appropriate for middle and high schools to encourage appreciate of individuals with LGBTQ identities.
- I would/do feel comfortable teaching students who are “out” as LGBTQ youth.

#### 17. To what extent to do you agree or disagree with the following statements?

- *Marriage should only be between a man and a woman.*
- I can accept LGBTQ people.
- *I have conflicting attitudes or beliefs about LGBTQ people.*
- *Sexual identity (for example gay, straight, bisexual) is a choice.*
- People who are transgender are born that way.

\*Items in italics will be reverse-scored (i.e., a “6” will be recorded as a “1”)

#### In the following prompts, the acronym LGBTQ stands for Lesbian, Gay, Bisexual, Transgender and Queer.

18. Have you ever heard positive comments regarding LGBTQ people from students? If so, what were they and how did you respond.

19. Have you ever heard negative comments regarding LGBTQ people from students? If so, what were they and how did you respond.

20. Have you ever heard positive comments regarding LGBTQ people from other faculty members? If so, what were they and how did you respond.

21. Have you ever heard negative comments regarding LGBTQ people from other faculty members? If so, what were they and how did you respond.



22. What supports, if any, are available in your school to facilitate the inclusion of LGBTQ students (e.g. Gay-Straight Alliance, teacher professional development on LGBTQ inclusion, etc.)?
23. Do you feel conflicts between your personal beliefs and your professional obligations regarding health education? If so, what are they and how do you address them?
24. Do you know anybody who is LGBTQ? (Yes, No, I don't know, Prefer not to answer).

**The following are hypothetical scenarios. Please describe how you think you would respond in these situations.**

25. A student reveals to you privately that he is questioning his sexuality or gender identity. What would you say or do?
26. During a lesson on pregnancy prevention, a student asks if a woman can become pregnant from same-sex activity. How would you respond?
27. During a lesson on sexually-transmitted disease prevention, a student says, "Gay people deserve AIDS." How would you respond?
28. During class, a student says, "Gay people should not be allowed to get married. This is not God's plan." How would you respond?
29. If you feel that LGBTQ students should be included in sexuality education, how would your instruction reflect this?
30. Is there anything else you would like to share related to health education in South Carolina?

### **Demographic Information**

Demographic information will be used only for analysis. The information you provide will be held in the strictest confidentiality.

31. What is your age?
32. Please describe your race/ethnicity. Check all that apply.
33. What is your primary religion, if any?
34. Which of the following do you consider yourself? (Female, Male, Transgender, Prefer not to answer, Other).
35. Which of the following commonly used terms best describes you? Check all that apply. (Bisexual, Gay, Heterosexual, Lesbian, Prefer not to answer, Other).

## **Appendix B**

### **Invitation Letter**

Dear Educator,

My name is Sarah Burnham. I am a doctoral candidate in the College of Education at the University of South Carolina. I am conducting a research study as part of the requirements for my degree in Curriculum and Instruction, and I would like to invite you to participate.

I am studying the Comprehensive Health Education (CHE) Act of 1988, and the attitudes teachers have toward certain aspects of it. I am also researching the amount of preparation health teachers have. The third issue I am examining is how confident teachers feel that their health instruction is effective. If you decide to participate, you will be asked to answer survey items related to the three topics mentioned above. You may feel uncomfortable answering some of the questions. You do not have to answer any questions that you do not wish to address. The survey will take about 15 minutes to complete.

Participation is confidential. Study information will be kept in a secure location at the University of South Carolina. The results of the study may be published or presented at professional meetings, but your identity will not be revealed.

Taking part in the study is your decision. You do not have to be in this study if you do not want to. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering.

I will be happy to answer any questions you have about the study. You may contact me at 803-439-2059 or [burnhams@email.sc.edu](mailto:burnhams@email.sc.edu); or my faculty advisor, Dr. Daniella Cook at 803-777-8076 or [Daniella.cook@sc.edu](mailto:Daniella.cook@sc.edu) if you have study related questions or problems. If you have any questions about your rights as a research participant, you may contact the Office of Research Compliance at the University of South Carolina at 803-777-7095.

Thank you for your consideration. If you would like to participate, please click on the link below to begin the survey.

With kind regards,  
Sarah Burnham

**Appendix C – IRB Approval Letter**



**OFFICE OF RESEARCH COMPLIANCE**

**INSTITUTIONAL REVIEW BOARD FOR HUMAN RESEARCH  
APPROVAL LETTER for EXEMPT REVIEW**

Sarah Burnham

College of Education

Department of Instruction & Teacher Education / Curriculum & Instruction

Wardlaw

Columbia, SC 29208

**Re: Pro00072164**

Dear Mrs. Burnham:

This is to certify that the research study *Not -So Comprehensive Health Education: Teacher Preparation and Attitude Toward Heteronormativity in the SC Sex Education Curriculum* was reviewed in accordance with 45 CFR 46.101(b)(2), the study

received an exemption from Human Research Subject Regulations on **1/16/2018**. No further action or Institutional Review Board (IRB) oversight is required, as long as the study remains the same. However, the Principal Investigator must inform the Office of Research Compliance of any changes in procedures involving human subjects. Changes to the current research study could result in a reclassification of the study and further review by the IRB.

Because this study was determined to be exempt from further IRB oversight, consent document(s), if applicable, are not stamped with an expiration date.

All research related records are to be retained for at least three (3) years after termination of the study.

The Office of Research Compliance is an administrative office that supports the University of South Carolina Institutional Review Board (USC IRB). If you have questions, contact Arlene McWhorter at [arlenem@sc.edu](mailto:arlenem@sc.edu) or (803) 777-7095.

Sincerely,



Lisa M. Johnson  
ORC Assistant Director  
and IRB Manager