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Leadership Traits of School Health Coordinators in Tennessee

A dissertation

presented to

the faculty of the Department of Educational Leadership And Policy Analysis

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Doctor of Education in Educational Leadership

by

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Keywords: Leadership Styles, Leadership Traits Questionnaire, School Health Coordinators

ABSTRACT

Leadership Traits of School Health Coordinators in Tennessee

by

Katherine Andrea Strickland

The purpose of this quantitative study was to explore the leadership traits of the school health coordinators (SHCs) for the state of Tennessee and to determine if self-perceptions of the SHC leadership traits coincide with supervisor and colleague perceptions of SHC leadership traits. The health challenges facing young Americans today are different from those of past decades and child health is a major federal and state policy platform. SHCs work at the nexus of 2 highly regulated and political entities: healthcare and education. Thus, it is critical for SHCs to possess strong leadership traits to navigate through the issues and politics that are inherent in this challenging career. By obtaining information regarding the leadership traits of current SHCs, this research provides insight into best practices and continuing education for current and future leaders.

The study population consisted of all SHCs, superintendents, principals, and Healthy School Council members in the state of Tennessee, totaling approximately 3,900. Thirty-nine districts out of 221 provided full responses where the SHC, at least one supervisor, and at least 1 colleague responded to the Leadership Traits Questionnaire (LTQ). Permission to use the LTQ was granted by Peter Northouse, the developer of the questionnaire (Appendix A).

Findings indicated that SHC self-reported perceptions of the leadership traits were significantly higher than colleagues' perceptions of the SHCs leadership traits. There were no significant

differences between SHCs' perceptions and supervisors' perceptions of the SHC leadership traits. Lastly, within the SHC group only there were no significant differences in the perceptions of self-reported leadership traits between city and county SHCs, years of experience, or number of memberships in professional organizations.

DEDICATION

This paper is dedicated to my wonderful husband David and amazing daughter Penelope. I could have never completed this challenge without your love and support. I can never thank you enough for your patience and sacrifices for my lifelong dream. You both are my inspiration and my motivation to having a better life.

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First and foremost I want to thank my husband David for the confidence he has in me. There were times I didn't think I could do this anymore. Your silly ways always make me laugh and your encouragement made me know I can do anything as long as I have you by my side.

I also have to acknowledge my daughter Penelope James. You inspire me everyday to be a better person and push myself to greater things. I want to you know that you can do anything you want in this world if you have the right people behind you.

I want to thank Sarah and Mike Larkin for the immense amount of help they have given me in completing this dissertation. Having the support of wonderful friends has made all the difference.

Mom, you also were my savior many times over through this process. Thank you for your unwavering support. I will always treasure sharing this experience with you.

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CHAPTER 1

INTRODUCTION

The healthy development of children and adolescents is influenced by many societal organizations. After the family, the school is the primary institution responsible for the development of young people in the United States. According to the Centers for Disease Control and Prevention (CDC) (2011), “schools have direct contact with more than 95 percent of our nation’s young people aged 5–17 years, for about 6 hours a day, and for up to 13 critical years of their social, psychological, physical, and intellectual development” (p. 1). Schools play a vital role in improving students’ health outcomes as well as promoting academic success.

Supporting school health programs to improve the health status of our nation’s children has never been more important. That is because many of the health challenges facing young people today are different from those of past decades. For the first time in our country’s history, the next generation is expected to have a shorter life span than the current one (Belluck, 2005). According to the Tennessee Department of Education (2011), this prediction is based on the “fact that childhood obesity rates are at unprecedented levels nationwide. Tennessee has the third highest rate of pediatric obesity in the United States and ranks 44th among the 50 states in health outcomes for its adult populace” (p. 1).

Childhood obesity negatively impacts children’s ability to learn, their test scores, behavioral and psychological health, ability to concentrate, energy levels, and school absenteeism (Schwimmer, Burwinkle, & Varni, 2003). In a major study conducted by Schwimmer et al. (2003) the authors concluded that “obese children and adolescents were 4 times more likely than healthy children and adolescents to report impaired school function.” (p. 1819). As noted by Schwimmer et al., their study is consistent with a study in Thailand, which

reported that “overweight children and adolescents in grades 7 through 9 were twice as likely to have low grades in math and language as healthy children and adolescents. Obese children and adolescents missed a mean of 4.2 days of school in the month prior to the evaluation” (p. 1819). Because healthy habits are learned during the early years in a person’s life, it is crucial to have intervention among school-aged youth to help prevent negative health outcomes later in life.

The health of young people is critically linked to the health-related behaviors they choose to adopt. These health-related behaviors play an important role in children’s academic success. According to the CDC (2011), “the health of young people is strongly linked to their academic success and the academic success of youth is strongly linked with their health” (para. 1). The Centers for Disease Control (2011) claims there is a strong link between poor academic performance and health-related factors such as chronic illness, physical and emotional abuse, and hunger. According to the CDC (2011) health-risk behaviors such as substance use, violence, and physical inactivity are consistently linked to academic failure and often affect students' school attendance, grades, test scores, and ability to pay attention in class. Thus, helping students stay healthy should be a fundamental part of the mission of schools.

In the last few decades school health has moved from the single-area approach such as health class toward comprehensive, multi-area approaches such as nutrition, physical activity, and mental and spiritual health. According to Ottoson, Streib, Thomas, Rivera, and Stevenson, (2004), “the change mirrors a shift from infectious diseases to chronic diseases as the leading causes of death” (p. 170). “The need for coordination was recognized early on and refined, sharpened and expanded, as early as 1977 a call was made to create a role in schools for an individual to focus specifically on coordination of school health programs” (Ottoson et al., 2004, p. 170). According to Fisher et al. (2003), “a coordinated school health program provides a

framework for school districts and schools to use in organizing and managing school health initiatives. It also provides an organizational framework for state agencies to use in planning and coordinating school health initiatives, synchronizing comparable public health and school health programs, and efficiently using multiple funding sources to improve the health and education of young people” (p. 9-4).

The Centers for Disease Control and Prevention (2008) has created the Coordinated School Health Program as a way for states to improve students’ health and learning in the schools. The CDC has recommended a specific framework to assist states with implementation of the Coordinated School Health Programs. The framework proposed by the CDC centers around eight components. These are:

1. Health education
2. Physical education
3. Health services
4. Mental health and social services
5. Nutrition services
6. Healthy and safe environment
7. Family and community involvement
8. Staff and Wellness (para. 1)

Despite the agreement among experts regarding the comprehensive approach, coordinated school health programs are typically still not appropriately comprehensive enough to address the problems in student and school health (CDC, 2011). This is partially because school health programs in the United States have resulted largely from a wide variety of federal, state and local mandates, regulations, initiatives, and funding streams. The result of these initiatives

in many schools is a pieced-together program of policies and procedures with differing standards and requirements. According to the CDC (2011), “the professionals who oversee the different pieces of the patchwork come from multiple disciplines: education, nursing, social work, psychology, nutrition, and school administration, each bringing specialized expertise, training, and approaches” (para. 5).

The position of School Health Coordinator (SHC) is vital to a successfully coordinated and quality school health program. The SHC provides leadership and direction to support effective school health policies, practices, and programs. In 1999, American Cancer Society (ACS) launched the National School Health Coordinator Leadership Institute (the Institute). Winnail, Dorman, and Stevenson (2004) state that findings regarding the Institute suggest substantial progress was made in standardizing the school health coordination programs in the school districts of participating SHCs. Program participants reported spending increased time on school health coordination and leadership roles in the community. Though the Institute did show some shortcomings from the training such as teaching the SHCs how to place more importance on the funding for school health coordination programs, it still proved to be relevant to the participant’s needs according to Olsen’s et al. (2001) evaluation.

Statement of the Problem

School health coordinators now more than ever need to have effective leadership traits to navigate through the issues and politics that come along with this position. Ottoson et al. (2004) evaluated the effectiveness of the Institute identifies what those researchers feel are the core elements to the SHCs job:

Even though each school district will have different elements the common core elements are expected in each [school health coordinator] by the national coordinated school health program (CSHP). The five major infrastructure areas are resources, structures,

links, leadership, and development. The resources include a plan that sets goals, defines roles, and sets strategies, personnel, space, funding, and resources. The structures supportive of CSHP include school health advisory councils and coalitions and a school health team. Links between school structures and the community include connection to agencies as well as family and community involvement. The commitment by and access to leadership is needed to make CSHP work as are supportive policies. Professional development and communication systems are needed to initiate and sustain the collaboration. (p. 170)

Ottoson et al. (2004) found that an SHC must have effective leadership skills in order to be able to meet these core elements for their job. The authors drew the following conclusions about the SHC's leadership abilities:

Findings suggest a good match between the institute training experiences and the job of school health coordination. Coordinators flourished in this environment, developing both the infrastructure of the school health coordination and their own leadership skills. Findings also suggest key coordination skills can be taught and that many of the barriers hindering school health coordination can be overcome by concentrated effort. However, coordinators lacked evaluation skills, which could threaten their continued success. They need leadership and advocacy skills, but coordinators also must support efforts to show that coordinated school health activities have an impact on the lives of students. Coordinators must convince their supervisors that their work produces tangible benefits, and that they also need to contribute to further development of the field. Isolated, undocumented successes will do little to build national support for increased investment in coordinated school health. (p. 170)

Considering all the different aspects of the SHC's responsibilities and all of the different entities coordinators have to interact with, the need for effective leadership traits and skills is imperative. The purpose of this study is to explore the leadership traits of the SHCs in the state of Tennessee. The goal of the study is to determine if a SHC's self-perception of leadership traits coincides with the perceptions of the supervisors and colleagues. This may help to improve the training and continuing education of current and future SHCs. This study will also compare the self-perception of city to county SHCs, the effectiveness of a SHC with the number of memberships of professional organizations, and the self-leadership perceptions of the SHCs that have more experience in the school systems with those who have less experience.

Significance of the Study

In the United States 53 million young people attend nearly 129,000 schools for about 6 hours of classroom time each day for up to 13 of the most formative years of their lives. More than 95% of young people aged 5–17 years are enrolled in school (Snyder & Hoffman, 2002). Because schools are the only institutions that can reach nearly all youth, they are in a unique position to improve both the education and health status of young people.

The position of SHCs in the state Tennessee is central to a successfully coordinated and quality school health program. The SHCs provide leadership and guidance to promote effective school health policies, practices, and programs including overseeing comprehensive school health education curriculum, instruction, and assessment. No study has been conducted to determine whether the SHCs' self-perception of leadership traits coincides with the perceptions of the supervisors and colleagues. The results of this study will provide insight into future SHC practices, professional training, and leadership traits.

Possibly one of the greatest challenges in the completion of the SHC's task has been the development of leadership traits that promote learning. The results of this study might help to

illuminate the degree to which an SHC's leadership traits impact others' perceptions and might aid the SHC in choosing a leadership style that successfully promotes the learning process. The results of this study could also lead to the development of a model for professional leadership training of Tennessee's SHCs.

Research Questions

The following research questions were investigated in this study:

Research Question #1: Are the mean scores of the self-assessments of school health coordinators significantly higher than their colleagues' assessments of the school health coordinators' leadership traits using the Leadership Traits Questionnaire?

Research Question #2: Are the mean scores of the self-assessments of school health coordinators significantly higher than the supervisors' assessment of the school health coordinators' leadership traits using the Leadership Traits Questionnaire?

Research question #3: Are the mean scores of the Leadership Trait Questionnaires significantly different for the city school health coordinators and the Leadership Trait Questionnaire scores for the county school health coordinators?

Research question #4: Is there a significant correlation between years of experience working in the school system and the self-perceived leadership traits scores of the school health coordinators?

Research Question #5: Is there a significant correlation between the number of professional organizations the school health coordinators are members of and leadership traits scores?

Limitations and/or Delimitations

Limitations of any study are the generalizability of results to other populations, individuals, and situations. The primary limitation of this study is its narrow scope. This study was conducted only within public school districts in the state of Tennessee. According to the United States Census Bureau (2011), in Tennessee there are 140 public school districts, but there are more than 14,000 public school districts in the United States. Therefore, this study is delimited to the perceptions of SHCs, principals, superintendents, and certain teachers in the state of Tennessee. No attempt was made to determine the study's external validity; i.e., the extent to which its findings can be generalized to other educational institutions outside the state of Tennessee.

A major limitation is the number of responses that were received compared to the number of responses that could have been received. This makes it difficult to assume the sample is representative of the population.

This study additionally relies upon self-reported data. Therefore, the validity of the study is dependent on the candor of study participants. As with all self-reported data, accuracy is dependent upon participants' familiarity with a leader's skill-area competencies.

Definitions of Terms

The following terms are defined and hereinafter used in the study:

1. *Coordinated School Health Program*: a model of support connecting students' health and their capacity to learn through the support of families, communities, and schools all working together in a coordinated and cost-effective manner. First developed by the Centers for Disease Control and Prevention (CDC) in 1987.
2. *Family and Community Involvement*: the concentrated effort of many different entities both at school and in the community with regard to providing an integrated approach to

health and well being of students, including students themselves, parents, representatives from the community, health specialists, and volunteers (TN.gov, 2011).

3. *Health Education*: any combination of learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes (WHO, 2012).
4. *Health Services*: services provided and/or supervised by school health nurses to appraise, protect, and promote the health of students. These services include assessment, planning, coordination of services, and direct care for all children including those with special health care needs. Health services are designed and coordinated with community health care professionals to ensure early intervention, access, and referral to primary health care services; foster appropriate use of primary health care services; prevent and control communicable disease and other health problems; provide emergency care for student and staff illness or injury; provide daily and continuous services for children with special health care needs; promote and provide optimum sanitary conditions for a safe school facility and school environment; and provide educational and counseling opportunities for promoting and maintaining individual, family, and community health (TN.gov, 2011).
5. *Healthy and Safe Environment*: Factors and conditions that influence the quality of the physical environment include the school building and the area surrounding it; transportation services; any biological or chemical agents inside and outside the school facilities that are detrimental to health; and physical conditions such as temperature, noise, lighting, air quality, and potential health and safety hazards. The healthy and safe environment also is concerned with the quality of the physical and aesthetic surroundings; the psychosocial climate, safety, and culture of the school; the school

safety and emergency plans; and the periodic review and testing of the factors and conditions that influence the environment (TN.gov, 2011).

6. *Healthy School Team or School Health Advisory Committees*: a committee that operates on the school-level to plan and carry out healthy school initiatives. School administrators, teachers, and school health staff in all components actively solicit family and student involvement and engage community resources, expertise, and services to respond effectively to the health-related needs of students and families. Qualified professionals such as principals, teachers, and school health staff, in partnership with students, parents, and volunteers provide leadership in this area (Adams, 2008).
7. *a) Leadership*: a process whereby an individual influences a group of individuals to achieve a common goal (Northouse, 2007).
b) Leadership: a complex process by which a person influences others to accomplish a mission, task, or objective and directs the organization in a way that makes it more cohesive and coherent (Clark, 2010).
8. *Leadership Trait Approach*: a theory that began with the emphasis on identifying the qualities of great persons; it shifted to include the impact of situations on leadership; most currently, it then shifted back to reemphasize the critical role of traits in effective leadership (Northouse, 2007).
9. *Leadership Trait Questionnaire (LTQ)*: a quantitative instrument that can be used to assess personal leadership characteristics. The LTQ quantifies the perceptions of the individual leader and selected observers such as subordinates or peers. It measures an individual's traits and points the individual to the areas in which he or she may have special strengths or weaknesses (Northouse, 2007).
10. *Local Education Agency (LEA)*: Commonly used synonym for a school district.

11. *Mental Health and Social Services*: services that are provided to assess and improve the mental, emotional, and social health of every student. These may include developmental classroom guidance activities and preventative educational programs in an effort to enhance and promote academic, personal, and social growth (TN.gov, 2011).
12. *Nutrition Services*: The introduction of healthy eating patterns and concepts to students, reinforcing nutrition concepts introduced in the health education curriculum, and contributing to students' overall health and readiness to learn in the school community. Nutrition Services supports the Coordinated School Health Program (TN.gov, 2011).
13. *Physical Education*: physical activity in an educational setting, which is further defined as a behavior consisting of bodily movement that requires energy expenditure above the normal physiological (muscular, cardiorespiratory) requirements of a typical school day (TN.gov, 2011).
14. *School Health Coordinator (SHC)*: an individual who provides leadership and guidance to promote effective school health policies, practices, and programs, including overseeing comprehensive school health education curriculum, instruction and assessment (Fisher et al, 2003).
15. *Staff Wellness*: health promotion for staff that includes opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities. These opportunities encourage school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program (TN.gov, 2011).

Overview of the Study

This dissertation is divided into five chapters. Chapter 1 provides an introduction to the study and conveys the statement of problem, research questions, significance of the study, delimitations and limitations, and defines significant terms used in the study. Chapter 2 presents a review of literature in 10 areas including Definition of Leadership, History of Leadership, Trait Approach of Leadership, Leadership in School Health, Data from the Office of Coordinated School Health Annual Report, Healthy Schools, The National School Health Coordinator Leadership Institute, Coordinated School Health, School Health Coordinators, and Tennessee Coordinated School Health Program. Chapter 3 presents and outlines the methodology of the research to be conducted including discussions of measurements, participants, data collection, and data analysis. Chapter 4 presents a statistical analysis of the survey results. Chapter 5 conveys the summary of the findings, conclusions, and recommendations for future research and practice.

CHAPTER 2

REVIEW OF LITERATURE

The purpose of this quantitative study was to explore the leadership traits of the school health coordinators (SHCs) for the state of Tennessee and to determine if self-perceptions of the SHC leadership traits coincide with supervisor and colleague perceptions of SHC leadership traits. In review of the relevant research literature examining the leadership traits of local SHCs, the following major sections of the literature are explored: Definition of Leadership, History of Leadership, Trait Approach of Leadership, Leadership in School Health, Data from the Office of Coordinated School Health Annual Report, Healthy Schools, The National School Health Coordinator Leadership Institute, Coordinated School Health, School Health Coordinators, and Tennessee Coordinated School Health Program.

Definition of Leadership

Today's leaders are of all ages, genders, races, and socioeconomic backgrounds. There is no one perfect definition for leadership and there is not one definite type of leader. Stogdill (1974) reported in a review of leadership research, "there are as many different definitions of leadership as there are people who have tried to define it" (p. 7). If the essence of leadership is change, it goes along with the Fleishman et al. (1991) statement that in the past 60 years as many as 65 different classification systems have been developed to define the dimensions of leadership. Typing "leadership" into a search engine on the internet will result in thousands of definitions. There are as many books and papers written on how leadership cannot be defined as there are ones trying to define it.

Northouse (2007) stated "despite the abundance of writing on the topic, leadership has presented a major challenge to practitioners and researchers interested in understanding the

nature of leadership” (p. 12). In his attempt to meet this challenge of defining leadership, Northouse (2007) states that leadership has many components that can be identified through the following: “Leadership is a process, leadership involves influence, leadership occurs in a group context, and leadership involves goal attainment” (p. 3). Using these components, Northouse defined leadership as “a process whereby an individual influences a group of individuals to achieve a common goal” (p. 3).

While there are numerous definitions and theories of leadership, there are enough similarities in the definitions to conclude two things about leadership: that it is an effort of influence and that it is the power to induce compliance (Wren, 1995). Following Northouse’s attempt to define leadership, one can see that leaders can be found in any number of positions in a school setting. Though principals are typically thought of as the leaders, leadership traits can be present in any member of the team.

History of Leadership

The concept of leadership and the study of what makes great leaders have been around since the beginning of civilization. Egyptian rulers, Greek heroes, and biblical patriarchs all have one thing in common—leadership abilities (Stone & Patterson, 2005). However, over the years the concept of leadership has evolved. According to Schultz (2001), “Leadership studies historically went hand-in-hand with studies of elites: political, financial, military, aristocratic, or cultural elites. Leadership was considered an art, for which some fortunate people had an inbuilt genius; the rest of us could only engage in admiring post-game analyses” (p. 2). This is referred to as the Great Man Theory.

According to Stone and Patterson (2005), “the organizational focus of the leader has evolved over this same period. Early organizations with authoritarian leaders who believed employees were intrinsically lazy transitioned into a way to make work environments more

conducive to increased productivity rates” (p. 1). Today, organizations are transforming into places where people are vested, encouraged, and supported in their growth throughout their professions. Because the focus of what makes a great leader has changed over time, it has influenced and developed the advancement of leadership theory.

Many theories have been developed over the decades in the study of leadership. The theories on trait leadership, one of the earlier models of leadership, arose out of the early 20th century concept of the Great Man Theory. “The trait approach was one of the first systematic attempts to study leadership” (Northouse, 2001, p.15). The trait approach expounds the possession of innate qualities that distinguishes leaders from followers. The trait approach is based on the assumption that the leader possesses certain traits that others do not possess. These qualities were seen as the exclusive possession of “great social, political and military leaders” (Northouse, 2001, p. 15).

According to Northouse (2007) a large number of leadership studies were conducted throughout the 20th century trying to establish the leader’s most important traits. In other words all these leadership studies focused their attention on finding a set of personal characteristics that define a great leader. Newer theories on leadership expel the notion that leadership arises only from one’s innate qualities. Bass's theory of leadership states that there are three basic ways that people become leaders (Bass, 1998). These theories are:

1. Some personality traits may lead people naturally into leadership roles. This is the Trait Theory.
2. A crisis or important event may cause a person to rise to the occasion, which brings out extraordinary leadership qualities in an ordinary person. This is the Great Events Theory.
3. People can choose to become leaders. People can learn leadership skills. This is the Transformational or Process Leadership Theory. (Bass, 1998).

Another theory of leadership is the Situational/Contingency Theory. Stone and Patterson were researchers who helped define the Situational/Contingency Theory through their study that matched leaders with what they deemed were appropriate situations based upon one's leadership skills. In their research they noted that "leaders did more than simply "act" they often had to "react" to specific situations, and thus, the situational/contingency theory of leadership evolved" (Stone & Patterson, 2005, p. 5). Hersey and Blanchard (1996) noted two different leadership behaviors made a difference in how you use this theory. The first factor is called job maturity, meaning relevant task and technical knowledge and skills, and the other factor is psychological maturity, meaning level of self-confidence and self-respect. "An employee who has a high level of job maturity and a high level of psychological maturity requires little supervision; while an employee who has a low level of both requires more hands-on attention" (Stone & Patterson, 2005). With regard to this theory, Northouse explained that, "effective leadership is *contingent* on matching a leader's style to the right setting" (p. 75).

Another leadership theory, Transactional Leadership Theory, focuses on the specific interactions between leaders and followers (Burns, 1978). This theory notes that transactional interactions comprise the bulk of relationships between leaders and followers (Burns, 1978). Transactional leadership focuses on ways to maintain the status quo and manage the day-to-day operations of a business. It does not focus on identifying the organization's goals and how employees can work toward and increase their productivity in alignment with these goals, thus increasing organizational profitability (Avolio, Waldman, & Yammarino, 1991).

The theory of Transformational Leadership came to light during the early 1980s. Transformational Leadership Theory focuses on the effects of followers' trust, admiration, and respect for their leader. As a result followers are motivated to perform at a higher level than expected (Bass, 1985). Although James Downton, a noted researcher in leadership theory,

conceived the term, Burns (1978) was the first to examine the relationship between the leader and the followers and to articulate their association with certain values such as ethics and goal achievement. Burns first introduced the concept of transformational leadership by describing it not as a set of specific behaviors but rather as an ongoing process by which "leaders and followers raise one another to higher levels of morality and motivation" (p. 20).

Transformational Leadership has evolved from and contains elements of preceding leadership types, such as trait and behavior theories, as well as charismatic, situational, and transactional leadership.

Bass (1997), stated that "it was clear from empirical evidence that transformational leadership could be exhibited by samples ranging from the housewives active in the community to students to....the President of the United States" (p. 132). According to Bass (1985) there are two main styles of leadership: (1) transactional, which describes the relationship between managers and employees as one in which employees exchange some form of task for reward, and (2) transformational, which is achieving greater performance by inspiring original ways of thinking and transforming followers' beliefs and aspirations, as well as their own. The transformational leader sees the importance of having a vision and can encourage commitment to that vision.

Another theory, the Leader-Member Exchange Theory (LMX), which came to researchers' attention in the mid-1970s, focused on the differences between the leader and each individual follower, rather than viewing followers as a collective entity. It found two types of interactional linkages or relationships: "those that were based on expanded and negotiated role responsibilities...called the *in-group* and a second set that were based on the formal employment contract...called the *out-group*" (Northouse, p. 112). According to Northouse (2001), "Membership in either the in-group or out-group depended upon how well the subordinate

related to the leader and how well the leader worked with the subordinate. One way of being in the in-group was dependent upon the subordinate's willingness to take on additional and varying job responsibilities. Disinterest in doing the above would land the subordinate in the out-group" (p. 112).

A later leadership theory, House's Path-Goal Theory, as described in Northouse (2001), was all about leaders' motivating subordinates to reach the goals by helping them become more competent and feel more satisfaction. Greenleaf (1977) proposed the Servant Leadership Theory. He focused on the dynamics of the relationships among leaders and their various followers. He asserted that leaders enhance followers' ability to reach their full potential as human beings. Greenleaf's model assumes that in order to achieve anything, much less excellence, leaders must support the ideas and actions of their followers rather than issue commands.

Regardless of the theory of leadership one adheres to, Meyer and Slechta (2002) emphasize that at no other time in history has there been such a demand for effective leadership. The challenge today is for effective leadership to accentuate the good decisions and then find a way to reshape the bad. Meyer and Slechta (2002) note that, "part of the universal challenge of leadership is defining it in a way that will apply to virtually everyone" (p. 19). Leadership is not defined by title, position, style, personality, or possession of certain skills. Meyer and Slechta (2002) contend that trust, commitment, and loyalty are not by-products of success but rather the causes of success.

Trait Approach of Leadership

According to Zaccaro (2007) in the most recent research trait theories are reaching predominance again. "More recently, a number of studies have linked personality variables and other stable personal attributes to leader effectiveness, providing a substantial empirical

foundation for the argument that traits do matter in the prediction of leader effectiveness” (p. 6).

Despite the rise and prominence of other leadership theories such as charismatic and transformational leadership, “These models, while recognizing the important role of the situation in leadership, pointed once again to the extraordinary qualities of individuals as determinants of their effectiveness” (House, 1988, p. 305).

For centuries people have been trying to determine what traits make a leader effective. Zaccaro (2007) reported that “trait approaches dominated the initial decades of scientific leadership research” (p. 6). Even though leadership traits fell out of popularity for several years, Zaccaro states, “more recently, a number of studies have linked personality variable and other stable personal attributes to leader effectiveness, providing a substantial empirical foundation for the argument that traits do matter in the prediction of leader effectiveness” (p. 6).

Many different lists and categories are available under leadership trait theories. The Leadership Trait Questionnaire “quantifies the perceptions of the individual leader and selected observers. It measures an individual’s traits and points the individual to the areas in which he or she may have special strengths or weaknesses” (p. 32). The personal characteristics are as follows:

1. Articulate: communicates effectively with others,
2. Perceptive: discerning and insightful,
3. Self-confident: believes in oneself and one’s ability,
4. Self-assured: secure with self, free of doubts,
5. Persistent: stays fixed on the goals despite interference,
6. Determined: takes a firm stand, acts with certainty,
7. Trustworthy: acts believably, inspires confidence,
8. Dependable: is consistent and reliable,

9. Friendly: shows kindness and warmth,
10. Outgoing: talks freely, get along well with others. (p. 33).

The Army has created an entire manual titled *Competency Based Future Leadership Requirements* that addresses the traits the Army feels a leader must have. For example, the Army has developed eight areas in which one must be competent in order to become a leader, known as “competencies”, and 55 components for their leadership framework. According to Horey et al. (2004) the eight competencies are as follows:

1. Leading others to success
2. Exemplifying sound values and behaviors
3. Vitalizing a positive climate
4. Ensuring a shared understanding
5. Reinforcing growth in others
6. Arming self to lead
7. Guiding successful outcomes
8. Extending influence (p. 67)

Many researchers have attempted to identify the leadership traits they feel are the important determinants for successful leadership. For example, Kouzes and Posner (2007) listed honesty, forward-looking, inspiring, and competency as some of the most important leadership traits. Honesty has consistently been at the top of the list and is the single most important factor in the leader-constituent relationship, according to Kouzes and Posner (2007). People expect their leaders to be truthful, ethical, and principled. Honest leaders stand on important principles. People won't trust or follow a leader who does not disclose and live by a clear set of values, ethics, and standards.

Another researcher who identified important determinates for successful leadership, Stogdill (1974), identified the following 10 characteristics of a leader:

1. a drive for responsibility and task completion,
2. vigor and persistence in pursuit of goals,
3. venturesomeness and originality in problem solving,
4. the drive to exercise initiative in social situations,
5. self-confidence and a sense of personal identity,
6. a willingness to accept consequences of decisions and actions,
7. readiness to absorb interpersonal stress,
8. willingness to tolerate frustration and delay,
9. ability to influence other person's behavior [sic], and
10. a capacity to structure social interaction systems to the purpose at hand (p. 25).

Many other researchers have studied and compiled their own lists of leadership traits. Lord, DeVader, and Alliger (1986) found that personality traits and leadership perception are strongly related. Their research supports that traits such as intelligence, masculinity-femininity, and dominance were associated with leadership perceptions, more than previously thought. Kirkpatrick and Locke (1991) stated that effective leaders are actually distinct types of people in several key respects. The key leader traits they felt were drive, leadership motivation, honesty and integrity, self-confidence, cognitive ability, and knowledge of the business. Kirkpatrick and Locke said that these traits could be learned, present at birth, or both. Zaccaro also created a list and a model to understand leadership traits. The model is based on the premise that "leadership emerges from the combined influence of multiple traits as opposed to emerging from the independent assessment of traits" (Zaccaro, 2007). The traits he lists based on his model include; extraversion, agreeableness, conscientiousness, openness, honesty, intelligence, and

decision making. Today there are so many research studies addressing trait theory that even an internet search will bring up a multitude of websites boasting titles such as “14 Most Important Leadership Traits” or “Top 10 Leadership Qualities You Must Have”. However, though different researchers all have developed different lists of leadership traits, it is clear that many of the traits are similar in concept if not in exact definition. And further, regardless of the specific traits identified, many researchers say that not only are people born with these traits, but they can also be cultivated over time if one is willing.

Northouse (2007) extracted from the multitude of research on trait theory and compiled a list of traits that he indicates are central to effective leadership, which are intelligence, self-confidence, determination, integrity, and sociability (p. 19). These traits are ones that Northouse (2007) states “contribute substantially to one’s capacity to be a leader” (p. 21). Table 1 shows Northouse’s definitions for each trait.

Table 1

Major Leadership Traits

| | |
|--|---|
| Intelligence | Having strong verbal ability, perceptual ability, and reasoning appears to make one a better leader. |
| Self-confidence | The ability to be certain about one’s competencies and skills. A sense of self-esteem and self-assurance and the belief that one can make a difference. |
| Determination | The desire to get the job done and includes characteristics such as initiative, persistence, dominance, and drive. |
| Integrity | The quality of honesty and trustworthiness. Adhering to a strong set of principles and take responsibility for ones actions. |
| Sociability | A leader’s inclination to seek out pleasant social relationships. One who is friendly, outgoing, courteous, tactful, and diplomatic. |
| Table 1 Adapted from Northouse (2007). | |

Leadership in School Health

The seven cardinal principles of education were issued by the National Education Association in 1918. The number one principle was “Health.” The principle stated, “A secondary school should encourage good health habits, give health instruction, and provide physical activities. Good health should be taken into account when schools and communities are planning activities for youth. The general public should be educated on the importance of good health. Teachers should be examples for good health and schools should furnish good equipment and safe buildings” (Raubinger, Rowe, Piper, & West, 1969).

David Satcher (2010), former U.S. Surgeon General, stated, “If we are ever going to eliminate disparities in health, we must transform communities; people need to have access to healthy behaviors, we need leaders who care enough, know enough, will do enough, and are persistent enough” (para. 6). Satcher also stated that “schools can be the great equalizer because the majority of all children spend more of their waking hours there than anywhere else” (para. 4). Studies by the National Academy of Medicine (2004) show a correlation between inactivity and obesity in children and poor school performance. Satcher (2010) stated “this often puts students at increased risk for low test scores, more absences, depression and withdrawal” (para 4). According to the Centers for Disease Control and Prevention (2010), the goals of school health should be:

1. Improve health knowledge, attitudes, and skills
2. Improve health behaviors and health outcomes
3. Improve educational outcomes
4. Improve social outcomes (para 2.)

How do schools accomplish these goals? One way may be through coordinated school health programs that emphasize leadership. According to Leithwood and Riel (2003), “School health is a program that must have goals that are “mutually satisfying” to several entities such as the School Board of Directors, Principals, teachers, students, parents, and the community” (p. 3).

In 2003 a study was conducted by a task force of the American Educational Research Association to promote high-quality research in educational leadership. The study focused on successful leadership practices and their importance to educational organizations. Leithwood and Riehl (2003) authors of the study discovered three categories of leadership practices that influenced school success: “setting direction, developing people, and developing the organization” (p. 3).

Deal and Peterson (2009) defined school leadership by discussing two essential steps to create a strong and positive program. The first step is to read the current school culture and the second is to take on several important leadership roles to help shape the culture. Effective leaders read between the lines to figure out what is really going on in the school’s culture. They understand the school’s patterns, purposes, and history. Deal and Peterson (2009) state that “trying to change a culture without first understanding it is a recipe for stress and failure. To read the culture, leaders together with staff need to listen, watch, sense, and interpret in order to understand the values, assumptions, and traditions already in place” (p. 9). To help school leaders assess the current state of the culture, they can ask questions such as the following:

1. Are staff and student work and accomplishments shared?
2. What are the key ceremonies and stories of the school?
3. What do people say (and think) when asked what the school stands for?

4. What are the social rituals of interaction and support?
5. What are people's hopes (spoken and unconscious) for the school's future?
6. What events are assigned special importance?
7. Who are the recognized (and unrecognized) heroes and villains of the school?
8. How is conflict defined and handled? (p. 9)

Leadership includes a mixture of qualities and characteristics such as influence and the ability to stimulate others into action that will result in meeting the goals of the group as well as those of the leader. Because the SHC has to meet several goals, the need to have the support of many different people at many different levels is great. A SHC is central to a well-coordinated health program. A SHC who demonstrates effective leadership traits can make the difference between a fragmented approach to school health and a planned, coordinated, and effective program.

The National School Health Coordinator Leadership Institute

The American Cancer Society launched a National School Health Coordinator Leadership Institute in 1999. According to Ottoson et al. (2004) this was a “groundbreaking initiative designed to enhance and invigorate school health in the nation's schools by training individual school health coordinators to act as change agents” (p. 170). The reason the leadership program was implemented is because according to Ottoson et al. (2004), “with more than 60% of cancers linked to behaviors that often start in childhood and with schools as the most organized system to reach the nation's 50 million youth, ACS has had a long standing interest in school health: ‘cancer risk reduction begins with school health’” (p. 171).

The Institute ran for three, week-long summer training sessions, and three, shorter midyear "booster" sessions, with the various sessions designed to build leadership capacities to coordinate school health (Winnail et al., 2004). The effects of the Institute were evaluated by Ottoson and her colleagues through a panel survey of the SHCs over an 18-month period. Ottoson et al. (2004) noted that five major program outcomes for the Institute were for the coordinators to "[1] demonstrate competency in building organizational capacity for the promotion of school health programs; [2] demonstrate skills necessary to be an effective advocate for school health programs; [3] demonstrate competencies in the use of multiple strategies, which identify and assess program status and evaluation of planned outcomes; [4] demonstrate the ability to teach and motivate others responsible for school health promotion; and [5] demonstrate competency in resource development and overall project management" (p. 171). The Institute's last session was in 2002, but they still contact the coordinators by implementing ongoing educational programs and communication strategies.

An outcome evaluation was conducted by professors at Georgia State University. According to Ottoson et al. (2004) the findings show steady and sometimes dramatic changes in the 18 months following the program among participants and in their school districts. The findings showed participants investing more time in school health coordination, possibly due to greater recognition of their role. The SHCs were more likely to possess an effective job description focused on school health coordination, due to being enrolled in the program. "Findings also suggest key coordination skills can be taught and that many barriers hindering school health coordination can be overcome by concentrated effort" (Ottoson et al., 2004, p. 175). A few weaknesses were found, such as "coordinators lacked evaluation skills, they need to learn how to advocate their programs, and they must learn how to convince their supervisors of

the importance of their position” (Ottoson et al., 2004, p. 175). The evaluation found that the Institute leadership program was a good match for the SHCs.

Data from the Office of Coordinated School Health Annual Report

The Office of Coordinated School Health Annual Data and Compliance Report (2011), (Report) generated by the Tennessee Department of Education provides data on surveys conducted annually at all public school systems in Tennessee. The Report monitors compliance with state school-health laws and assesses the scope of school health services provided to Tennessee public school students. According to the 2009-2010 report in Tennessee school’s “166,222 students had a medical diagnosis. This represents approximately 17% of all Tennessee public school students. Most students were diagnosed with Asthma (31%), ADHD/ADD (19%), Intellectual Disability (15%) and Severe Allergy (11%)” (p. 2).

The Report also states that the total number of students with “selected chronic illnesses or disability diagnoses increased by 32% between 2004-2005 and 2009-2010. The most challenging health diagnosis to manage was diabetes (55%), followed by asthma (10%), and mental health issues (10%)” (p. 2). Student health screenings in most school systems provided vision, hearing, BMI, and blood pressure screening. According to the data approximately “48% of all local education agencies (LEAs) provided scoliosis screening, and 47% of all LEAs provided some type of dental screening. The percentage of all school-health screenings increased by 7% from 2008-2009 to 2009-2010. The most significant increases occurred with hearing (19%), dental (10%) and BMI (9%) screenings. Decreases occurred in the percentage of students screened for scoliosis (-6%) and vision (-4%)” (p. 4).

Table 2 shows the type, number, and percent of health services provided in all Tennessee public schools for 2009-2010. As shown, the most common types of health services provided in

Tennessee schools included emergency planning (97%), medication administration (97%), Care of Ill/Injured Staff and Students (96%), and training/supervision of nonmedical personnel (95%).

Table 2

Health Services Provided in Tennessee Schools in the 09-10 School Year

| Health Services | Number of Schools | % of All TN Schools: (N=1,758) |
|--|-------------------|-----------------------------------|
| Emergency Planning with School Staff and Community Partners | 1,701 | 97% |
| Medication Administration | 1,698 | 97% |
| Care of Ill/Injured Staff | 1,696 | 96% |
| Care of Ill/Injured Students | 1,686 | 96% |
| Training and Supervision of Nonmedical Personnel | 1,672 | 95% |
| Vision Screening | 1,614 | 92% |
| Health Counseling/Referral | 1,605 | 91% |
| BMI Screening | 1,604 | 91% |
| Hearing Screening | 1,590 | 90% |
| Blood Pressure Screening | 1,585 | 90% |
| Health Education for Students | 1,562 | 89% |
| Immunization Compliance Monitoring | 1,526 | 87% |
| Staff Wellness Activities | 1,517 | 86% |
| CSH Healthy School Team Member | 1,489 | 85% |
| Nursing Services to Students with Special Needs (CDC/Special Education Classroom) | 1,277 | 73% |
| Scoliosis Screening | 662 | 38% |
| Home Visits by Nurses | 551 | 31% |

Table 2 (continued)

| | | |
|---|-----|-----|
| Dental Screenings | 492 | 28% |
| CSH Healthy Advisory Council Member | 478 | 27% |
| Nursing Services to Students with Special Needs (IEP/504) | 145 | 8% |
| Table 2 | | |
| Adapted from Tennessee Department of Education (2011) | | |

The Report also discussed laws with which the school systems must be compliant. Table 3 identifies the different laws and data regarding compliance.

Table 3

Laws for Compliance

| Law | Results |
|--|---|
| The Physical Education/Activity Law (T.C.A. 49-6-1021) | In 2009-2010 only 24% of all school systems provided daily physical education for their students |
| | Twenty seven percent (27%) of all school systems provided daily physical education for their elementary school students. |
| | Twenty-nine percent (29%) of all school systems provided daily physical education for their middle school students. |
| | Sixteen percent (16%) of all school systems provided daily physical education for their high school students |
| Food Vending and A La Carte Law (T.C.A. 49-6-230) | During the 2009-2010 school year, 86% of Tennessee school systems were in compliance with the food vending and a la carte law. |
| HIV Staff Training Law (Tennessee State Board of Education HIV/AIDS Policy for Employees and Students of Tennessee Public Schools 5.300) | LEAs reported that 89% of Tennessee school systems were in compliance with the HIV and Blood-borne Pathogens staff training law |

Table 3 (continued)

| | |
|---|--|
| Annual Staff Suicide Prevention Training Law (T.C.A. 49-6-3004) | School systems reported that 84% of all school systems provided annual staff training on suicide prevention during the 2009-2010 school year. |
| Cardio-Pulmonary Resuscitation (CPR) (TCA 49-5-414) | During the 2009-2010 school year, 15,465 full-time school employees are currently certified in CPR: |
| | In 2007-08, 130 school systems provided CPR training as a professional development opportunity this past school year. Ten school systems did not provide CPR training |
| | In 2009-2010 school year, 328 schools provided CPR training to students. |
| | 29,357 students received CPR training during the 2009-2010 school year |
| Tobacco Education Program | LEAs are not required to provide tobacco education to students however, 81% of all school systems report that some type of tobacco prevention program was provided to their students during the 2009-2010 school year. |
| Table 3 | |
| Adapted from Tennessee Department of Education (2011) | |

Healthy Schools

According to the Centers for Disease Control and Prevention (CDC) (2011), childhood obesity rates have tripled in the last 30 years. “The percentage of children aged 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 20% in 2008. Similarly, the percentage of adolescents aged 12–19 years who were obese increased from 5% to 18% over the same period” (para. 1). The CDC defines overweight “as a BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex. Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex” (p. 1). Childhood obesity has both immediate and long-term effects on health and well-being. The CDC (2010) released the following facts about childhood obesity:

Immediate health effects:

- Obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. In a population-based sample of 5- to 17-year-olds, 70% of obese youth had at least one risk factor for cardiovascular disease.
- Obese adolescents are more likely to have pre-diabetes, a condition in which blood glucose levels indicate a high risk for development of diabetes.
- Children and adolescents who are obese are at greater risk for bone and joint problems, and sleep apnea
- Obese children and adolescents have a greater risk of social and psychological problems, such as discrimination and poor self-esteem, which can continue into adulthood (para. 2)

Long-term health effects:

- Children and adolescents who are obese are likely to be obese as adult and are therefore more at risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. One study showed that children who became obese as early as age 2 were more likely to be obese as adults.
- Overweight and obesity are associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gall bladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin's lymphoma (para. 3)

By establishing a safe and supportive environment with policies and practices that support healthy behaviors, schools play a vital role in preventing childhood obesity. Lack of daily quality physical activity in schools, sugar drinks and less healthy foods on school campuses, and no safe and appealing place in communities to be active are some of the leading reasons why children are obese and overweight according to the CDC. Tennessee ranks 47th in overall prevalence, with 36.5% of children being considered overweight or obese according to the National Initiative for Children’s Healthcare Quality (2010). The national average for childhood obesity is 32% (CDC, 2010). Tennessee is taking steps to remedy its childhood obesity problem such as applying for and being awarded grants like the Robert Wood Johnson Foundation’s Healthy Kids and HEAL Appalachia and implementing programs focused on coordinated school health. However, as the numbers make clear, these efforts still are not sufficient. Tennessee Department of Education (2010) stated, “since healthy habits learned during the formative years are crucial to preventing negative health outcomes later in life, early intervention among school aged youth is necessary and essential in reducing these alarming trends” (p. 6).

Coordinated School Health

According to the United Nations Children’s Fund (UNICEF, 2012) two major determinates of whether a child will grow up to be self-sufficient and a productive member of society are health and education. Many people and organizations in a child’s life will play important roles in teaching these qualities, one of which will be that child’s school. However, it is often not sufficient for a school to simply implement health-related programs. Studies have shown that the implemented health program must be a coordinated program in order for it to be effective.

O' Brien et al. (2010) conducted a study about the impact of school health programs among intervention and nonintervention schools. The authors of this study classified the schools as intervention and nonintervention schools. Intervention schools are schools that have implemented and have continuing effective coordinated school health programs (CSHPs) in place. Nonintervention schools have either no CSHP or ineffective SHCs. The results of the study showed "intervention schools were more likely to be associated with physical activity intramural offerings, improved nutritional offerings, and tobacco cessation programs. In intervention schools, supportive school policies were associated with decreased soda consumption, decreased inactivity, and decreased tobacco use" (O'Brien et al., 2010, p. 176).

Many schools include different health programs, such as implementing nutritional regulations for cafeteria and vending machines or physical education programs. However, according to Winnail et al. (2004), "few schools include all the recommended components of a coordinated program. Even fewer provide administration or coordinate the components" (p. 79). Realizing the need for program management, Davis and Allensworth (1994) stated the "next step in realizing the potential of an expanded concept of comprehensive school health programs includes developing a 'focusing', or 'integrating' component to integrate the elements of a comprehensive school health model" (p. 400).

The Centers for Disease Control and Prevention (CDC) developed the Coordinated School Health Model in 1987. To find a solid definition of coordinated school health program (CSHP) is difficult because the programs need to be customized to that state, district, school, and community's needs. Basically, it is a planned and organized set of health related programs and/or policies coordinated to meet the community's, district's, and school's needs. The CDC recommends the CSHP as a way to improve student's health and learning in the schools. From 2000-2008, Tennessee's CSHP was modeled after and partially funded by the CDC. Maine is

one of the first states to implement a CSHP. Maine's governmental webpage dedicated to CSHPs states that "a coordinated school health program is an effective system designed to connect health with education. This coordinated approach to school health improves students' health and their capacity to learn through the support of families, communities and schools" (State of Maine Department of Education, 2010, para 1).

The CDC has provided a framework for states to use to start their own CSHPs. The framework proposed by the CDC centers around the following eight components.

1. Health education
2. Physical education
3. Health services
4. Mental health and social services
5. Nutrition services
6. Healthy and safe environment
7. Family and community involvement
8. Staff wellness (Fisher et al., 2003, p. 9-4)

By focusing on these eight components a school can coordinate already-existing policies and procedures that have been put in place to improve students' health. According to the CDC (2010) by focusing on these components schools will be able to:

1. Eliminate gaps and reduce redundancies across the many initiatives and funding streams.
2. Build partnerships and teamwork among school health and education professionals in the school.
3. Build collaboration and enhance communication among public health, school health, and other education and health professionals in the community.

4. Focus efforts on helping students engage in protective, health-enhancing behaviors and avoid risk behaviors. (p. 1)

The CDC released a packet called *Make a Difference in Your School!* in 2008 as a resource guide promoting coordinated school health efforts to help prevent obesity in young children. The packet has strategies for school systems to implement health-related programs in the classrooms. This packet states, “Emerging research documents the connections between physical activity, good nutrition, physical education and nutrition programs, and academic performance” (CDC, 2008, p. 2).

School health may have started as a few hours of instruction in a classroom with a school nurse handing out aspirin and Band-Aids. Research, however, shows that a comprehensive program is needed in schools on a daily basis because health and learning go hand-in-hand. Dunkle and Nash (1991) provided some of the first comprehensive school health ideas in a government document from the Council of Chief State School Officers. They stated that effective health instruction involves the following important areas: “growth and development, nutrition, infectious and chronic diseases, health promotion, and substance abuse” (Dunkle & Nash, 1991, p. 13). They additionally stated, “School health services include vision, hearing, and other screening tools, food services, counseling, a fitness room or program, a nurse or aide, referrals to community health services, or a school based health clinic. A healthy school environment involves a safe structure and location, buildings free from asbestos, tobacco smoke, and other hazardous substances, and a supportive learning environment” (Dunkle & Nash, 1991, p. 13). This list of ideas was an early precursor to the current CDC components for coordinated school health.

According to the Centers for Disease Control and Prevention (CDC) numerous studies have found school health programs can have a positive effect on educational outcomes as well as

on health risk behaviors and health outcomes. Adams (2008) claims that children who come to school in good health are more likely to experience desirable academic outcomes including higher grades, class participation, school attendance, and standardized test scores. As a result many states and school systems have taken on the challenge of promoting positive student health.

School Health Coordinators

In 1995 the School Health Policies and Program Study recommended strengthening school health education by “increasing the number of districts that appoint an individual responsible for coordinating health education” (Winnail et al., 2004, p. 1). The Joint Committee on Health Education and Promotion Terminology described a school health coordinator (SHC) as a “certified or licensed professional at the state district or school level responsible for managing, coordinating, implementing, and evaluating all school health policies, activities, and resources” (Winnail et al., 2004, p. 1). The National Association of State Boards of Education (2010) have defined the responsibilities of the SHC as follows:

Each school/district shall appoint a school health coordinator to assist in the implementation and coordination of school health policies and programs by:

1. developing community resource listings (e.g., medical, dental, vision-related, mental health, and social services);
2. assuring that offers from community agencies and professionals to provide schools with products or services are assessed and, if accepted, applied appropriately to school programs;
3. helping teachers develop health- and safety-related activities that involve students' families and the community;
4. acting as a liaison or representative to school and community partnerships;

5. coordinating school health and safety teams, and serving as a resource for school and district health and safety advisory councils;
6. coordinating efforts of school nurses, counselors and other staff members to identify and address primary causes of student absences, student injuries, and disease outbreaks;
7. coordinating efforts to assess the school environment for contradictory health- and safety-related messages;
8. identifying potential funding sources for supporting programs; and,
9. evaluating and revising components of school health and safety programs, including coordination itself. (para. 30)

With the guidance of the CSH office, SHCs are able to provide the crucial link in each school system that allows for implementation of the state mandates and laws that include:

1. Assessments of student's Body Mass Index
2. Physical Activity
3. Vending/Competitive Foods
4. HIV/Family life
5. Safety instruction
6. Bloodborne Pathogen Training
7. Character Education
8. Suicide Prevention Training
9. Child Nutrition and WIC Reauthorization Act of 2004
10. Data and Compliance Report. (p. 12)

Another resource for SHCs are the State Advisory Boards. These boards meet annually and are comprised of several state agencies and institutions providing the SHCs with guidance, collaboration, and an external evaluation source. According to the CSH office (2011) parents and students are also involved with the Advisory boards. The SHCs involve faculty and staff to participate in different elements of the program, they also provide ongoing professional development and promote wellness among the faculty and staff. Coordinating these standards in a school environment can help organize all the different aspects of schools policies and procedures aimed at improving student health.

Tennessee Coordinated School Health Program

Tennessee's School Health Program is special because Tennessee was the first state to provide funding to all school districts to establish the Centers for Disease Control and Prevention's (CDC) Coordinated School Health model. Tennessee's Office of Coordinated School Health was established by the Department of Education in February 2001. The primary mission of the office is to improve student health outcomes as well as support the connection between good health practices, academic achievement, and lifetime wellness. This happened under the leadership of the late Connie Hall Givens. She served as the program director until her death in 2009. The Tennessee General Assembly passed legislation renaming the state's Coordinated School Health Program in honor of Connie Hall Givens. It is now called the Connie Hall Givens Coordinated School Health Grant Program.

In 2000 Tennessee's state legislature funded a 5-year pilot program to implement coordinated school health in 10 counties. According to Adams (2008) the Tennessee Legislature passed the Coordinated School Health Improvement Act and the State Board of Education created Coordinated School Health (CSH) Standards and Guidelines. Implementation of the CSH Initiative, aimed at improving the health of Tennessee public school children, got underway

in 2001. The project began in 10 pilot districts and expanded to the rest of the state on July 1, 2007 with additional state funding. As of 2009 Tennessee was the only state in the nation with a legislative mandate to implement the CDC's Coordinated School Health (CSH) model in all local education agencies. On the basis of this successful pilot, school health advocates convinced state legislators to expand and fund coordinated school health statewide. Tennessee has been moving toward full implementation of coordinated school health by the 2012–13 school year.

All school districts in Tennessee have been pushing to be in compliance with Tennessee school health laws and coordinated school health standards. According to Fetro and Carroll (2010), “They are hiring full-time coordinators for the programs; sending educators to mandatory professional development institutes; and establishing community school health advisory committees, district-level staff coordinating councils, and healthy school teams” (p. 32). Several school districts are completing the School Health Index and Youth Risk Behavior Survey and they are using the results to develop yearly achievement plans.

According to the Executive Summary of CSH (2010), “CSH coordinators in each local education agency provide the leadership necessary to develop school health policy, partnership and activities that advance health and thereby improve student academic outcomes” (p. 6). Marx, Wooley, and Northrop (1998) describe the eight components of coordinated school health programs. They are nutrition; physical education; healthy school environment; mental health; school staff wellness; student, family, and community partners, health services; and health education. The purpose of coordinated school health, according to the Tennessee Department of Education (2011), is to “improve student’s health and their capacity to learn through personal responsibility, and the support of families, communities, and school” (para. 3).

Tennessee is focusing on integrating and coordinating the eight components of the framework. According to Marx et al. (1998) they hope to improve grades and reduce absenteeism and dropout rates. The authors make the point that building successful health programs in the schools can be linked to students' ability to learn.

The Executive Summary of Tennessee Coordinated School Health (2010) states, "over 8,000 fewer children were classified as overweight or obese in 2008-2009 compared to the previous year" (p. 6). Tennessee schools have made great strides in improving the quality of food and drinks sold on their campuses. According to the Summary "the percent of Tennessee schools that did not sell soda or high-calorie fruit juice increased from 26% in 2006 to 74% in 2008. Tennessee now ranks second in this category [non-soda schools]" (p. 6). "In, addition, 64.7% of Tennessee secondary schools sold only foods that met the state's minimum nutritional guidelines."(p. 6). Tennessee was recognized for its achievements in school health and is now used as a "best practice" for other states' coordinated school health programs to refer. Other achievements, according to the Executive Summary are listed below:

1. Seventy-one percent of elementary schools, 57% of middle schools and 37% of high schools reported they are in compliance with the legislative mandate for 90 minutes of physical activity per week.
2. Out of the 2,700,234 student visits to school nurses during the academic year, 61.3% of these students returned to the classroom to receive instructional time. Thereby increasing class attendance, which has the potential to have a positive impact on the student.

3. Over 27% of Tennessee children Pre-K through 12th grade were screened at school for health problems. With over 1 million screening's completed, 116,659 referrals were made to health professionals, which may have not occurred without the CSH program.
4. An average of 21 CSH community partnerships per school system were in place during the 2008-2009 school year. These community partnerships are crucial to building support and sustainability for health related CSH initiatives (p. 6-9).

With all of these responsibilities, it is vital that the SHCs have leadership traits that will allow them to meet these goals. There are plenty of resources for SHCs to take advantage of such as the Tennessee State office of Coordinated School Health (CSH). In the Executive Summary for the CSH (2010), the State provides not only technical assistance to each district but the following support as well:

1. Collaborates with the State CSH Advisory Committee
2. Maintain and revise the CSH grant application which is used to monitor the statewide CSH initiative
3. Provide ongoing professional development for CSH coordinators through annual CSH Training Institute and CSH regional training events
4. Create CSH communication materials and public reports
5. Provide professional development for faculty and staffing the school systems
6. Revise state standards for Health Education, Physical Education and Lifetime Wellness
7. Implement U.S. Department of Education's schools and Mental Health Systems Integration grant statewide
8. Develop and oversee the revisions of the universal School Health Screening Guidelines for schools. (p. 12)

CHAPTER 3

RESEARCH METHODOLOGY

This chapter consists of a description of the study, population, research design, instrumentation, data collection, and data analysis that were used in this study. This is a descriptive, quantitative study designed to explore the leadership traits of school health coordinators (SHCs) as reported by the SHCs themselves, their supervisors, and their colleagues. Descriptive statistics were used to organize, summarize, and report the data.

Research Questions and Null Hypothesis

The following research questions served as the guide for this study:

Research Question 1: Are the mean scores of the self-assessments of school health coordinators significantly higher than the colleagues' assessments of the school health coordinators' leadership traits using the Leadership Traits Questionnaire?

Ho1: The mean score of self-assessments of the school health coordinators are not significantly higher than the mean scores of the colleagues' assessments for leadership traits using the Leadership Traits Questionnaire.

Research Question 2: Are the mean scores of the self-assessments of school health coordinators significantly higher than the supervisors' assessment of the school health coordinators' leadership traits using the Leadership Traits Questionnaire?

Ho2: The mean score of self-assessments of the school health coordinators are not significantly higher than the mean scores of the supervisor assessments for leadership traits using the Leadership Traits Questionnaire.

Research question 3: Are the mean scores of the Leadership Trait Questionnaires significantly different for the city school health coordinators and the Leadership Trait Questionnaire scores for the county school health coordinators?

Ho3: The mean scores of the Leadership Trait Questionnaires are not significantly different for the city school health coordinators and the county school health coordinators.

Research question 4: Is there a significant correlation between years of experience working in the schools system and leadership traits scores of the school health coordinators?

Ho4: There is not a significant correlation between years of experience working in the schools system and leadership traits scores of the school health coordinators?

Research Question 5: Is there a significant correlation between the number of professional organizations the school health coordinators are members of and leadership traits scores?

Ho5: There is not a significant correlation between the number of professional organizations the school health coordinators are members of and the leadership traits scores.

Instrumentation

The Leadership Traits Questionnaire (LTQ) (Northouse, 2009) was used to measure personal characteristics of leadership. The LTQ form questions can be viewed in Appendix A. Permission to use the LTQ was granted by Peter Northouse, the developer of the questionnaire (see Appendix B). The LTQ is a 10-item questionnaire designed to measure how the SHCs see themselves as leaders compared to how their supervisors and colleagues view their leadership traits. One important note is that all the responses to the survey questions were based on the perceptions of the SHCs themselves, their peers, and their superior. Given the limited size and diversity of the sample, a quantitative methodological approach was used for the current study in an effort to maximize the generalizability. Permission was granted by the Institutional Review

Board (IRB) to have an expedited review status due to the limited risk involved with the study and the assurance of confidentiality.

Population

The study population consisted of all SHCs, superintendents, principals, and Healthy School Council members in the state of Tennessee, totaling approximately 3,900. Thirty-nine districts out of 221 provided full responses where the SHC, at least one supervisor, and at least one colleague responded to the Leadership Traits Questionnaire (LTQ).

Data Collection

Prior to beginning this research project, permission to conduct research was obtained from the IRB of the researcher's home institution. The email addresses were obtained from public state websites such as the State of Tennessee school district maps on the Board of Education website. Other email addresses were obtained by the individual school's website. A sample of the email can be found in Appendix C. Any email addresses that were inactive or incorrect were addressed. An online survey instrument generated an electronic hyper-link that included all sections of the IRB approved survey. Using an online survey administrator was chosen for practicality reasons.

The electronic instrument is comprised of seven demographic questions for the SHCs and two demographic questions for the rest of the participants. The Leadership Traits Questionnaire included 10 questions 5-point Likert-scale ranging from strongly agree to strongly disagree. All responses were confidential and the demographic information collection did not reveal the participants of the study. After a 10-day period, all who had not responded to the official invitation received a reminder asking them again to participate. Through the web link, each participant may review the results and each was thanked for his or her participation. All statistical analyses are presented in summary form to protect participants' identities.

Data Analysis

The compiled data were transferred into SPSS software for analysis and a series of paired *t*-tests were completed for research questions 1 and 2. For research question 3 an independent *t*-test was conducted. For research questions 4 and 5 the data were analyzed using correlations between the different demographics. The level of significance used in the statistical analysis was .05.

Summary

Chapter 3 produced the research design of the study, the participating population, the procedure used for data collection, the research questions and null hypotheses, and data analysis. Quantitative procedures were used throughout the study to determine if differences existed between the school health coordinators' self-perception of the leadership traits and the supervisors' and colleagues' perception of the SHCs leadership traits. The study population consisted of all of the SHCs and school superintendents, principals, Healthy School Committee chairs and/or Staff Coordinating Council on School Health in the state of Tennessee. The study consisted of five research questions with one null hypothesis each. The data are analyzed in Chapter 4. Chapter 5 includes a summary of the study, findings, conclusions, and recommendations for practice and future research.

CHAPTER 4

RESULTS AND ANALYSIS OF DATA

This chapter contains the results of the data analysis as it relates to the five research questions proposed in Chapters 1 and 3. The purpose of this study was to explore the leadership traits of the school health coordinators for the state of Tennessee and to determine if self-perception of SHC leadership traits coincides with supervisor and peer perceptions. An electronic survey with 12-17 questions depending on the position was used to capture data. The first section included demographic questions. A 5-point Likert-type scale was used on the last 10 questions to assess the varying level of leadership traits the school health coordinator exhibited. Data were retrieved following the execution of the survey. All SHCs, superintendents, principals and Healthy School Council members in the state of Tennessee, totaling approximately 3,900, were invited to respond. Two hundred twenty-one (5.6%) responses were captured; however, only 155 (4%) were used in the analysis of the data. This is because, of the 221 respondents only 39 districts had a complete response, which resulted in 155 surveys, meaning the SHC, at least one supervisor, and at least one colleague all answered the survey. Therefore, of the 140 districts invited to participate in this study, 39 (27.8%) were fully represented. As indicated earlier, this is a major limitation.

Research Questions and Analysis

Research Question 1: Are the mean scores of the self-assessments of school health coordinators significantly higher than the colleagues' assessments of the school health coordinators' leadership traits using the Leadership Traits Questionnaire?

Ho1: The mean score of self-assessments of the school health coordinators are not significantly higher than the mean scores of the colleagues' assessments for leadership traits using the Leadership Traits Questionnaire.

A paired *t*-test was conducted on school health coordinators' self-assessment of their leadership traits and their colleagues' assessments of their leadership traits. The test was significant, [$t(39)=2.774, p=.008$]. Therefore, the null hypothesis was rejected. The school health coordinators ($M=4.46, SD=.475$) tended to report higher self-assessment scores for leadership traits than colleagues ($M=4.04, SD=.712$). The 95% confidence interval for the differences in means was (.112 to .713).

Research Question 2: Are the mean scores of the self-assessments of school health coordinators significantly higher than the supervisors' assessment of the school health coordinators' leadership traits using the Leadership Traits Questionnaire?

Ho2: The mean score of self-assessments of the school health coordinators are not significantly higher than the mean scores of the supervisor assessments for leadership traits using the Leadership Traits Questionnaire.

A paired *t*-test was conducted on school health coordinators' self-assessment of their leadership traits and their supervisors' assessments of their leadership traits. The test was not significant, [$t(39) = .200, p=.843, ns$]. Therefore, the null hypothesis was retained. The school health coordinators ($M=4.46, SD=.475$) reported similar self-assessment scores for leadership traits as did their supervisors ($M=4.48, SD=.409$). The 95% confidence interval for the differences in means was (-.208 to .171).

Research question 3: Are the mean scores of the Leadership Trait Questionnaires significantly different for the city school health coordinators and the Leadership Trait Questionnaire scores for the county school health coordinators?

Ho3: The mean scores of the Leadership Trait Questionnaires are not significantly different for the city school health coordinators and the county school health coordinators.

An independent *t*-test was conducted to evaluate whether the mean scores for the Leadership Trait Questionnaires differ based on if the school is a county or city school. The self-assessment of the school health coordinators was the dependent variable and the group variable was city versus county. The test was not significant, [$t(38)=.274$, $p=.786$, ns]. Therefore, the null hypothesis was retained. The city school health coordinators ($M=4.49$, $SD=.49$) reported similar self-assessment scores as the county school health coordinators ($M=4.44$, $SD=.47$). The 95% confidence interval for the difference in means was (-.277 to .364).

Research question 4: Is there a significant correlation between years of experience working in the schools system and leadership traits scores of the school health coordinators?

Ho4: There is not a significant correlation between years of experience working in the schools system and leadership traits scores of the school health coordinators?

A Pearson correlation coefficient was computed to test the relationship between the self-reported Leadership Trait Questionnaire scores and the number of years' experience the school health coordinators had in the school system. The results of the analysis revealed a weak negative correlation between self-assessments ($M=4.4575$, $SD=.475$) and years experience ($M=10.13$, $SD =9.12$) scores. It was not a significant correlation ($r(39)=-.186$, $p=.251$, ns). Therefore, the null hypothesis was retained. The results suggested that the more years experience the school health coordinator had in the school system resulted in a slightly, but not significantly, lower self-assessment score than the school health coordinators who had fewer years experience in the school system.

Research Question 5: Is there a significant correlation between the number of professional organizations the school health coordinators are members of and leadership traits scores?

Ho5: There is not a significant correlation between the number of professional organizations the school health coordinators are members of and the leadership traits scores.

A Pearson correlation coefficient was computed to test the relationship between the self-reported Leadership Trait Questionnaire scores and the number of professional organizations the SHCs belonged to. The results of the analysis revealed a weak positive correlation between self-assessments ($M=4.4575$, $SD=.475$) and number of organizations ($M=3.4.13$, $SD =1.85$) scores. It was not a significant correlation ($r(39)=-.090$, $p=.579$, ns). As a result the null hypothesis was retained.

CHAPTER 5

SUMMARY, CONCLUSIONS, IMPLICATIONS FOR PRACTICE, AND RECOMMENDATIONS FOR FUTURE RESEARCH

This chapter contains the findings, conclusions, and recommendations for readers who may use the results as a resource when reviewing and revising the continuing education of school health coordinators (SHCs) or when looking for certain leadership qualities in future hiring practices. The purpose of the present study was to explore the leadership traits of the local school health coordinators for the state of Tennessee and to determine if self-perception of SHC leadership traits coincides with supervisor and colleague perceptions. Data obtained from 221 participants, including school health coordinators, principals, superintendents, and Health School Council members were presented and analyzed. There were five research questions and five null hypotheses. All data were collected through an online survey distributed via school email accounts.

Key Findings

The purpose of this quantitative study was to explore the leadership traits of the school health coordinators (SHCs) for the state of Tennessee and to determine if self-perceptions of the SHC leadership traits coincide with supervisor and colleague perceptions of SHC leadership traits. The study also evaluated whether there were any significant differences in the self-reported LTQ scores between city and county SHCs, the number of years experience the SHCs had in the school systems, and the number of professional memberships.

There were two surprising findings in this study. One was the significant difference that was found between SHC self-assessment scores and the scores of colleagues. The SHCs self-perceived leadership traits were higher ($M=4.46$) than those perceived by their colleagues ($M=4.04$). These findings indicate the SHCs have a higher opinion of their leadership traits than

do their colleagues. The other surprising result was that the more years of experience the SHCs had in the school system actually generated a similar but slightly, non-significant, lower self-assessment score than SHCs with fewer years of experience.

This research assessed the perceptions of 155 professional members of school systems in Tennessee. It is important that readers use caution in the findings of this study because it may not be generalizable to other populations due to two key constraints: 1) The return rate for this study was approximately 5.6%, and (2) the respondents consisted of only Tennessee professionals. However, the following conclusions were based upon the findings from the data of this study:

Research question 1 addressed the differences between the self-assessment scores and colleague assessment scores with regard to the Leadership Trait Questionnaire. A paired *t*-test provided evidence of significant differences in the means of assessment scores between the two groups. The school health coordinators ($M=4.46$, $SD=.475$) tended to report higher self-assessment scores for leadership traits than the colleagues ($M=4.04$, $SD=.712$).

Research question 2 addressed the differences between the self-assessment scores and supervisors' assessment scores with regard to the Leadership Trait Questionnaire. The school health coordinators ($M=4.46$, $SD=.475$) tended to report similar self-assessment scores for leadership traits to the supervisors ($M=4.48$, $SD=.409$). This indicated no significant differences between the scores of school health coordinators and the supervisors.

The analysis of research question 3 involved comparing the city versus county school health coordinators scores. The city school health coordinators ($M=4.49$, $SD=.49$) reported a similar self-assessment score to the county school health coordinators ($M=4.44$, $SD=.47$). It was not significant.

Research question 4 focused on the relationship of the self-assessment scores compared to the number of year's experience the coordinator had in the school system. The results of the analysis revealed a weak negative correlation between self-assessments ($M=4.4575$, $SD=.475$) and years experience ($M=10.13$, $SD =9.12$) scores. Even though this was not significant, it was noteworthy to see the coordinators with more years experience rate their leadership traits slightly lower than the ones with less experience.

Research question 5 concentrated on the relationship between self-assessment scores and the number of memberships to professional organizations. The results of the analysis revealed a weak positive correlation between self-assessment ($M=4.4575$, $SD=.475$) and number of organizations ($M=3.4.13$, $SD =1.85$) scores. This was not significant.

Summary

The statistical analyses reported in this study were based on five research questions presented in Chapters 1 and 3. In Chapter 3, each research question was supplemented with one null hypothesis. A series of paired *t*-tests were completed for research questions 1 and 2, research question 3 was analyzed by using an independent *t*-test, and research questions 4 and 5 were analyzed using a correlation between the different demographics. Two hundred twenty-one respondents were captured; however, 155 were used in the analysis of the data. Of the 221 respondents, only 39 districts had a complete response, meaning the school health coordinator, at least one supervisor, and at least one colleague all answered the survey. The level of significance used in the statistical analysis was .05. Findings indicated that school health coordinators self-perceptions of the leadership traits are significantly higher than the colleagues' perceptions of the leadership traits of the SHC. There were no significant differences between the self-reported leadership traits of the school health coordinators and the supervisors' results of the leadership traits. Lastly, there were also no significant differences in the city versus county

SHCs, the years experience the SHC had in the school system or the number of memberships to professional organizations.

Recommendations for Practice

Leadership traits are critical for SHCs because they are dealing with so many different entities, including supervisors, colleagues, students, the community, and the press. In order to balance all of these aspects of the job, SHCs must demonstrate leadership traits such as articulation, trustworthiness, self-confidence, and dependability. SHCs fill a vital role in the learning and health of students, staff, and the community. The results of this study might help to illuminate the degree to which SHC leadership traits impact the perceptions of others. Understanding this impact might aid the SHC in choosing a leadership style that successfully promotes the learning process. The results of this study could lead to the development of a model for professional leadership training for SHCs.

Recommendations for Future Research

Future research is needed in the study of leadership traits and skills in regard to SHCs. Not all administrators or colleagues of Tennessee SHCs were provided the opportunity to rate perceptions of their SHCs' leadership traits. As such, their perceptions may be different than those surveyed. It would be useful if the research study was expanded to include perceptions of all the different people who work with SHCs.

A longer period for data collection and reminder follow-up emails could help to provide a larger response rate. The researcher had to eliminate several responses because the supervisor or colleague from that district did not answer the survey. It may have been possible to use those responses with a different statistical analysis. It could have potentially saved 66 additional responses. An individual item analysis for each component on the LTQ could yield more in depth results.

Additional research could also include a deeper analysis of the more experienced school system professionals and the self-reporting of the leadership traits and skills. It could be useful to know if self-efficacy declines the longer they work in the school system. Disenfranchisement theory could serve as a conceptual framework guiding a focused study with this population.

Conclusion

In conclusion, this research provides important information for SHCs, health leaders, and education leaders. It should also serve as a basis for the further development of leaders in the Coordinated School Health Programs. The SHCs need to know where to focus their leadership traits in the school districts and what traits to prioritize. The Healthy School Council members need to be able to perceive strong leadership traits in their SHC in order to have a successful coordinated school health program.

Leithwood et al. (2004) concluded that influential leaders in the school system are not just principals and superintendents but include many other members of the staff as well. That research further found that efforts to improve the recruitment, training, evaluation, and ongoing development of school leaders should be considered a highly cost-effective approach to successful school improvement.

Supporting the assumption that professional development and leadership training for current and future SHCs could be beneficial, a study found that principals who participated in a leadership preparation program consisting of a year-long and carefully mentored field-based internship scored higher on the newly developed performance assessment test, received higher performance evaluation ratings by supervisors, and were perceived by teachers as being more effective in managing their schools (Valentine, 2001). There is no doubt that an SHC participating in the similar training and development could benefit similarly to those principals.

The results of this study may provide insight into future SHC practices, professional training, and leadership traits. According to the evidence that was compiled for this study, research shows that leadership not only matters, but that it is second only to teaching among school-related factors in its impact on student learning.

REFERENCES

- Adams, D. (2008). Tennessee's coordinated school health initiative. *National Association of State Boards of Education*, 13(2) 1-2.
- American Cancer Society. (2000). *School health program elements of excellence: Helping children to grow up healthy and able to learn*. Atlanta, GA: Author.
- American Heritage Dictionary. (2011). *Definition of perception*. Boston, MA: Houghton Mifflin Harcourt.
- Avolio, B.J., Waldman, D. A., & Yammarino, F.J. (1991). Leading in the 1990s: The four Is of transformational leadership. *Journal of European Industrial Training*, (15) 9-16.
- Bass, B. (1985). *Leadership and performance beyond expectations*. New York, NY: Free Press.
- Bass, B. (1998). *Transformational leadership: Industrial, military, and educational impact*. Mahwah, NJ: Erlbaum.
- Bass, B. (1997). Does the transactional-transformational leadership paradigm transcend organizational and national boundaries? *American Psychologist*, 52, 130-139.
- Belluck, P. (2005). Children's life expectancy being cut short by obesity. *New York Times*. March, 17, 2005.
- Burns, J. (1978). *Leadership*. New York, NY: Harper and Row.
- Centers for Disease Control and Prevention. (2008). *Make a difference at your school!* [Data file]. Retrieved September 27, 2011, from www.cdc.gov/HealthyYouth/keystategies/pdf/make-a-difference.pdf
- Centers for Disease Control and Prevention. (2011). *A case for coordinated school health*. [Data file]. Retrieved September 1, 2011 from www.cdc.gov/healthyyouth/cshp/case.htm
- Centers for Disease Control and Prevention. (2011). *Coordinated school health-key strategies*. [Data file]. Retrieved August 14, 2011 from <http://www.cdc.gov/Features/StudentHealth/>
- Clark, D. (1997). *Complete guide to leadership*. Retrieved December 6, 2011, from www.nwlink.com/~donclark/leader/leader.html
- Council of Chief State School Officers. (1991). *Transforming education: Delivering on our promise to every child*. Retrieved December 17, 2011, from http://www.ccsso.org/Documents/2009/Transforming_Education_Delivering_2009.pdf.
- Davis, T.M., & Allensworth, D.D. (1994). Program management: a necessary component for the comprehensive school health program. *Journal of School Health*. 64, 400-404.

- Deal, T. E., & Peterson, K. D. (2009). *Shaping school culture: Pitfalls, paradoxes, and promises* (2nd ed.). San Francisco, CA: Jossey-Bass.
- Downton, J.V. (1973). *Rebel leadership: Commitment and charisma in a revolutionary process*. New York, NY: Free Press.
- Dunkle, M. C., & Nash, M. A. (Eds.). (1991). *Beyond the health room*. [Data file]. Washington, DC: Council of Chief State School Officers.
- Fetro, J., Givens, C., & Carroll, K. (2009/2010). Coordinated school health: Getting it all together. *Educational Leadership*, 67(4), 32-37.
- Fisher, C., Hunt, P., Kann, L., Kolbe, L., Patterson, B., & Wechsler, H. (2003). Building a healthier future through school programs. *CDC's Promising Practices in Chronic Disease Prevention and Control*. Retrieved September 28, 2011, from www.cdc.gov/healthyyouth/publications/pdf/PP-Ch9.pdf
- Fleishman, E.A., Mumford, M.D., Zaccaro, S.J., Levin, K.Y., Korotkin, A. L., & Hein, M.B. (1991). Taxonomic efforts in the description of leader behavior: A synthesis and functional interpretation. *Leadership Quarterly*, 2, 245-287.
- Greenleaf, J.W. (1977). *Servant leadership: A journey into the nature of legitimate power and greatness*. New York, NY: Paulist.
- Hersey, P., & Blanchard, K. (1996). Great ideas revisited. *Training and Development*, 50(1), 42-49.
- Horey, J., Fallesen, J., Morath, R., Cronin, B., Cassella, R., Franks, W., & Smith, J. (2004). *Competency based future leadership requirements*. United States Army Research Institute for the Behavioral and Social Sciences. [Field Manual].
- House, R. J. (1988). Power and personality in organizations. *Research in Organizational Behavior*, 10, 305–357.
- Kirkpatrick, S.A., & Locke, E. A. (1991). Leadership: do traits matter? *Academy of Management Executive*, 5(2) 48-60.
- Kouzes, J., & Posner, B. (2007). *The leadership challenge* (4th ed.). San Francisco, CA: Jossey-Bass, 23-43.
- Leithwood, K., & Riehl, C. (2003). *What we know about successful school leadership*. Retrieved September 28, 2011, from www.aera.net/
- Lord, R. G., de Vader, C. L., & Alliger, G. M. (1986). A meta-analysis of the relation between personality traits and leadership perceptions: An application of validity generalization procedures. *Journal of Applied Psychology*, 71 402-410. doi: 10.1037/0021-9010.71.3.402.

- Marx, E., Wooley, S. F., & Northrop, D. (1998). *Health is academic: A guide to coordinated school health programs*. New York, NY: Teachers College Press.
- Meyer, R., & Slechta, R. (2002). *The 5 pillars of leadership*. Tulsa, OK: Insight
- National Academy of Medicine. (2004). *Obesity in young children: Impact and intervention*. [Research Brief]. Retrieved December 5, 2011, from <http://nihcm.org/pdf/OYCbrief.pdf>
- National Association of State Boards of Education: Center for Safe and Healthy Schools. (2010). Retrieved January 23, 2012, from <http://nasbe.org/healthyschools/hs/natstandbytopics.php>
- National Initiative for Children's Healthcare Quality. (2010). *Childhood obesity action network*. [Data file]. Retrieved January 10, 2012, from www.nichq.org/
- Northouse, P. (2001). *Leadership theory and practice* (2nd ed.). Thousand Oaks, CA: Sage
- Northouse, P. (2007). *Leadership theory and practice* (4th ed.). Thousand Oaks, CA: Sage
- O'Brien, L. M., Polacsek, M., MacDonald, P. B., Ellis, J., Berry, S., & Martin, M. (2010). Impact of a school health coordinator intervention on health-related school policies and student behavior. *Journal of School Health, 80*, 176-185.
- Olsen L, English G, Dorman S, Evans D, James T, Ragon B, Richter J, Rosado L, Stinson B, Temple M, O'Hara N, Brynteson P, & Winnail S. (2001). American cancer society national school health coordinator leadership institute: Review and results of the pilot study, *Research Quarterly for Exercise and Sport, 72* (1), A33-A34 Supplement.
- Ottoson, J., Streib, G., Thomas, J., Rivera, M., & Stevenson, B. (2004). Evaluation of the national school health coordinator leadership institute. *The Journal of School Health; 2004; 74*, 170-176.
- Raubinger, F. M., Rowe, H. G., Piper, D. L., & West, C. K. (1969). *The development of secondary education*. New York, NY: Macmillan.
- Satcher, D. (2010). *Leadership in reducing health disparities*. [Televised lecture]. Northwestern University Feinberg School of Public Health. <http://www.northwestern.edu/newscenter/stories/2010/10/david-satcher.html>
- Schultz, W. (2001). *Leadership: an overview*. Retrieved January 14, 2012, from www.infinitefutures.com/
- Schwimmer, J.B. Burwinkle, T. M., & Varni, J. (2003). Health-related quality of life of severely obese children and adolescents. *Journal of American Medical Association 289*, 1813-1819. doi: 10.1001/jama.289.14.1813

- Snyder, T., & Hoffman, C. (2002). National center for education statistics. *Digest of education statistics 2001. Table 2* (Pub. #2002130).
- State of Maine Department of Education. (2010). *State of Maine guidelines for coordinating school health programs*. [Data file] Retrieved November 3, 2011, from www.maineceph.com/guidelines.html
- State of Tennessee School District Maps. (2011). *School district geographical locator and information system*. [Data file]. Retrieved October 5, 2011, from www.state.tn.us/education/districtmap/
- Stogdill, R.M. (1974). *Handbook of leadership: A survey of theory and research*. New York, NY: Free Press.
- Stone, A. & Patterson, K. (2005). The history of leadership focus. *School of Leadership Studies: Regent University. Servant Leadership Research Roundtable*. [unpublished paper]. Retrieved October 5, 2011 from www.regent.edu/acad/global/publications/sl_proceedings/2005/stone_history.pdf
- Tennessee Department of Education. (2010). *Tennessee coordinated school health 2008—2009 executive summary*. Nashville, TN: Department of Education.
- Tennessee Department of Education. (2011). *Office of coordinated school health annual data and compliance report 2009-2010 school year*. Nashville, TN: Author.
- Tennessee State Board of Education. (2011). *Childhood obesity prevention*. Retrieved October 5, 2011, from www.tn.gov/education/schoolhealth/Obesity.shtml
- United Nations Children's Fund (UNICEF). (2012). *The state of the world's children 2012*. New York, NY: United Nations Publications.
- United States Census Bureau. (2011). *School districts*. Retrieved December 1, 2011, from www.census.gov/did/www/schooldistricts/index.html
- Valentine, J. (2001). *Goals 2000 principal leadership development project: Final report*. Columbia, MO: Illinois State University, Center for the Study of Education Policy, State Action for Education Leadership Project.
- Winnail, S., Dorman, S., & Stevenson, B. (2004). Training leaders for school health programs: the national school health coordinator leadership institute. *Journal of School Health*, 74 (3), 79-84.
- World Health Organization (WHO), (2012). *Health promotion glossary*. Geneva, Switzerland: World Health Organization.
- Wren, J. T. (1995). *The Leaders Companion: Insights on leadership through the ages*. New York, NY: Free Press.

Zaccaro, S. J. (2007). Trait-based perspectives of leadership. *American Psychologist*, 62(1), 6-16.

APPENDICES

APPENDIX A:

Leadership Traits Questionnaire (LTQ)

Permission from P.G.Northouse

Instructions: The purpose of this questionnaire is to measure personal characteristics of leadership. You are asked to complete it because you are familiar with the leader.

For each adjective listed below, indicate the degree to which you think the adjective describes the leader. Please, select the following responses to indicate the strength of your opinion.

Key: 5=Strongly agree 4=Agree 3=Neutral 2=Disagree 1=Strongly disagree

| | |
|---|-----------|
| Q1. Articulate: Communicates effectively with others | 1 2 3 4 5 |
| Q2. Perceptive: Discerning and insightful | 1 2 3 4 5 |
| Q3. Self confident: Believes in oneself and one's ability | 1 2 3 4 5 |
| Q4. Self assured: Secure with self, free of doubts | 1 2 3 4 5 |
| Q5. Persistent: Stays fixed on goals despite interference | 1 2 3 4 5 |
| Q6. Determined: Takes a firm stand, acts with certainty | 1 2 3 4 5 |
| Q7. Trustworthy: Act believably, inspires confidence | 1 2 3 4 5 |
| Q8. Dependable: Is consistent and reliable | 1 2 3 4 5 |
| Q9. Friendly: Shows kindness and warmth | 1 2 3 4 5 |
| Q10. Outgoing: Talks freely, gets along well with others | 1 2 3 4 5 |

APPENDIX B

Permission to Use Leadership Traits Questionnaire

Email received on February 18, 2011:

From: peter.northouse@wmich.edu

To: Strickland, Katherine A.

Kate,

Thank you for the kind words. You have permission to use the trait questionnaire. You might also look at the trait questionnaire in my redbook - Introduction to Leadership.

Be sure it is traits that you are trying to identify.

All the best,

Peter Northouse, Ph.D.

Email sent on February 12, 2011:

From: Strickland, Katherine A.

To: peter.northouse@wmich.edu

Good morning Dr. Northouse,

I am a doctoral student in the EdD. program at East Tennessee State University. I have your wonderful book Leadership-Theory and Practice, which was very helpful in understanding all the different approaches to leadership.

I am starting on my dissertation process. I would like to conduct a survey using your Leadership Trait Questionnaire to measure the leadership characteristics of our local School Health Coordinators.

I am not sure if I am supposed to contact you directly or Sage Publications. So I am trying you first. Please let me know what steps I need to take to use this fantastic instrument.

Thank you very much.

Kate Strickland, MPH, CHES

APPENDIX C

Email Invitation to Participate in Survey

Good morning-

My name is Kate Strickland and I am an ETSU student in the Educational Leadership program. I am currently working on my dissertation titled "Leadership Traits of School Health Coordinators in Tennessee". The link to the survey is below. **I need all principals, superintendents, physical educators, and school health coordinators to fill this out, please!** I need as many responses to this survey as possible to finish my dissertation. **It is very short and should only take a couple of minutes to complete.**

I realize you are extremely busy with your own issues. Thank you so much for taking the time to assist me in my quest for a doctorate and a brighter future. If you have any questions or concerns please email me at stricklk@etsu.edu

<http://strickland.herokuapp.com/>

Sincerely,

Kate Strickland, Doctoral Candidate
East Tennessee State University

APPENDIX D

Opening Introduction to Survey

PURPOSE:

The purpose of this research study is to explore the leadership traits of the school health coordinators in the state of Tennessee. By determining their self-perception of their own leadership traits compared to that of their supervisors and colleagues, this research may help improve hiring practices, training, and continuing education of current and future school health coordinators.

DURATION

This 15 question survey should only take about 10 to 15 minutes to complete.

POSSIBLE RISKS/DISCOMFORTS

There are no known or expected risks/discomforts.

POSSIBLE BENEFITS

There is no direct benefit to you participating in this research.

The possible benefits of your participation are to improve hiring, training, and continuing education courses for school health coordinators.

VOLUNTARY PARTICIPATION

Participation in this research experiment is voluntary.

CONTACT FOR QUESTIONS

If you have any questions, problems at any time, you may call Kate Strickland, MPH at 423-483-5785, or Jasmine Renner, PhD at 423-439-7629. You may call the Chairman of the Institutional Review Board at 423-439-6054 for any questions you may have about your rights as a research subject. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you can't reach the study staff, you may call an IRB Coordinator at 423-439-6055 or 423-439-6002.

By completing this survey, you confirm that you have read this document. You freely and voluntarily choose to be in this research project. Thank you.

VITA

KATHERINE A. STRICKLAND

- Personal Data: Date of Birth: December 5, 1976
 Place of Birth: Vinings, Georgia
 Marital Status: Married
- Education: Doctor of Education in Educational Leadership, East Tennessee
 State University, Johnson City, TN 2012
 Masters in Public Health, Georgia Southern University, Statesboro,
 Georgia 2002
 B.S. Community Health, Georgia Southern University, Statesboro,
 Georgia 2000
- Professional Experience: Clinic Manager, St. Jude Tri-Cities Affiliate Clinic; Johnson City,
 Tennessee, 2004-present
- Conference Presentations: Gupta, D., Popescu, M., Klopfenstein, K., Strickland, K., McElroy,
 C. (January 2012). *Hodgkin's Disease: It is in the neck, alright!*
 East Tennessee State University Department of Pediatrics.
 Johnson City, TN.
- Mozen, D., Strickland, K. (February 2010). *Health and Physical
 Education in the Top Ten Industrial Countries*. Presentation at the
 SDAAPHERD Convention, Myrtle Beach, S.C.
- Russell (Strickland), K., Clabby, M. (March 2000). *College
 Students: Are you Healthy?* A paper presented at the Annual
 AAHPERD Convention, Orlando, FL.
- Honors and Awards: Outstanding Senior Award in Community Health winner 1999-
 2000
- American Association of Health Education Outstanding Senior of
 the Year Award winner 1999-2000
- Georgia Southern University Dean's List 1999-2002