Koinonia

Richard Keeling

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The Challenge of AIDS in Higher Education

This is an edited transcript of a speech given at the 1990 ACSD National Conference

Dr. Richard Keeling

Health issues and health risks for young people with HIV and AIDS in particular, is a changing field. What I'm going to talk to you about this morning is where we are and what we think we know as of June, 1990, with the clear warning that we may know a lot more than this, and be able to expand this information by June of 1991.

As we look at HIV prevention issues among college and university students in 1990-1991, we're looking at a very different kind of approach to AIDS prevention that we might have used in 1989 and even earlier this year.

New approaches to HIV prevention have four critical elements. First, we think that new approaches will involve being much more broader, that is that we'll have a broader program that will connect risks of HIV and AIDS to a whole variety of other health issues that are closely related. Obviously, the behaviors that create risks of HIV or AIDS infection also create risks of other sexually transmitted diseases, unwanted pregnancy, acquaintance rape, alcohol and substance abuse, stress management, etc.

Second, we will be approaching HIV and AIDS more deeply than we have in the past. Instead of working at the superficial level of simply talking to people about this virus and how it is transmitted, we will be building their skills at prevention. We will do this by going back to some fairly fundamental issues about what they want for their lives. If they want health in life, and love in relationships, and a future, then there are certain things, skills that they must learn to make those things possible for them.

Thirdly, we are beginning to realize that we can't just talk to individual students about changing their behavior.

1990 ACSD NATIONAL CONFERENCE

Over 300 professionals attended the 1990 ACSD National Conference held at Calvin College in early June. The theme for the conference was "A Firm Footing and a New Song".

Keynote speakers included Lewis B. Smedes, Professor of Theology and Ethics at Fuller Theological Seminary, Mary Stewart Van Leeuwen, Professor of Interdisciplinary Studies at Calvin College, and Richard P. Keeling, Director, Department of Student Health and Associate Professor of Internal Medicine at the University of Virginia. Michael Kelly Blanchard, a contemporary psalmist, performed for the conference on Wednesday evening.

Wednesday afternoon excursions (always a favorite), included a Dutch Heritage tour, a museum excursion to downtown Grand Rapids, the annual ACSD golf outing, the Lake Michigan Beach, and Amway and Steelcase Corporation tours.

Fifty-two workshop sessions were presented on a variety of topics. Three pre-conference workshops were available. Topics were, designing alcohol programs, current legal issues, and zap-interviewing.

The ACSD Executive Committee wishes to thank Don Boender, Jeannette Bolt De Jong, and the Calvin College staff for a tremendous conference.

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We can’t just say, “change, change change”. We also have to be aware how they connect to each other and how their relationships develop, so we’ll be talking not just about individuals and their own single issues, but also seeking the common ground between people and how they build relationships. Talking not just about how you decide about you, but how you work with other people to make decisions for healthier relationships and healthier sexual decisions.

And finally, the fourth key word is community. We have come to realize that many of the risks of HIV are not individual risks, not even single relationship risks, but in fact, are risks that we share as a community. As we as a community have areas of risks, we also have areas of solution to those risks, so future solutions to this problem of AIDS on campuses will involve dealing with a whole set of community issues in a community environment.

So, four key words: broader, deeper, connections, community. These words come from where we think we are about AIDS, where students are, where our society is. If you look at the image of HIV infection and AIDS in 1990 this is what you see. It is not in the paper everyday anymore. It’s not on the evening news every night. The sort of crisis atmosphere we had of AIDS back in the past has dissipated, to be replaced by the sense that this has just become part of our lives as a society. We are beginning to have the perception that the problem has been solved because people hear about drug therapy and possible fewer new cases being diagnosed, and the perception is that somehow it is just not a big problem anymore. This perception of the slower increasing cases is a big problem. Mostly what has happened is that because there are better treatments that delay time at which people get sick, the diagnosis has slowed down, that is, the speed with which people become ill slows down, so that we do not diagnose AIDS itself as rapidly. People have the perception that there are not as many cases. This is not the case. It is just that they are being delayed. The perception that AIDS is becoming even more of a big city minority problem has allowed many people, particularly in mainstream America, to deny the problem, but this could be their problem more than ever before. Then there’s this problem of snapshot thinking. Snapshot thinking is illustrated by a book called The Myth of Heterosexual AIDS, where somebody will die of AIDS. This image, then of AIDS, has cast us into a different position from where we were before, and we now have to build some interest in this, and begin to look at it with a different set of assumptions than we had when it was perceived to be a crisis. The reality is that by 1994, nobody in America will not know somebody who has, or who has died of AIDS. As this begins to develop for us we will witness the extent and effects of this epidemic, which will be much broader than what we have thought of so far. The extent and effects of the epidemic of HIV infection in higher education, in particular, are far more measurable than we thought. It is not just a matter of how many students have HIV. It is also a matter of what the effects of HIV infection and AIDS is and will be on psychological development. For example, this past September we admitted to American colleges the first entering class who came to sexual maturity entirely after the epidemic of AIDS was known about. These are people who have never known a world without AIDS. It didn’t exist for them. They do not remember a time when there was not AIDS. Therefore, the connection between sex and death, between love and intimacy and disease has been made for them ever since they were eleven or twelve years old. What effect that will have on how they develop in terms of intimacy and sexuality is still speculative.

The numbers of cases continues to rise. Irrespective of this public image that this problem has been solved, the cases will continue to rise well into the mid 1990’s. We also expect that the current major trends in the epidemic will continue. These trends are: there is a decreasing percentage of cases of AIDS occurring among men who had sexual contact with other men. The perception of AIDS as the gay disease will die fast and very quickly sometime in the next year as the percentage of cases among gay men drops below 50%. What’s happening is that because of major change in behavior in America’s gay communities, the rates of infection drop, and because the rates of infection drop, the numbers of new cases of AIDS diagnosed among gay men is now dropping substantially and suspected to continue to drop into the next five years.

The second trend is that the percentage of cases among people who share needles to use intravenous drugs continues to rise. Health education behavior change is much more difficult in the territorial and unhappy atmosphere of urban America than it is in the gay communities. It has been extremely difficult to produce effective, consistent
behavioral change among people who use needles. Given the atmosphere of poverty, impoverishment, and limitation of access to services in many American cities, it is not hard to understand.

The third trend is that heterosexual transmission is continuing to increase slowly, focusing most currently on two populations. First, is the sexual partners of people who use needles, and second, among young sexually active adults. The current major focus of heterosexual transmission of HIV in the U.S. is for people between fifteen and twenty-one years of age, American teenagers. The pattern of transmission of HIV looks like that in Africa rather than that in traditional America. That is, it emphasizes heterosexual spread of the virus rather than the traditional American pattern of other so-called risk groups.

As we look at all of these trends there are a couple of others to be aware of. One is the increasing effect of HIV infection and AIDS among people of minority race in the U.S. This trend is truly alarming because we do not yet have appropriate or adequate solutions. For example, 12% of the American population is black, but 27% of Americans with AIDS are black adults, and in fact 53% of American children with AIDS are black. 8% of Americans are Hispanic, but 14% of Americans with AIDS are Hispanic, and 26% of American children with AIDS are Hispanic. If you add all of this up together, what it tells you is that there is a disproportionate impact of HIV infection and AIDS in minority communities, and this happens not because of any biologic susceptibility based on race, but because of the sociological issues related to access to services, poverty, discrimination, prejudice, and depression, which continue to be major concerns for minority people, particularly in big cities in the U.S.

The other major trend of interest to us is the increasing focus of AIDS on younger people. For men and for women, the average person being diagnosed with AIDS is about thirty-two years old. This tells us again why AIDS is such a tragedy, because of the very young age of the people who are affected.

Our major concern in higher education is we know that this diagnosis of AIDS happens a long time after people get infected with the virus. Current information is that the average length of that incubation period is 11.6 years. If this is 11.6 years, ending at age 32, these people got infected with HIV much earlier, when they were somewhere around 20. The current concept is that if the average age at which you get diagnosed with AIDS is from 25 to 40, the average age that you get infected with the virus is between 15 and 30. The current average age at which an American is infected with HIV is 21.6 years of age. The age range of high risks of HIV in our country is for people between 15 and 28, which is 96% of students on American college campuses. So we are dealing with people who are at their maximum chronological lifetime risk of HIV infection. The challenge in higher education is to deal with this reality of chronological risk in some effective and meaningful way.

We begin to have some idea of what the challenge is because we begin to have some idea of how many people are infected with HIV on college campuses. In a nationwide sample done in 1989-90, we found out that 0.2%, which means two out of a thousand college students are already infected with HIV.

This raises two major questions about AIDS programming on college campuses. The first is should you be identifying people who have HIV? There is no administrative reason to do that, but there is a profound clinical reason. We now have a sense that it is possible to intervene in HIV infection by offering people treatment earlier, thereby delaying development of the disease. So, basically the question of whether people should be tested or not comes down to this: if they are tested and found to test positive, that gives them a fighting chance to delay the development of AIDS. Every American student should have access to barrier-free, nondiscriminatory, uncomplicated, HIV antibody testing. People who are concerned about risks, can then find out if they are infected. The question is not whether to be tested, but when, and with what safety precautions. The safety precautions are critically important. Information in psychological and counseling literature over the past couple of years has shown that the experience of HIV antibody testing is very tough for people. People being tested for HIV antibody routinely have somewhere between six and twelve weeks of psychological dysfunction in association with the test. The testing process also causes anxiety, depression, self destructive and suicidal behavior, and a variety of other reactions. It is absolutely unethical and immoral to do HIV antibody testing on people in the absence of pretest and post test counseling, and successful and sensitive psychological referral services. To do HIV antibody testing for administrative as opposed to clinical reasons violates a whole series of principles of ethics and justice to individuals, which is why nobody seriously recommends things like HIV screening programs which put students at great risks psychologically. Social safety is also important because the results of these testing procedures may cause discriminatory practices in housing or employment.

The other question is when to test people. This has probably become the issue that has caused people the greatest stress clinically in the past year. When do you test somebody after exposure to HIV? We used to talk about testing people two or three months after they might have been exposed. Last year we talked about three or four months. By the end of 1989 we were talking about four to six months. The bad news is that it now appears that at least 10% of the people who get infected with HIV do not develop a positive test for more than a year. At least 5% do not develop a positive test for a year and a half. This means that if you wanted to know absolutely that you were not

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infected, you have to wait 18 months after the last possible exposure to HIV before you know for sure. It is also a fundamental reason that HIV antibody testing has to be combined with sensitive psychological services, because this waiting period is extremely stressful and difficult for the people who are being tested.

The other major issue that we want to talk about today is the most important one raised by the presence of HIV on a campus. The question is: Is it going to spread further, and what do we do about that? Our major concept is basically very simple. Yes, it is going to spread further, and the reason we think that, is HIV is simply the latest one in a whole series of other sexually transmissible infections which have appeared on college campuses. We understand that there are behavioral realities about life in college which have fostered these other previous epidemics. What we fear is that AIDS is one of these viral epidemic curves which takes many years to begin, then accelerates sharply near the end of its termination stage. The fear is that if we are not very careful about prevention messages and prevention education, we may see a similar pattern to HIV, three, four, five, or seven years from now on American college campuses. It is not going to be 10% of the population this year or next year, but if we don't do something substantially to change behavioral factors that factor transmission of HIV, then we may see a much more extensive epidemic by the mid to late 1990’s. The problem is that if we are going to change, then we have to start yesterday.

It is clear that sexual behavior is common among college students. A study from the U.S. Department of Education studied the frequency of heterosexual intercourse among American teenagers starting at age 15. Basically what it establishes is that by age 19, 80% of boys and about 67% of girls in the U.S. are sexually experienced. The bottom line is that these nationwide studies do not suggest substantial variation from place to place, college to college, big or small, private or public, secular or religious. These patterns of behavior appear to be consistent across people widely scattered across the U.S. As people actually go into college, studies illustrate not only the frequency of behavior, but the paradox of health education. We can demonstrate in a study from Bradford College that approximately 80% of their students are sexually active, and, 97% of their students know about HIV. They know how to prevent HIV from happening, but the last time they had intercourse only half of them did anything substantial to protect themselves. Over the past year only 5% were consistent about protecting themselves every time.

This is the paradox of health education. HIV infection is a behavioral disease. It is entirely controllable by steps that individuals can take to protect themselves, but people who know how to protect themselves don't do it. In this case, it is a critical issue because the major challenge for us now is to figure out how to help people who already know what to do, do that. How do we help people who already have the information, make that information into effective behavior in their own lives? Again, the key to this is probably understanding why they don't. The average student will never see somebody else like him who has AIDS. We've stereotyped the disease. None of us think that anything is going to happen to us. We buy into the "it can't happen to me".

We've also become aware of the frequency not just of sexual assault and acquaintance rape, but also the frequency of sexual activity that was not wanted. The commonness of this is truly amazing. Studies done at Texas A&M and other places last year showed that 94% of the men and 98% of the women at Texas A&M had some kind of sexual intimacy in the year prior to the survey that they really did not want to have. 63% of the men and 47% of the women have had intercourse that they really did not want to have. We go back to those students, and say; how did this happen? How come you had intercourse that you didn't really want to have? What happened to you? The first thing they will tell you is alcohol. In some places they'll tell you cocaine, crack, and ice. But in most places, they'll tell you alcohol. Clearly, alcohol is the single most important connection to unsafe or unwanted sexual activity for American college students. We know that 80% of students are sexually active, that 90% drink alcohol. You multiply 80% by 90%, you come up with about 70% who have what you could call SUI (sex under the influence). Sex under the influence of alcohol is the single most risky issue of sexually transmitted disease and HIV infection among American college students. Alcohol is related to the majority of unwanted pregnancies, sexual assaults, and events of sexually transmitted disease on American college campuses. Studies just being completed at the University of California System demonstrated this past spring that 67% of the students admitted that they had used alcohol on purpose in order to make sex happen, to make it easy, or to remove conflicts about it. We know what college students grow up with is important, that their religious and other values are important, how they grow and develop as psychological entities is important. What we've come to know in the past couple of years is the strong influence on them of external standards. That is their peers. The basic message is that what happens to them in terms of messages from their peers and from their culture and society, is in fact conflictual with the message of health promotion. Most of the things that we would like them to do to protect themselves, they do not find validated in the culture around us. You may say to your students, "Just say no". You may say to them, "Don't mix sex with alcohol". That's a great and wonderful message, but they hear some other things as well. They hear out of pop culture, whether it's in music or anywhere else, some other things. If you are a parent you're worried about what they hear, what they see on record albums, the culture of young people. And as much as you try to provide varied direct input by very targeted messages, there are very targeted messages on the
other side that say something different.

And the question that people always ask is: "that's great. What are the skills for the prevention of AIDS?" The skills for the prevention of AIDS are self esteem, assertiveness, decision making, knowing yourself and other people, being intimate and having a relationship, managing stress, coping with substances and stress and alcohol, being aware of how our society talks to us and how it influences our behavior. These are the skills for the prevention of AIDS. The fundamental skill for the prevention of AIDS is self esteem. If we are going to work at the level of what will actually do something, we should be working at the level of self esteem, assertiveness, intimacy, relationships, decision making, taking people back to what they want out of life. If we are somehow able to do this at the individual level, then we will achieve skill building in a hundred small areas that will enable them to protect themselves. As we build their skills, that will reinforce their self esteem. As we reinforce their self esteem, they will learn to build better skills.

We want to summarize all of this in terms of a new approach. It means we go way back to values, what people want for themselves. I want life, health, a future, good relationships. I want to mean something. Fine, if that's what you want, then let's work on this. Talk about knowing yourselves, talk about knowing other people, talk about how you build relationships, talk about how you fit in with our society. As we begin to help, you will learn that there is a specific set of things that are going to keep you healthy in the context of what you want. And within that specific set of things there are some very specific skills that relate to sexual behavior. If what you decided back there was that you wanted life and health and a future in good relationships, then by the time you get out of here, it's not a questions about what you do about sexual behavior. If you've done all these, your self esteem, intimacy skills, etc. are developed and health promotion skills are built. It will happen the right way because it will be inevitable within this context. That's individual behavior change. Each individual is supported by a community that cares about other people as they do about themselves. They provide support for the changes that each individual makes as he or she cares about himself. This means we need to build community. Build a community of concern and support. Building community will require leadership from us, the building of consensus among people who are concerned, together fostering an ethic of community.

A complete transcript of this speech given at the 1990 ACSD National Conference is available from the Koinonia Editor for $2.00 (copying and postage).

1990 CACSD NATIONAL CONFERENCE

The second annual Christian Association of Canadians in Student Development conference was held May 23-25th, 1990 at Canadian Bible College in Regina, Saskatchewan.

Fifteen colleges were represented with a total of thirty members attending. Dr. Larry McKinney, Vice President for Student Development at Philadelphia College of Bible was the general sessions speaker. The conference theme was: "The Growing Edge: The Challenge of Exploring New Frontiers in Student Development". Dr. McKinney addressed the conference with three main challenges: "Readiness for the '90's", "Resources For the '90's", and "Reality For the '90's".

Other highlights of the conference included the ratification of a constitution and by-laws for the association, which came into being one year ago, a presentation of a recent student survey by Harvey Zink, Dean of Students at Canadian Bible College, and presentations on leadership, New Age, crime on campus, sexual abuse, AIDS, discipline and career counseling.

Anyone interested in joining CACSD, or wishing more information may contact the following individuals:

Arnold Friesen, Winnipeg College
Vern Longstaff, Eastern Pentecostal Bible College
Wendy Nelligan, Bethany Bible Institute
Memories of
Calvin College
Position Changes

Paul Ardelean from Dean of Students to Executive Director of Alumni Association at Bryan College.

Randy Bowyer to Vice President of Student Affairs at Central Wesleyan College.

Danette Burgess from Resident Director to Counselor at Northwestern College (MN).

Laura Carmer from Coalition for Christian Outreach to Resident Director at Gordon College.

Angela Cook from Cedarville College to Resident Director at Gordon College.

Lisa Dombrowsky from Stonehill College to Director of Campus Activities and Leadership Development.

Glenda Droogsma to Dean of Students at Reformed Bible College.

Raydora Drummer from Resident Director at Wheaton College to Graduate Advisor at Michigan State University (Ph.D program).

Randy Erickson to Resident Director at Northwestern College (MN).

Doug Faulkner from Resident Director to Director of Residence Life at Greenville College.

Jim Fleming from Resident Director to Director of Student Leadership at George Fox College.

Beth Goldsmith from Resident Director to Director of Learning Assistance at Huntington College.

Monica Groves from Resident Director to Associate Dean of Students at Northwestern College (MN).

Sue Hakes to Resident Director at King College.

Becky King from Resident Director at Gordon College to Director of Student Ministries at Northwestern College (IA).

John Krueger from Urban Baptist Ministries, Toronto, to Career and Placement Coordinator at Redeemer College.

Katherine Magnuson to Resident Director at Northwestern College (MN).

Koby Miller from Residence Life at Biola University to Resident Director at Asbury College.

Pete Mills to Resident Director at Asbury College.

Matt Nussbaum to Resident Director at Huntington College.

Jan Schregardus from Director of Residence Life at Dordt College to Minister of Education at Woodlawn CRC (MI).

Chuck Thompson to Director of Counseling at King College.

Trudi Thompson from Office Manager to Resident Director at Northwestern College (MN).

Mark Troyer from Director of Student Academic Advising Center at Grace College to Director of Student Leadership Development at Asbury College.

Quentin Van Essen from Career Planning and Placement to Admissions at Dordt College.

Sheryl Vasso to Director of Residence Life at Philadelphia College of Bible.

Steve Wilson from Coordinator of Student Activities to Director of Student Activities and Commuter Students at Ontario Bible College.

Leo Wisniewski to Assistant Dean at Geneva College.
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Regional Directors

(Left to Right) Steve Beers, Central; Dwain Harwick, Appalachian; Lee Demarais, South Central; Tim McKinney, North Central; Linda Cummins, Lake; Dave Harden, Northeast. Not pictured: David Waggoner, Northwest; Jeff Ederer, California.

DO YOU HAVE NEWS FOR THE KOINONIA?

The Koinonia will be providing space in the future for short informational news releases on new, innovative, and creative events or programs on your campus. Position changes may also be sent to the Koinonia using a news release. Please copy and use the new press release form frequently.

Position Available

Indiana Wesleyan University has a new position open for a Coordinator for Student Activities and Conferences. This is a twelve month position starting immediately. For more information call Scott Makin, Associate Dean, at 317-677-2202 or write Indiana Wesleyan University, 4201 S. Washington, Marion, IN 46952.

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Koinonia is the official publication of ACSD (Association of Christians in Student Development). The purpose of the publication is to provide interchange, discussion, and communication among Christian professionals in the field of Student Development. It is published three times per year, in fall, winter, and spring. Both solicited and unsolicited manuscripts and letters may be submitted to the editor for possible publication.

The Koinonia is mailed to all members of the Association. Annual ACSD membership dues are $15.00 per year. Information on membership may be obtained by contacting Jack Braun, ACSD Membership Chairperson, Tabor College, 400 South Jefferson, Hillsboro, KS 67063, telephone (316) 947-3121, ext. 259. Address changes may also be sent to the Membership Chairperson.

The ideas and opinions published in the Koinonia are not necessarily the views of the executive officers, or the organization of ACSD, and are solely those of the individual authors or book reviewers.