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# The emplotment of human dignity and social responsibility : college health promotion comes of age in the time of AIDS

Raymond Quirolgico

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**The University of San Francisco**

THE EMPLOTMENT OF HUMAN DIGNITY AND SOCIAL RESPONSIBILITY:  
COLLEGE HEALTH PROMOTION COMES OF AGE IN THE TIME OF AIDS

**A Dissertation Presented**  
**to**  
**The Faculty of the School of Education**  
Leadership Studies Department

In Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Education

by  
Raymond P. R. Quirolgico  
**San Francisco**  
May 2010

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THE UNIVERSITY OF SAN FRANCISCO

Dissertation Abstract

The Emplotment of Human Dignity and Social Responsibility:  
College Health Promotion Comes of Age in the Time of AIDS

At the end of 2003, between 1,039,000 and 1,185,000 persons in the United States were living with HIV/AIDS (Glynn and Rhodes 2005) and the United States Centers for Disease Control and Prevention (CDC) estimates that approximately 40,000 more persons in the U.S. become infected with HIV each year (CDC 2003). According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), the international statistics are even more sobering: there were approximately 39.4 million people living with HIV/AIDS in 2004, and an estimated 4.9 million newly infected people in 2004 with 3.1 million human deaths attributed to AIDS in that year alone (UNAIDS 2004). The disease pandemic emerged in North America in 1981 (Vargo 1992), and in just over two decades, the disease has become one of the greatest pandemics in human history (in contrast, the bubonic plague took over 2,000 years to cause 50 million deaths) (Walker 1991).

The American College Health Association was founded in 1920 and serves as a leadership and advocacy organization for college and university health. In the early 1980s, the association created an HIV (Human Immunodeficiency Virus) Task Force and then a short time later, a Human Dignity Task Force. Both work groups were established to expand the working definition of “health” in the higher education context as a response

to the AIDS (Acquired Immune Deficiency Syndrome) pandemic. In less than ten years, both task forces were dissolved or subsumed into other committees. This dissertation examines the evolution of the association in response to the continuing AIDS pandemic in a critical hermeneutic paradigm, with particular focus on the organizational and cultural forces that led to changes in structures and philosophies.

This critical hermeneutic inquiry (Herda 1999) examines those organizational changes using narrative data from research conversations with twelve health and higher education professionals, following participatory inquiry research methods (Herda 1999). The narratives were analyzed within the categories of Narrative Identity (Kearney 2004; Ricoeur 1992, 2004), Oneself as Another (Ricoeur 1992), and Mimesis and Imagination (Kearney 1999; Ricoeur 1992). A narrative approach in critical hermeneutics is employed to discover unique characteristics of a professional organization's evolution and the implications for leadership in college health, for educational initiatives, and for public health policies in general.

The findings include defining health as a condition of human dignity, reorienting organizations around individuals, and re-imagining leadership development for social responsibility. The implications of this study include suggestions for organizations (such as professional associations), higher education practitioners, curricular initiatives at the undergraduate and graduate level, and future collaborations for college health promotion. The co-constructed narratives of this study describe the metaphor of HIV/AIDS as a disease pandemic that has infected all of human existence. This re-imagined narrative compels the future consideration of the intersections of the personal and political, of the

individual and the community, and of the privilege of health and the experience of illness for all people and in all communities/organizations.

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This dissertation, written under the direction of the candidate's dissertation committee and approved by the members of the committee, has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of Doctor of Education. The content and research methodologies presented in this work represent the work of the candidate alone.

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## CHAPTER ONE

### STATEMENT OF RESEARCH

#### A Personal Reflection

When I was earning my Master of Education degree at the University of Vermont from 1991-1993, one of the favorite breaks from work and school that my friends and I were able to enjoy was walking down the hill from the campus to the pedestrian area of downtown Burlington, Vermont, and then stop at a particular street vendor's cart. We would treat ourselves to a freshly baked pretzel and (in the cold, long, winter months) a cup of steaming hot chocolate or (in the hot and humid summer months) a glass of freshly squeezed lemonade. The vendor's name was Chris, and he always greeted us with a genuinely warm smile, a cheerful conversation, and a friendly exchange, no matter how brutally extreme the weather was, and no matter how busy the long line at his popular cart may have been.

Shortly after I graduated in 1993 and entered the working world as a higher education professional, I received news from a friend back in Vermont. She called me to tell me that Chris had appeared in an obituary in the local newspaper: he had died of AIDS. I was surprised at my own emotional reaction to this news: that nice, sweet, forever genial man was gone. He and his pretzel cart had become such a part of my graduate school memory it was difficult to imagine what life in Vermont could possibly be without him. My friend in Vermont clipped the obituary out of the local newspaper and sent it to me. I admit that when I received it in the mail and saw Chris's smiling face in the photo that accompanied the lovingly written obituary, I honestly had no idea what to do with it. I certainly felt sadness for his passing and death at such a young age, but I

also felt a mix of emotions that made me feel like I had to withdraw and protect myself from feeling too close or too sad. I filed that newspaper clipping away with some other graduate school memorabilia and tried not to let the news consume me. But I found myself going back to review it every once in a while. There was no nostalgia driving my periodic recollection of this man – instead, there I felt somehow connected to his life, despite my internalized admonitions to remain a distant observer, a role that I presumed was more suited to my connection to a street vendor from my past.

Several more years passed and then in 1996, I traveled with a group of friends from Oxford, Ohio to Washington, DC, to see the last full display of the NAMES Project AIDS Memorial Quilt. I looked up Chris's name and found the quilt panel with the designated number. And there on the grass of the National Mall were two memorial panels for him: each one featured bright sunny landscapes of the most verdant pleasant days in Vermont, and each one prominently featured a pretzel. As I stood there, surrounded by the thousands of the living, experiencing these memorial quilts of thousands of the dead, I thought about so many things: mortality, life, death, simple pleasures, food, service, chance encounters, passing acquaintances, and lasting friends. But mostly I thought of all the people who must have been touched by the "Pretzel Man" (as we called him in Burlington, Vermont) over the years – could they all possibly know how they were so closely connected to an issue that had seemingly passed into a manageable memory?

Like everyone in my generation, I have barely known life without the AIDS pandemic. It is still a reality, and I think it is still worthy of examination. And so I offer this.

## Introduction

The American College Health Association was founded in 1920 and serves as a leadership and advocacy organization for college and university health. In the early 1980s, the association created an HIV (Human Immunodeficiency Virus) Task Force and then a short time later, a Human Dignity Task Force. Both work groups were established to expand the working definition of “health” in the higher education context as a response to the AIDS (Acquired Immune Deficiency Syndrome) pandemic. In less than ten years, both task forces were dissolved or subsumed into other committees. This dissertation examines the evolution of the association in response to the continuing AIDS pandemic in a critical hermeneutic paradigm, with particular focus on the organizational and cultural forces that led to changes in structures and philosophies. This dissertation describes an orientation to health as an issue of justice and social responsibility and not just a biomedical diagnosis, using HIV/AIDS interventions as a model. These themes are examined in the context of the professions of student affairs administration and college health promotion. The ultimate aim of this dissertation is to propose policy and practice implications for health in higher education.

The categories that guided this dissertation are:

1. Narrative Identity: the construction of an individual’s or an organization’s story using characters and events in a sensible plot;
2. Oneself as Another: the interconnection of individual identities;
3. Mimesis and Imagination: configuring the past in the present and proposing new actions in the future.

## Statement of Research Topic

Dr. Mathilde Krim, the co-founder of the American Foundation for AIDS Research (amfAR) has described the ineffectiveness of HIV/AIDS prevention strategies when she cited surveys that show “95% of Americans know how to prevent infection with HIV, but they just cannot apply this knowledge to their own lives” (Sischy 2005:129). Prevention and education interventions that focus merely on the acquisition and transmission of knowledge are not enough to effect the behavior changes that will slow or stop this pandemic (Andreasen 1995; McLoughlin 1999; Social Medicine 2006). In examining other health promotion initiatives, the Higher Education Center for Alcohol and Other Drug Prevention stated that “the chief lesson from working in public health is that people’s behavior is shaped by their environment, so if we are to change their behavior, we need to change that environment” (DeJong et al. 1998:9).

Researchers have shown that in some cases, the effect of HIV prevention programs is statistically non-significant in producing behavior changes to reduce exposure to HIV via sexual intercourse (Leaver, Allman, Meyers, and Veugelers 2004). Even in South Africa, where the prevalence of HIV/AIDS among people between the ages of 15 and 24 is the highest in the world, educational interventions have produced no significant change in the rate of infection among adolescents (Hartell 2005).

The need to address this pandemic with different approaches unique to HIV/AIDS that enable individuals and communities to take preventive action was also highlighted at a summit on AIDS and HIV held in San Francisco in 1998 (Goldstein et al. 1998). At the same meeting, the myriad of environmental factors complicating effective prevention and

treatment of the epidemic were also detailed. Even findings from modified variations in educational interventions are confusing.

One study conducted in Tijuana, Mexico found that an educational workshop for high school students combined with access to condoms produced at least a short-term positive impact on sexual behavior, although the researchers pointed out the many cultural factors that complicate generalizing or applying their work in any other context (Martinez-Donate, Hovell, Zellner, Sipan, Blumberg, and Carrizosa 2004). The research on sexual behavior and HIV has even questioned the validity of quantitative survey research and the depth of qualitative phenomenological studies in this topic, leading to the perplexing reality that education and condom use appear to be systematically unrelated (Obermeyer 2005). Health promotion professionals now believe that understanding health decisions is very contextual (and not only clinical) in nature (Mui 2005).

The effectiveness of HIV prevention and AIDS education interventions in the population of college students is particularly challenged by the persistent assumption those students make that they are not at risk of infection, disease, or death (Burns 1999). Although this may be an epidemiological fact (albeit perhaps only a temporary fact that changes as any one student ages), American higher education has a responsibility to produce future leaders who are educated about the complexities of a multicultural society in a globally interconnected world, and those future leaders will inherit the problem of the AIDS pandemic, and all the inequities it represents (Reed 1999). Therefore, any educational interventions for the college student population must be multidisciplinary, intellectually rigorous, culturally competent, and socially engaging (Laureano 2005).



As with other health initiatives, strategies and programmatic interventions for AIDS/HIV education have been proposed (NASPA 2004). The research about the effectiveness of these initiatives in producing the necessary behavior changes to decrease the risk of infection is seriously lacking. Previously, researchers have described planning processes and have identified common thematic elements through qualitative analysis (Hedgepeth and Helmich 1996) but “none of the studies has specifically evaluated program effectiveness for college students” (Hoban, Ottenritter, Gascoigne, and Kerr 2003:56). Although program evaluations may assist in the refinement of training models and provide justification for resource allocation decisions, the actual educational objective of promoting healthy living in college students, with particular attention to HIV/AIDS has not been met (Kenzig 2004). Obermeyer (2005) has pointed out that the weaknesses and limitations in past HIV/AIDS prevention research suggest that research must be done to understand not just knowledge and awareness but perceptions and contexts in highly specific local environments.

In recent years, the college health profession and the higher education student affairs administration profession have both shifted their health promotion approaches to focus on campus health ecology and the quality of health as an issue of human dignity and social justice (Moses, Keeling, and Quirolgico 2005). This shift reflects the health promotion and HIV/AIDS research professions’ works to study individuals in contextual environments. To assist college health promotion professionals and related student affairs administrators, this study examines this shift in orientation to the issue of health and its impact on health promotion effectiveness, with specific attention to health promotion in the subject of HIV/AIDS.

To restate my research in specific terms, this study examines the organizational changes that occurred in the American College Health Association's responses to the AIDS pandemic, beginning in the 1980s, via the narratives of professionals who were involved with those changes and who continue that work in the present. This study inquires about the subsequent applications of those changes in thinking about health as a social responsibility for all people. The themes that emerge from this critical hermeneutic narrative exploration are interpreted and applied to campus health promotion strategies and student affairs administration work to evaluate the effectiveness not just of the delivery of content of such interventions, but also of the impact of such interventions on long-term behavior change(s) affecting student persistence and student success. I also explore the broader implications of this ontological orientation to health in terms of education, public policy, and practice.

#### Background of Research Topic

At the end of 2003, between 1,039,000 and 1,185,000 persons in the United States were living with HIV/AIDS (Glynn and Rhodes 2005). The United States Centers for Disease Control and Prevention (CDC) estimates that approximately 40,000 more persons in the U.S. become infected with HIV each year (CDC 2003). According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), the international statistics are even more sobering: there were approximately 39.4 million people living with HIV/AIDS in 2004, and an estimated 4.9 million newly infected people in 2004 with 3.1 million human deaths attributed to AIDS in that year alone (UNAIDS 2004). Genetic researchers have traced the likely evolution of HIV back to a spontaneous mutation in simian viral genetics in 1931 (Engel 2006).

Although the symptoms of AIDS were first identified between 1902 and 1911 in Europe (Vargo 1992), highly sporadic cases of individuals dying with symptoms that are now known to be AIDS occurred throughout Western Europe and North America in the 1950s through the early 1970s (Engel 2006). The disease pandemic emerged in North America in 1981 (Vargo 1992), and in just over two decades, the disease has become one of the greatest pandemics in human history (in contrast, the bubonic plague took over 2,000 years to cause 50 million deaths) (Walker 1991). Jonathan Engel (2006:291) recounts the speed with which the pandemic has affected the human community:

By the year 2000, 21.8 million people had died of AIDS, and 50 million people had been infected with HIV. Over 2.5 million people were dying yearly, and 5.6 million people were becoming newly infected. While over 90 percent of all new infections were in Africa and Asia, even the healthy and wealthy United States had suffered; its 440,000 AIDS deaths over the previous two decades totaled more than all United States military fatalities in World Wars I and II combined.

Engel (2006) adds that the continent of Africa has been the most affected by the pandemic, followed by the Caribbean, Russia and the other former republics of the Soviet Union, and rapidly emerging in the 21<sup>st</sup> century in frightening numbers in China and India.

In the United States, adolescents make up one of the fastest growing population groups in HIV infection rate (Nelson 1998) and one early study estimated that in one year, “25,000 of the 2.5 million college students in the United States may become infected” (Chng and Moore 1994:154). More recently, the Alan Guttmacher Institute similarly estimated that 20,000 new HIV infections occur each year among people under the age of twenty-five (Weinstock, Berman, and Cates 2004, cited in Laureano 2005). As of August 2008, the CDC released a new estimate of new HIV infections in the United States and admitted that the epidemic in the country was worse than previously known:

56,300 people were newly infected with HIV in 2006, much more than the CDC's previous estimate of 40,000, with the most affected populations being young, black men who have sex with men, young Latino/Hispanic men who have sex with men, and black women (CDC 2008).

Student affairs administrators and college health educators have never had any single, consistent strategy for addressing this issue with college campus populations, and education and intervention strategies have varied widely since the mid-1980s (McLoughlin 1999). The dissemination of information was at once inundating, sometimes inaccurate, often culturally inappropriate for target audiences, and very often inconclusively evaluated (if at all) (McLoughlin 1999). Campus health education efforts to educate about HIV and AIDS were largely of the most ineffective type: facts and data presented as cold information, which is a format that has never resulted in consistent, lifelong, sustained risk-reducing behavior in people (Cates and Bowen 1990). Even as the prevalence of education efforts has waned through the 1990s and into the 2000s, the disease itself has not abated (McLoughlin 1999). Throughout all the years of the attempts of the health education and health promotion profession, college students continue to be members of a population that is at-risk of infection and one of the only hard lessons educators have learned is "Knowledge alone does not alter behavior, even when the knowledge is of a serious, life threatening hazard and the changes required for prevention are within reach" (Keeling 1996:6). Although a body of research addressing health behavior among sexually active adults does exist, very few of these studies have dealt specifically with college students who are experiencing their own unique kinds of developmental and intellectual challenges (Keeling and Engstrom 1992b).

### Significance of Study

In recent years, the college health promotion profession and the higher education student affairs administration profession have adopted similar approaches to addressing the topics of HIV and AIDS with the college student population. What these new approaches have in common is an orientation to health that is not simply a biochemical summation of quantifiable diagnostic measures but an individual and a community capacity for success (American College Health Association [ACHA] 2005; National Association of Student Personnel Administrators [NASPA] 2004). This approach expands a traditional clinical view of health by adding dimensions of complex systems of campus ecology and considerations and advocacy for the non-clinical value of human dignity. Understanding health as more than the traditional concept of health being only a biomedical quality but now as a shared community reality helps place responsibility for individual and community health in the hands of all people, not just highly trained, skilled specialists. This orientation can empower entire communities to fashion constructive changes for the future because the leadership for every person's health is no longer confined to a few experts but to all people who share the common world.

### Summary

The purpose of this study is to identify the organizational and social realities that influenced changes in thinking in the college student health promotion profession. As the professions of student affairs and college health promotion have advanced their thinking in recent years to conceive of health as a shared community capacity integrated with student learning, the responsibility for caring for students and ensuring their success has correspondingly broadened and become more complex. A narrative approach in critical

hermeneutics is employed to discover unique characteristics of a professional organization's evolution and the implications for leadership in college health, for educational initiatives, and for public health policies in general. In the next part of this dissertation, I will discuss health understood from a classical, biomedical perspective and health interpreted in critical hermeneutics.

## CHAPTER TWO

### REVIEW OF LITERATURE

#### Introduction

Medicine has traditionally defined health in biomedical, clinical terms or metrics and diagnostics. In this phenomenological construct, health is the summation of certain characteristics (including the subtraction of negative characteristics). In the ontological paradigm of critical hermeneutics, health is a condition of being, and each human being is a reality that involves relationships with self and others over time. This review of literature will describe some of the concepts from these two traditions of thought. In the classical, positivist paradigm of health, the themes include structure, function, and systems-level ecology. In the critical hermeneutic paradigm, the themes include oneself as another, narrative identity, and mimesis and imagination. An understanding of the dialectic relationship between these paradigms will be essential for understanding the shifts that will be described in the organization under study.

#### Health Interpreted in the Classical Positivist Paradigm

The positivist, reductionist view of medicine is demonstrated in the introduction to a work that is a standard textbook for all medical students, *Gray's Anatomy*. Grotta-Kurska (1974:ii) explains the importance of the study of human anatomy by stating that we “can only begin to know who we are once we understand *what* we are.” This classical paradigm of health as an internal composite of biomedical diagnostics that are measured by an external clinician is similar to a classical school of thought in anthropology: that of structural functionalism. Structural Functionalism was the dominant school of thought in British anthropology from the 1930s to the 1960s (Partapuoli and Nielsen 2005d), and is

closely related to Functionalism (Gingrich 1999; Partapuoli and Nielsen 2005d).

Functionalism and Structural Functionalism focus on how social systems meet needs in order to survive and are based on a biological model of life that sees pieces of a system contributing to the system as a whole organism (Chilcott 1998; Partapuoli and Nielsen 2005b). This integrated systems perspective developed from the work of Durkheim, who in turn responded to the evolutionism and diffusionism schools of thought in British anthropology (Eriksen and Nielsen 2001a).

Bronislaw Malinowski pioneered Functionalism as an approach with a narrow focus on individual persons who fulfilled functions in order to satisfy needs and also developed the fieldwork methodology of participant observation and immersion (Chilcott 1998; Partapuoli and Nielsen 2005a). Alfred Radcliffe-Brown championed a similar systemic view of anthropology, but focused on the social whole (as opposed to Malinowski's individual actors), studied less by immersion methodology but instead by examining networks of kinship connections (Partapuoli and Nielsen 2005a; 2005c). In the Structural Functionalist approach, Radcliffe-Brown claimed that a society's rules of conduct coordinated defined roles that created a social structure and understanding the society required understanding how those social relationships functioned (Chilcott 1998). Structural Functionalism explains social patterns in terms of how integrated systems fulfill individual and societal needs (Sperling 1991). The focus of Structural Functionalism on interrelated networks in social systems also became the dominant school of thought in American sociology from the 1940s to the early 1970s (Gingrich 1999).



The major criticisms of Structural Functionalism (and of Functionalism) represented the *Zeitgeist* of the late 1960s and 1970s, leading to both traditions falling into disfavor (Gingrich 1999). Critics contended that the Structural Functionalist approach presented a static model of society that involved interdependent systems seeking homeostatic equilibrium and could not account for change or deal with any dysfunctions (including the dominant features in American society at the time such as poverty, political and economic power of the wealthy, and social unrest and dissent) (Chilcott 1998; Eriksen and Nielsen 2001b; Gingrich 1999). The rise of deconstructionist theories and feminist philosophies challenged Structural Functionalism (and several other anthropological and sociological schools of thought) for favoring historically defined and academically sustained biases that over-emphasized male dominance, rigid structure and linear thinking, reductionist attitudes that behaviors must always have a cause, and that functional consequences explained evolutionary history despite the history of constantly changing environments (Sperling 1991).

Responding to such criticisms, recent work has supported Structural Functionalism as a methodology and grounding theory for ethnographic research (Blot 1998; Chilcott 1998), and as a way of studying and describing the moral and ethical contexts of human conditions (Kleinman 1999). Chilcott (1998) specifically proposed using Structural Functionalism to inform educational anthropology by probing for answers to questions about the effects, purpose, values, and intentions of schools. Chilcott (1998) further supposed that applying Structural Functionalism on a macroscopic level could lead to systemic improvements in education systems. Kleinman (1999) similarly argued for the value of informed systems-based methodology to understand the

moral and ethical realities of health conditions and issues as problems of human equity and justice. Recent shifts in thinking in both medical practice and public health promotion support a systems-based methodology for addressing health problems (Lasker et al. 1997).

Systems-based health promotion strategies have also been employed in higher education interventions. Recent literature in college health promotion and in student affairs administration has recognized the necessity of systems-level approaches in effective health strategies (Fineberg 1990). The recognition of the interconnectedness of health systems leads to the observation that we are all connected to each other and everything in the universe. That universal connection compels us to consider the ethical nature of every action we take (Maturana and Varela 1992; Wheatley 1996). What Pfeffer and Salancik (2005 [2003]) described as the symbolic role of management takes on the additional responsibility of ethical role modeling. Student affairs educators need to further role model the health messages they transmit to their other interconnected entities by way of actions, language, attitude, cultural competence, policies, and programs. Developing this professional identity is a process that can be sustained by intentional training and professional development programs (Hoban et al. 2003).

Understanding health as networked systems also implies the role of leaders to manage the environmental contexts of the systems (Morgan 1997), not just the traditionally accepted biomedical diagnostic states or behavior changes of the individual. The model of health as a dynamic, complex adaptive entity teaches that small changes in actions and understanding can have large effects (Morgan 1997). The management of information not as a commodity but as a process is one way that educational

administrators can equip a system to survive phase transitions in health and continue to survive (Wheatley 1999). Leadership in this complexity model recognizes the power of relationships in the system and relationships can be sustained by leadership that encourages conversation and storytelling as a way of engaging other complex entities (Wheatley 2002). This influence of others is power in network systems (Capra 1996). Genuine conversations as a way of truly connecting with others have also been described as a process of “engaging the soul at work” (Lewin and Regine 2001:16).

Wheatley (2002) describes the process of connecting with another person in a genuine social relationship to be the sacred experience of life’s natural systems. Van Eijnatten and Van Galen (2002:395) proposed simple guidelines for establishing genuine dialogues: “be present, pay attention, speak truth, and let go.” The deep understanding of our interconnectedness to each other brings a spiritual dimension to our work within the system (Capra 1996). Maturana and Varela (1992) defined this acceptance of our connection to social processes as love. As relationship-based administrators for a college campus, student affairs professionals are particularly well poised to engage others in these soulful, loving conversations about purpose and vision.

For such creative work to be sustained to the point of influencing an entire professional association or profession, Gladwell (2002) suggests taking on the roles of connectors (socially networked people who can link complex entities together), mavens (people who serve as skilled information brokers), and salespeople (people who are influential and passionately persuasive). When these critical members of the connected community manage information that has been carefully and subtly designed to fit a

specific context, then actions within a system can be affected in small ways that produce large changes.

Gladwell (2002) describes these intelligent actions in the context of social fads, but the same concepts can be applied to the question facing the professional association now: how to continue the work of the ecological model and sustain that systems thinking in the profession once the final grant award (i.e., the resources) ends? Facilitating knowledge is a strategy that can be especially helpful in such research contexts (Magnusson and Nilsson 2003). In Gladwell's (2002) terminology, the model itself can be promoted by the professional association until its constituent members accept and promulgate the information (the mavens), share the information with colleagues outside of the association membership (the connectors), and pass along the ecological perspective of health to the influential senior faculty and staff (the salespeople) who can shape the professional preparation programs and continuing education work that train current and future professional colleagues. The small group of authors of the ecological model document can also serve as the first mavens (employing their first-hand learned expertise in the subject) and connectors (leveraging their existing relationships with professional colleagues) for a cultural shift in the professional population.

Lowney (2003) simplifies some of the same complexity science characteristics described earlier in his descriptions of the leadership style of a 450-year old religious order. He identifies the four pillars of "self-awareness," "ingenuity," "love," and "heroism" (Lowney 2003:9) as central to effective leadership today. The longevity of his case study example further suggests processes for sustaining the work of this conceptual model, through generations of educators: a pattern of behavior that Maturana and Varela

(1992) define as cultural behavior. Complexity science as applied to college health issues challenges student affairs educators to work with clarity of purpose and recognition of their interconnectedness (self-awareness), to open opportunities of creativity and innovation in the phase transitions of problem solving (ingenuity), to honor the relationships with other complex adaptive entities (love), and to balance on the edges of chaos and order to survive (heroism).

While managing such a cultural revolution in thinking for a single international professional association and an entire profession seems as daunting as the original challenge of describing “health as everything,” luckily student affairs is not alone in leading this charge. In fact, several other professions are experiencing the self-organizing patterns of ecological thinking about health. The CDC has developed an entire professional network that recognizes not only the interconnectedness of epidemics but also the need to understand health at the level of communities not at the level of isolated health problems (CDC n.d.).

The American College Health Association has traditionally had minimal contact with its student affairs counterparts because of the classical paradigm that placed all responsibility for managing health in their hands. Their recent work, however, mirrors the thinking proposed by an ecological model, and places the responsibility for health promotion into the hands of all college professionals who are connected to the larger institutional mission of learning (ACHA 2005). The Association of American Colleges and Universities has also supported an academic orientation to health (and HIV/AIDS, specifically) as a community property, as an institutional responsibility, and as an

opportunity for liberal learning (Corrigan and McClear 1999; Cronon 1999; Keeling 1999).

Continued work managing these interconnected relationships of everyone who has a stake in higher education through conversations may result in enhanced student learning, improved community relations, and increased health capacities for all. Such a grand vision of collaboratively constructed, socially just systems once again might appear to be too large a goal to achieve. Fortunately, a system that continually creates possibilities will only need a few critical changes to sustain itself through phase changes (Gleick 2000). As the complex adaptive entity of the ecological model for campus health has already pointed out, this goal is achievable because it is a character of the living system of health itself. The next step for the professional association and the student affairs profession will be to honor this self-organized pattern in its work for the greater benefit and continued survival of all systems. The pattern of college health has emerged, and now the leadership work to tip the system of higher education towards a new phase of health begins. As Boynton (1971:285) stated in her comprehensive history of the American College Health Association's first fifty years of existence: "Much has been done, but there remains a great deal to do."

An ecological model for school systems that considers various multidisciplinary, interacting systems existing at different levels of social structures over time has already been proposed (Berns 2004). This kind of multilayered and multidimensional approach to addressing health issues has been promoted by higher education and health promotion professional associations (NASPA 2004; National Institutes of Health [NIH] 2005). A community organizing approach serves to expand the self-interests of each participant to

increasingly wider spheres of action, eventually teaching participants to take an active role in shaping their communities (NIH 2005).

The ecological model of human development described by Berns (2004) identifies four levels of social structures: microsystems (activities and relationships in small settings like families, schools, and peer groups), mesosystems (interrelationships between various microsystems), exosystems (settings external to individuals in microsystems that still cause indirect effects on those individuals), and macrosystems (entire societies and subcultures that sustain belief systems, lifestyles, and patterns of social interactions). These four systems are also embedded in a chronosystem, meaning the entire ecology changes over time. The interactions of these systems on an individual are what create the human socialization process: we learn as a result of all the systems creating the life-space we inhabit, and this life-space contributes to and is in turn affected by our individual health. Therefore, we can begin to imagine recommendations for addressing health (and specific health issues such as HIV and AIDS) by examining each separate, but interconnected, system in the ecology.

This ecological systems approach to understanding health pushes the sphere of health issues past traditional biomedical domains into the boundaries of shared responsibilities (Institute of Medicine 2002; Keeling 2006). Although this more holistic model considers multiple relationships between the individual, the individual's communities, and the forces that impinge upon the individual and the community, it is still a model rooted in the positivist scientific tradition that considers health as the sum of multiple influences. In order to understand health as a condition of a person's entire

being, we may turn to an alternative paradigm, and this is where the philosophy of critical hermeneutics may be most useful.

### Health Interpreted in Critical Hermeneutics

The critical hermeneutic paradigm of language has many implications for teaching and learning about health. Geertz (2000a:16) argues that “local knowledge” is the awareness of self as a locality within a larger more diverse human context. This suggests that there are different ways of knowing (that do not all have to follow the cause-and-effect rules of deduction of the natural sciences). The refiguration of social thought is about symbols and meanings (Geertz 2000b:21), so we are free to search for knowledge and truth in multiple ways that make sense to us. Teaching in culturally appropriate ways is also possible when we are aware of “culture as an assemblage of texts” (Geertz 1973:448). This educational process places shared responsibility on the student and teacher (Stewart 1983:389), and legitimizes the limitations of humans who do not have all the answers and yet can still freely engage in the process of discovering shared meanings. The connection between teacher and student is similarly described by Cajete (1994:127) who comments on the communion experience of myths and states that “learning and teaching are always about, and for, life through community and leadership,” and later, that “indigenous education has always been characterized by a process of co-creation between teachers and students” (Cajete 1994:139).

The shared experience of teaching is also reflected by Bateson (1994:10) who writes, “shared ways of seeing are socially constructed.” She clearly states that education involves the same kind of oral traditions described by Cajete (1994:138-139) and that “our species thinks in metaphors and learns through stories” (Bateson 1994:11) and it is



this “replication and recombination” of stories that transmits information across generations (Bateson 1994:28). Arendt (1968b:196) adds that education as the shared construction of meaning “is the point at which we decide whether we love the world enough to assume responsibility for it.” So the ethical implication for educators is that co-constructing meanings ultimately charges us with a mission to create a better world and to work for social justice.

Understanding the narrative of the college health profession allows us to examine the history and present context of health promotion work. Gadamer (1976) pointed out that history plays an important part in authentic understanding. A classic, scientific view of history might simply be the chain of events that occurs over the passage of time. However, Gadamer (1988) differed from this view and instead thought of history as providing the contexts for present meaning, thus creating understanding. Gadamer (1988) also stated that tradition is no mere fragment of the past world, but enters the sphere of meaning it expresses and moves into the present with that meaning. With that understanding of past and present, we can re-interpret and imagine policies and effective interventions that leaders must accept responsibility to craft and fulfill, thereby creating a new text of informed practice for a shared future. Ricoeur continued this line of thinking by writing about narrative identity. For Ricoeur, one’s present-day identity comes from our past and our imagined future. Ricoeur (1988:144) stated that each of us reconfigures the past in the present through temporal distancing in order to create “an identification with what once was.” Ricoeur referred to these references to the past as traces: a trace “is left by the past, it stands for it” (Ricoeur 1988:143). Creating new, authentic understandings from the history of the organization under study is a goal of this research.

Ricoeur's definition of narrative identity further states that through the act of telling, narratives recreate the past and imagine the future in a process that captures the "union of contingency and consecution, of chronology and configuration, of sequence and consequence" (Ricoeur 1981:292). This process of narrating human action calls forth "productive imagination" so that we can see "what is essential in reality" (Ricoeur 1981:296). A narrative approach also mediates between description of human action and prescription of human action (Ricoeur 1992:170): the description opens the full complexity of our identities (in past, present, and future), while honoring the past in the present opens us to new possible actions for the construction of ethical worlds in imagined futures. Such imagination is what informs the prescription of human action.

New thinking in anthropology recognizes that the linear thinking of traditional science's reductionist view does not accurately describe the complexity and diversity of the natural world (Sperling 1991). Sperling (1991:25) recognized that "facts are meaningful within stories" and that anthropologists seeking to understand problems of biology must first address the "historical, economic, and cultural causes" of those problems (Sperling 1991:27). An anthropological perspective of scientific research and (Western) medicine challenges the anthropocentric view that human beings can employ technology and apply knowledge over other forms of life, and proposes alternate ways of knowing (Bowers 1993). In this anthropological view, there is authority in memory, communication is participatory and contextual, and human communities exist in cultures and in time (Bowers 1993).

In order to examine the layered stories in the narrative of the American College Health Association's response to HIV/AIDS, some specific concepts from the tradition of critical hermeneutics relevant to health will be addressed here.

### The Patient as the Other

Even an expanded view of health as a relationship between the individual and the environment (Fineberg 1990; Foucault 1986) focuses on health as a discretely observable summation of physical factors that mostly place the individual in a subjugated position as an organism within an environment (Foucault 1986). The larger dimension of one's surrounding environment exerts a power of domination to define and control what is healthy and normal (Foucault 1978).

Because medicine is embedded in a cultural context, medical understanding is also subject to an interpretation of individuals (i.e., patients, humans) as other objects to be identified, codified, diagnosed, and evaluated. The biomedical tradition in which one is diagnosed and ascribed a value of health (or not) is challenged in critical hermeneutics because it lacks a value for the self-consciousness of the other (Ricoeur 1992). Ricoeur (1992:3) describes a "dialectic of self:" a process that requires the elimination of the separation between oneself and another. Ricoeur (1992) identified two temporal facets that exist in the self: *ipse*, the selfhood that changes over time; and *idem*, the sameness that stays constant throughout time. Ricoeur (1992:140, 148) described a dialectic process mediating the *ipse* and *idem* to create narrative identity. In narrative identities, the past is re-created and the future is imagined. This process requires the admission that conceiving of oneself automatically places one separate and distant from the other, but those delineations become meaningless without both existing at once. Therefore, the

classifications that separate each of us can instead pass through each of us in a more universally connected way (Ricoeur 1992). Ricoeur (1992:3) explained that this concept of oneself as another “suggests from the outset that the selfhood of oneself implies otherness to such an intimate degree that one cannot be thought of without the other [and] instead one passes into the other.” This description emphasizes the idea that humans are connected to all other humans, so the health of one must pass into the other. Indeed, Ricoeur (1992:115) referred to “the connectedness of life” applied not only to individual identities, but also to the full complexity of interconnected ethical issues.

The notion that individuals exist in communion with their larger contexts can also be supported in Heidegger’s concept of *dasein*, a German word that can be translated as “being there.” Heidegger (1962:53) wrote that *dasein* or “being in the world” is a “unitary phenomenon... [that] cannot be broken up into contents which may be pieced together.” This concept of existing in wholeness of self and in connection with all others presents a strong argument for redefining the relationship of doctor and patient not as one expert evaluating a weaker person, but as two complete individuals who interact with each other. This understanding of the inseparable nature of our being also acknowledges the power of imagination in narrative identity.

Caring for a patient (as an object receiving medical attention) is a concept that is also challenged by the hermeneutic concept of solicitude (Ricoeur 1992). When one accepts that autonomy does not require a separation from the other, then it becomes possible for one to value each person as “irreplaceable in our affection and our esteem” (Ricoeur 1992:193). This is a different way, and perhaps an elevated way, of framing the medical path to do no harm. Ricoeur adds the ethical perspective of aiming for the good

life for and with others in just institutions (Ricoeur 1992:180). This ethical aim that provides a definitive direction for the action of health care can be combined with the value of solicitude to reframe the concept of a health profession. In fact, Ricoeur (1992:194) states that the ethical aim exists far beyond interpersonal relations, and extends “to the life of institutions,” where institutions refer to a group of people living together as part of a historical community. He also warned that “there is no ethically neutral narrative” (Ricoeur 1992:115), so understanding individuals and organizations in the critical hermeneutic tradition also opens new understandings of the ethical natures in complex narratives.

This hermeneutic shift in thinking has also recently been evidenced in the medical community as more clinicians have understood the value of narratives that can accurately describe the human drama of illness better than a list of diagnostics (Garro & Mattingly 2000). The power of illness narratives or of health provider narratives is that stories describe what is meaningful in life, what is inspiring, what is dangerous, and what is worth taking risks for (Garro & Mattingly 2000). A hermeneutic approach to health presumes that each person (or patient) has a story to tell and that story can include ideas, conflicts, depth, emotion, and characters that can have a much greater impact than data alone (Mullan, Ficklen, Rubin, & Iglehart 2006).

Another reality that challenges a classic Western biomedical approach to treating a patient as an “other” is the fact that health is not a quality that can be conferred by a doctor onto another person (Gadamer 1996). The state of being healthy or unhealthy is not something that a health professional can place upon a patient. As in the positivist paradigm, health can be understood to be the absence of illness or harm or disease, but it

is not something that can necessarily be given to another. Here again, the dialectic of doctor as “one” and patient as “other” begins to erode into a process of flowing between healthy and unhealthy states. Gadamer (1996) proposes that this recognition of the functional limits of medicine as a science must be replaced with an acknowledgement of medicine as an art that ultimately requires the doctor withdrawing from the patient and setting the patient free, to a healthy state. In this view, there is a fundamental connection between the doctor and patient, instead of a separation between the two.

Kearney (2003:3) states, “Strangers are almost always other to each other.” In his view, a stranger is the other with whom we do not (yet) share an understanding. Kearney (2003:5) also explained that the other can be an internalized reality even though “we refuse to acknowledge ourselves as others.” We experience this internal stranger identity when we compare what we observe to the rules within our subconscious and allow invalid claims to direct us when our observations do not align with our expectations. This presents a critical hermeneutic challenge to the doctor-patient relationship: if the patient is expecting the doctor to provide healing, then the patient’s own health will always be a stranger within because that patient’s health is being dictated by another set of rules and not being proclaimed from within. For the doctor, the task of providing healing to the patient must first begin with an understanding of the patient: that is, the patient must cease to be a stranger to the doctor; there must be an understanding of the patient.

Examining this fundamental shift of the patient not as an unrelated organism, separated from the health educator, the doctor, or higher education administrator; instead to the patient as a member of the same human community in which the health educator,

doctor, and higher education administrator are conjoined will be one of the implications examined in this narrative research.

### Human Dignity

How we understand ourselves is consciousness (Ricoeur 2004:104). When individuals are objectified by a health care system or by a biomedical culture that relies upon expert opinions to define health or lack thereof, individuals are caught in a self-preserving structure and process that dominates and subjugates them and robs them of their consciousness and full human dignity (Arendt 1968b; Foucault 1986). The preservation of human dignity frees an individual's creativity to act politically (Arendt 1968b). Therefore, a model of health as the full experience of human dignity can allow individuals or organizations to pursue definitive actions and possible solutions to social problems.

Gadamer (1996:116) writes that human beings "must always defend themselves against constant and threatening attacks on their health." However, he also frames this human need as a process that must exist in and with nature to sustain an "'inner' equilibrium" (Gadamer 1996:116). This view that places value and worth on each person as well as the entire natural world is further reinforced when he comments that chronic illness is something that affects all of us and which must teach us how to "treat ourselves properly" (Gadamer 1996:100). By this he means to honor what he calls our "life-world" (Gadamer 1996:101) in a way that accepts our limits of being, even in light of our technological and scientific advances. Bowers (1993) also advocates for honoring the autonomous dignity of each person as an interdependent participant in a larger ecological system.

Herda (1999:7) states that “the identity of an individual is found in a moral relationship with others which, in aggregate form, makes up more than the sum of the membership.” She goes further to state that “we are always in relationship – in our personal life and our professional life – and are in the position of responsibility to the other” (Herda 1999:9). This critical hermeneutic understanding of individual identity interconnected with and in an ethical relationship with others reflects a concept of the human dignity of health that carries with it a sense of the human responsibility for health. In this refiguring of the definition of health, we can appreciate human beings in the way that Heidegger described *dasein*: in the most authentic way of honoring the wholeness of human experience.

The theme of honoring the full dignity of the human experience in health is also explored in this study.

#### Mimesis and Imagination in the Organization

The sociocultural and political dynamics that shape the direction, organization, and activities of the association under study reflect the dialectic of control and command and subordination that also connects to the conception of the self (Foucault 1986:94). When an organization is free to act and can imagine itself in new forms, it makes the improbable potential an actual reality (Arendt 1968b). More importantly, the active creation of understandings, which is part of the history of the organization under study here, represents what Ricoeur describes as the “mimesis of human action” (1998 [1981]:292). When an organization like the American College Health Association changes its concept of health, it changes its meaning and metaphor of reality (even before its logical or organizational structure changes) (Ricoeur 1998 [1981]:292). What other



positivist paradigms might define as organizational evolution, development, or change is simply (in the critical hermeneutic paradigm), the creation of an imagined future, based on a past history, made manifest in the present.

Ricoeur (1992) also describes the narrative movement of character and action in the process of emplotment: how a story is told. Specifically, Ricoeur (1992) describes emplotment as the process of making sense out of random events that have occurred over the course of time and binding those once-disparate moments into a single cohesive plot. Kearney (2002) also describes this storytelling process as a way of providing context and meaning to an identity or action. As organizations and communities wrestle with the realities of policies and facts and data, a hermeneutic approach in narratives can be a powerful way of reflecting ideas and values in the stories we tell (McDonough 2006). In the lifespan of an organization, one can imagine each participant or member as a personal narrative: each with an unfolding story of action and character. These narratives contain contexts of their traces and interact in human contexts.

When narratives interact in a fusion of horizons, there is the possibility of new insights and newly imagined futures (Stewart 1983). Gadamer (1976:xix) defines “fusion of horizons” applied to text narratives:

...the concept of understanding as a ‘fusion of horizons’ provides a more accurate picture of what happens in every transmission of meaning...a text speaks differently as its meaning finds concretization in a new hermeneutical situation and the interpreter for his part finds his own horizons altered by his appropriation of what the text says.

In this conception of understanding, we can remember our past (with all of the traces that come with it), appreciate our present, and imagine our future. The past that we bring forward into the present necessarily affects the vision we see before us, forming a

horizon. Gadamer (1988, 2004:305) states “the horizon of the present is continually in the process of being formed because we are continually having to test all our prejudices.” For Gadamer, prejudices are not incorrect judgments, but biases that are created by the traces of our histories that serve to open us to historical and existing opinions. This process of connecting past, present, and future in a narrative is also experienced in the lifespan not only of individuals but also of organizations.

Imagination in an organization also has tremendous educational impact. When we engage one another’s narratives, “there resides the possibility of seeing and understanding the world, and therefore one’s self, differently” (Herda 1999:7). This process of creating and sharing stories allows comprehensive thinking from all dimensions, and leads to greater learning (Cajete 1994). While the “past grounds us and gives us perspective” (Herda 1999:72), we must use history to “carry our minds far beyond the sphere of private and public memory into the range of the possible” (Ricoeur 2004:182). In order to imagine the future, as informed by the past configured in the present, narratives provide meaning. “When we tell a story we capture time. One can say that in a story our past and future belong to us, and the story we have to write (or read) only takes on meaning in the here and now of our lives” (Herda 1999:76). Kearney (2002:4) provides an example of this:

When someone asks who you are, you tell your story. That is, you recount your present condition in the light of past memories and future anticipations. You interpret where you are now in terms of where you come from and where you are going to. And in doing so you give a sense of yourself as a narrative identity that perdures and coheres over a lifetime.

This mimetic existence of the organization is a critical concept in our attempt to seek new understanding from its history of changes. A hermeneutic orientation to the

stories that are presented in this study can challenge how organizations and communities can raise our practical skill level “to be more intelligent consumers of stories” (McDonough 2006:13). And for a professional organization such as the one under study here, the learning that can be offered for its members can carry depth of understanding through the interaction of experiences in stories (Bateson 1994).

Stories are communicated and thus follow the model of communicative competence described by Habermas (1985:137) which requires a successful act of communication to be grounded in the agreement of five claims: that the utterance is true, that the speaker is sincere or truthful, that the utterance responds to the appropriate values, that it is fitting to the relation between the speaker and listener, and that it is comprehensible. Kearney (2002:7) describes the power of stories to confront great problems and issues, throughout human history:

In seeking to provide responses to such unfathomable conundrums – both physical and metaphysical – the great tales and legends gave not only relief from everyday darkness but also pleasure and enchantment: the power to bring a hush to a room, a catch to the breath, a leap to the curious heart, with the simple words ‘Once upon a time.’

Kearney (2002:133) restates what Ricoeur called the “circle of triple *mimesis*: (1) the prefiguring of our life-world as it seeks to be told; (2) the configuring of the text in the act of telling; and (3) the refiguring of our existence as we return from narrative text to action. Ricoeur (1991a:115) further explains that “by telling stories and writing history, we provide shape to what remains chaotic, obscure, and mute.” Ricoeur (1992:141) summarizes that “narrative is key in that it links cosmic time to future possibilities.” For Ricoeur, a narrative is not only the sensible emplotment of characters and actions in the past told cohesively in the present, but it is also an ethical thrust towards an imagined

future. Geertz (1995:2) states that stories "...we can construct...are hindsight accounts of the connectedness of things that seem to have happened: pieced-together patternings, after the act" and from those stories we derive meanings.

### Summary

Critical hermeneutics allows us to understand and interpret the world into which we are thrown, with an orientation to the fullness of the human existence (Bernstein 1988 [1983]:113) and is thus proposed here as a relevant philosophy for the study of health as a state of well-being and a fundamental human right, which is actually how the World Health Organization defined health in the 1970s, but is not the practical reality of health employed in the world (Social Medicine 2006:2). With particular reference to education (or even more specifically, American higher education), Arendt (1968b) suggested that we all share a responsibility for the world. Applying this philosophical orientation to the topic of this research, this study examines how an ontological understanding of health may motivate individuals to act upon this shared responsibility for the care of the world.

## **CHAPTER THREE**

### **RESEARCH PROTOCOL**

#### Introduction

This research explored how a national organization has changed over more than two decades since it first responded to a global health problem. Because these changes involved many people over time working in different locations, a critical hermeneutic paradigm served as the foundation for this research because understanding what happened with the organization involved sifting through multiple stories about the association, told from multiple characters in multiple life-worlds. This part of the dissertation describes the protocol for an examination in the critical hermeneutic tradition.

#### Conceptual Framework

The critical hermeneutic theory that drives this research centers on the use of language and narrative. Herda (1999:1) explained that interpretive “research in a critical hermeneutic tradition invokes language, understanding, and action.” Stewart (1983:384) summarizes Heidegger’s argument of language as the “House of Being” which means that language is not something used to represent reality as object(s) but is instead the process by which reality is disclosed to us. Similarly, the philosopher Martin Buber (1958:3) wrote, “The one primary word is the combination *I-Thou*...Primary words do not describe something that might exist independently of them, but being spoken they bring about existence.” This paradigm of thought views language as a humanly made and socially constructed process of bearing witness to reality and discovering its meanings. Geertz (2000a:12-13) provides an example of how a word like “charisma”

changes meaning over time and in various contexts. For him, interpretive explanation is about constructing meaning, which happens through language (Geertz 200a:22). Cajete (1994:137) identifies this form of the meaning-making power of language and describes stories as "...the first ways humans shared information; they were the basis of the oral traditions of all Tribal people." So language can be thought of as the way humans create social worlds. Geertz (2000a:14) further explains that knowledge and schools of thought or academic disciplines are "social activities in a social world." One social structure he examined is the theatre and ritual theory argues that theatre has the power to change people through the experience of playing a game of constructed meanings on the stage (Geertz 2000b:28). The work of these interpretive anthropologists reflects an orientation to considering individuals in environments in co-defined contexts, much like the recently published thinking about college student health (ACHA 2005).

The narrative function is a central concept in the philosophy of critical hermeneutics. Narrative discourse is what Ricoeur argues gives our lives plot, history, and constructed reality (1998:274-296). Ricoeur states that the concept of *mimesis*, as first described by Aristotle (1998:179), is an action of interpreting stories. This same action creates human understanding by reorganizing our world (past and present, or *mimesis*<sub>1</sub> and *mimesis*<sub>2</sub>) in terms that we can comprehend, thus also creating possibilities for the future (or *mimesis*<sub>3</sub>) (Ricoeur 1998:292-296). *Mimesis*<sub>1</sub> is the prefiguration of our world, *mimesis*<sub>2</sub> is the configuration of our world, which exists in a dialectic with an imagined or refigured world in *mimesis*<sub>3</sub> (Herda 1999:78).

Ricoeur states that emplotment is the bringing together of random, disparate "intentions, causes, and contingencies" along temporal lines (Ricoeur 2005:100) to allow

us to understand and make sense of those events. The resulting plot forms a story of characters and actions over time. This “plot is grounded in a pre-understanding of the world of action, its meaningful structures, its symbolic resources, and its temporal character” (Ricoeur 1984:54). In this way, emplotment of a story is an act of mimesis and Ricoeur (1984:67) further states:

To understand the story is to understand how and why the successive episodes led to this conclusion, which, far from being foreseeable, must finally be acceptable, as congruent with the episodes brought together by the story.

A narrative approach that utilizes stories thus provides a depth of understanding that not only includes characters and actions emplotted over time, but also ethical directions and motivations that enmesh those actions (Ricoeur 1984:55). Furthermore, because “narratives draw together disparate and somehow discordant elements to the concordant unity of a plot,” (Ricoeur 1992:142), one can gain a deep understanding of rich meanings.

Whereas looking at the past informs understanding, looking forward to the future requires imagination. Kearney (2001:46) describes the connections between memory and imagination stating, “the hermeneutic hypothesis... [is] the view that the retelling of the past is an interweaving of past events with present readings of those events in the light of our continuing existential story.” He describes the need for imagination in a narrative as the force that “enables us to empathize with those characters in a story who act and suffer, [and] it also provides us with certain aesthetic distance from which to view the events unfolding, thereby discerning ‘the hidden cause of things’” (Kearney 2002:12-13).

This process of telling stories rooted in the past, interpreted in the present, and imagining futures is the foundation for this current study’s methodology. The story of the American College Health Association will have a beginning and an end (at least until

the present time), and is thus a configuration of time over successive elements (Ricoeur 1991:427).

In describing the process of understanding a written text, Ricoeur (1991b:430) states “the meaning or the significance of a story wells up from the intersection of the world of text and the world of the reader.” This openness allows me as the researcher to create a new world from the collective imaginations of my conversation partner(s) as they interpret a story for me (Bernstein 1988 [1983]:130). In this way, their histories are interpreted through words and action to portray an imagined future in a process of creating narrative distance (Ricoeur 1998:280). This emplotment of past, present, and future is what makes stories so memorable over time because they assemble otherwise haphazard elements into a storyline of human action (Kearney 2002:3). Kearney states that we become full agents of our history and transcend mere biological life to create our distinctly human lives through this process of storytelling (2002:3). He goes on to describe that historical and fictional mythic narratives from all cultures manage to persist because the stories they tell are familiar to each one of us, yet still open to fresh reinterpretation (Kearney 2002:8-10). The stories constructed in the narrative of this research will allow us to understand one another and open us to the complexity of existence beyond ourselves. This deeper and greater understanding restores our true human power to create just communities. The stories we create preserve “the relation of the present to the past” (Ricoeur 1999b:10) and we become heirs to that memory, to imagine a future of better possibilities.

Ultimately narrative identities and stories also connect the private individual with public life. Ricoeur (1976:16) said:



...my experience cannot directly become your experience... Yet, nevertheless, something passes from me to you. ...This something is not the experience as experienced, but its meaning. Here is the miracle. The experience as experienced, as lived, remains private, but its sense, its meaning, becomes public.

For this exploration of how an organization that exists in the public sphere was experienced in the private lives of many individuals, a narrative approach in critical hermeneutic research seems particularly well suited for the investigation. Additionally, the critical hermeneutic protocol may open new imagined possibilities in the areas of public policy.

It should be noted that the employment of many conversation texts to understand the narrative identity of the association under study will not always be seamless. In fact, critical hermeneutic research “chronicles the events, goals, means, people, and consequences of our lives” and may conclude with a narrative that often includes several plots, even plots that may appear to be contradictory (Herda 1999:4). However, these contradictions are important, because “in actuality [they] provide a new sense of time and order of importance of our activities” (Herda 1999:4). Ricoeur (1991a:149) further stated that the process of understanding a text includes the simultaneous action of “light[ing] up our own situation... [and]...the spirituality of discourse manifests itself through writing, which frees us from... [limits] of situations by opening up...new dimensions of our being-in-the-world.” In this way, critical hermeneutic research will not only narrate a story, but move us towards action. The responsibility to carry the narrative into future action is described by Herda (1999:10) who states that “the researcher and the participants mediate through conversations and actions the interconnections, the points of accord...” This research protocol of understanding different narratives emplotted together in a single story leads to changed understandings and new proposed actions.

### Entrée and Research Sites

The research site for this study is not fixed in location: it is an entire professional association. I was first invited to work with this professional association, the American College Health Association (ACHA), by a former colleague at the University of San Francisco, where I am currently employed, and which also supported both of us to present workshops for the association in 2002. My own work with the association has continued and developed over the years since those first presentations and I remain involved with the association through my collegial relationships. My first-person involvement with these associations and with many of the invited participants helps establish a basis of trust and common knowledge necessary for gaining entrée with the participants (Herda 1999:97). The research sites for this study will vary with and be partly defined by the participants. (A brief history of the American College Health Association is included here in Appendix A.)

This research has abided by the Human Subjects regulations of the University of San Francisco.

### Selected Participants

My work with another professional association, the National Association of Student Personnel Administrators (NASPA), starting in 1996 was focused on the broad subject of health and higher education. My involvement with NASPA led to some collaborative working relationships with members of ACHA. My continued involvement with NASPA and ACHA has resulted in trusted working and collaborative relationships with colleagues around the country. Participants for this study were identified primarily through these personal affiliations, and these same colleagues identified other possible

participants to me as I explored this topic. The specific individuals I chose to invite to participate in this study all have significant experience in college health (either in direct clinical treatment, health services administration, or health promotion and educational interventions, or a combination of those competencies) or higher education. Some of the invited participants were directly involved in the leadership of ACHA through the 1980s, and some applied that pioneering work in later years. By collecting data from conversations with individuals who have been involved with the association under study at different times and in different capacities, I hoped to build a narrative of deep understanding about the organization's changes, informed by the intersections of multiple life stories. Additionally, engaging with conversation partners creates the possibility of a fusion of horizons that creates new understandings for each individual involved: the researcher, the participant, and eventually, the reader (Herda 1999). The participants in this research (and their organizational affiliations at the time of the research conversations) included:

Name	Title	Organization
Dr. Patricia Fabiano	Professor, Student Affairs Administration	Western Washington University
Dr. Alan Glass	Director, University Health and Counseling Service	Washington University in St. Louis
Ms. Jenny Haubenreiser	Director, Health Promotion	Montana State University
Dr. Luoluo Hong	Dean of Student Affairs, West Campus; Associate Professor, Women's Studies	Arizona State University
Dr. Richard P. Keeling	Chairman and Senior Executive Consultant	Keeling & Associates

Name	Title	Organization
Ms. Melissa Kenzig	Director, Alice! Health Promotion Program	Columbia University
Dr. Patricia Marin	Researcher/Lecturer; Research Associate	University of California – Santa Barbara; University of California – Los Angeles Civil Rights Project
Ms. Sarah Mart	Director, Health Promotion & Services	University of San Francisco
Ms. Karen Moses	Assistant Director for Health Promotion, Student Health and Wellness Center	Arizona State University
Dr. Katrina Rodriguez	Assistant Professor, Higher Education and Student Affairs Leadership	University of Northern Colorado
Ms. Paula Swinford	Director, Health Promotion & Prevention Services	University of Southern California
Dr. Ric Underhile	Prevention Practice Manager	Outside The Classroom

#### Invitation to Conversations

Participants were invited to take part in this research with initial contact by telephone or electronic mail. A formal letter describing the research was sent to each participant after he or she indicated interest to do so (Appendix B). Participants were asked to complete a consent form which also summarized the study, and reiterated the context of the research protocol and the goals of the study. When a conversation with a participant was arranged, I sent a confirmation letter (Appendix C), and a follow-up letter (Appendix D) thanking the research participant was sent after the conversation.

## Research Categories and Questions

In order to understand how this organization first responded to the AIDS pandemic in the 1980s and how it has subsequently changed since those initial interventions, I examined in my research conversations broad topics such as the history of the ACHA response to the AIDS pandemic, its conceptions of the life-space of college health, and the imagined possibilities for the association. The research categories I used to organize the conversations with participants were: (1) Narrative Identity, (2) Oneself as Another, and (3) Mimesis and Imagination. Participants were invited to engage in conversations loosely structured around these questions:

### Research Category: Narrative Identity

- What are your earliest memories of AIDS? What do you remember about the “dawn” of AIDS? What were you studying/learning/teaching/reading/researching about when you were first aware of AIDS?
- What was college health like back at the start of the pandemic?
- What has been your experience with the American College Health Association?
- How have responses to AIDS developed and changed over the course of the pandemic?
- What gives an organization legitimacy?

### Research Category: Oneself as Another

- How do you define “health?” How do you define “college health?”
- What role does fear have in the AIDS pandemic? What role does fear have in an organization?
- How do you relate HIV/AIDS to social justice?

### Research Category: Mimesis and Imagination

- What is college health like now? Why?

- What do you think is the future for American college health in higher education?
- What future do you imagine for AIDS?
- What implications do you suggest for any campus working on “health?”

These conversation starters were intended to draw out the participants’ stories to reflect their personal histories and experiences with the topic at hand. Their stories provided the data needed to reach new understandings. The initial focus on their earliest memories of AIDS allowed me to understand the prefigured past that informed each conversation partner’s configured present.

The boundaries of this research were created by the people who agreed to participate within the selected categories for data collection and analysis. How the data are understood and interpreted by each reader depends on what each reader brings to the text.

#### Data Collection: Conversations

Data included text from transcribed conversations, personal journals, and documents. Conversations with participants were audio-recorded, and then transcribed by the researcher. Each conversation lasted approximately one hour. The transcription process achieved two goals: one was fixing the conversation’s temporality into the permanence of text, and the other was providing the researcher with the distance to conduct an analysis of the resulting text as data (Herda 1999:97-98). In this linguistic process, the articulation of a historical world is built up in a way that preserves the contextual experience of each participant (Gadamer 1976:13). Participants were asked to review transcripts, and their suggestions for edits were honored as part of a continuing conversation with the data. Herda (1999:83) explains that this research process:

...requires reflection, risk, and, for the most part, a change in orientation toward research and social reality in general. Often the lay person we invite to participate in our research project has not experienced such paradigmatic shifts. This burden is on the researcher to understand and assume responsibilities of teacher, in a broad sense.

Herda (1999:31) adds that data analysis in this process is “discourse characterized by ethical considerations” and this research protocol addressed those considerations and was approved by the researcher’s institution.

The initial conversations were conducted at a time and in a place that were most convenient for both the researcher and the participant, allowing for one-on-one discussion. All of the conversations were pre-arranged. Almost all of the conversations were scheduled after the receipt of the participants’ consent forms. One conversation was conducted in person, and the other conversations were conducted as scheduled telephone appointments, due to the distance between the researcher and all participants (which made travel for personal conversations impossible). The researcher kept notes during each conversation that were later used to check the accuracy of the audiotaped recordings. How the data may be interpreted and applied by the reader depends on the history, tradition, and biases of each reader, since each reader will bring something different to the text.

#### Data Collection: Personal Journal

Another source of data for this research is the researcher’s own personal journal. A record of my own thoughts, observations, questions, fears, hopes, and insights contributed to the process of meaning-making and documented my own new understandings throughout the research process (Herda 1999:98). Herda (1999:98) supports the use of such a researcher journal as “the life-source of the data collection

process for in it goes the hopes, fears, questions, ideas, humor, observations, and comments of the researcher.” Because the personal journal is its own text (i.e., a transcript of my own evolving thoughts), this self-constructed narrative exists as another source of data available for analysis. (Excerpts from my personal journal are included here in Appendix E.) Often, creating text in this journal was helpful in the process of playing with the texts in the data analysis process.

#### Data Collection: Documents

A final set of data comes from an analysis of relevant documents. These documents include references that will be cited in the research bibliography, and can include published academic research, online sources, and works available in popular media (e.g., newspapers, magazines). Additional analysis may come from documents produced by the association under study or related organizations. Finally, in some cases, documents were provided or identified by the research conversation partners.

#### Data Analysis

The process of analyzing the data in this research proceeded in the critical hermeneutic tradition of playing with the texts in a creative and imaginative way (Herda 1999:98). The data consisted of the texts of the research conversations. Once those conversations were fixed into text, I read and interpreted the texts, searching for conceptual highlights. This process represented “an act of distancing, a distancing ourselves from our conversations” (Herda 1999:97). The data were examined for significant statements that I then developed and sorted into cogent themes and categories. While I, as the researcher, unfolded the text in this way, I was also open to the text and my new understandings of the text informed and shaped my new understandings of the



world and the topic under study (Herda 1999:99). Ricoeur (1985:100) described the value of such reinterpretation and stated that “only the confrontation between the world of the text and the life world of the reader will make the problematic of narrative configuration tip over into that of the refiguration of time by narrative.”

Follow-up conversations with the participants brought out additional insights in an ongoing conversation about the data. Finally, these insights were configured into a research narrative, grounded in the theoretical framework, and appropriated for implications for further study and practical applications (Herda 1999:98-99). This understanding and resulting imagined possible set of implications results when “what is to be interpreted in the text is a proposed world which I could inhabit and in which I could project my own possibilities” (Herda 1999:75). In other words, the constructed narrative text configures and fixes the pre-figured past into the present, opening possible futures in the imagination of the researcher. Herda (1999:75) emphasizes the importance of interpretation in this research: “To understand the meaning of the text calls for an interpretation – an appropriation here and now of the intention of the text.” Herda (1999:75) adds:

The referential dimension of a text unfolded in the process of interpretation is an important aspect of Ricoeur’s philosophy of field-based hermeneutic research. The referential dimension points to future possibilities and alternatives for our social problems and requires creativity on the part of the interpreter(s) to imagine new possibilities and configurations of social life and policy.

The boundaries of this research were created by the people who agreed to participate within the selected categories for data collection and analysis. How the data are understood and interpreted by each reader depends on what each reader brings to the text.

## Pilot Study

### Introduction

A pilot study was conducted in the fall of 2006 with Dr. Richard P. Keeling, a private consultant based in New York City, who has extensive professional experience in higher education, medicine, public health, and student learning outcomes. The purpose of the pilot study was to field test research categories and questions and provided me with practical experience to engage in a critical hermeneutics protocol (Herda 1999:97,109). An additional benefit of this pilot study was some initial conversation that identified other potential participants. (A brief summary of the pilot study conversation and the complete transcript of the pilot study and subsequent communications with the pilot study conversation partner is included here as Appendix F.)

### Conversation Partner

In order for me to learn more about how ACHA first responded to HIV and AIDS and then changed in response to the pandemic, I turned to a longtime friend and trusted colleague, Richard P. Keeling, M.D. Dr. Keeling and I both earned undergraduate degrees from the University of Virginia. By the time I had earned mine in Biology and Psychology, Rich had returned to his alma mater where he had earned his degree in English, *summa cum laude*, years before me. He subsequently received his doctorate in medicine from Tufts University and completed his residency training in internal medicine and a fellowship in hematology at the University of Virginia. One of the earliest memories we share about our friendship was our attendance at the same University of Virginia committee meeting, when I was attending as a student leader, and he was attending as the youngest Director of a university health service in the country.

Rich directed the Department of Student Health at Virginia for 13 years and left to become the Executive Director of University Health Services and Professor of Medicine at the University of Wisconsin at Madison (at the request of Dr. Donna Shalala, who was leaving the position to work for the administration of President Bill Clinton, and who then became the nation's longest-serving Secretary of Health and Human Services). Rich was the only person on the campuses of Virginia and Wisconsin to hold simultaneous tenured faculty positions and senior student affairs administrative posts. He is a past-president of the American College Health Association and has received the highest awards from ACHA and NASPA and in 1996 was named Health Educator of the Year by the American Association for Health Education. He has received two honorary doctorate degrees in science and maintains a full schedule of speaking, training, consulting, and research projects.

Even as a student at Virginia, I had always known Rich as a medical professional who is an expert on HIV and AIDS. What I did not know (until this study) is that during his tenure as Director of the Department of Student Health, he attended to the patient who was the first diagnosed case of AIDS in the state of Virginia. After I graduated from Virginia in 1991, I was not in communication with Rich again until 1996, when I looked him up and asked him for information about a national task force on HIV and AIDS in higher education to which I had just been appointed. He very graciously came to my aid, and I learned he was helping the same task force as a senior consultant and had been involved with its grant funding award from the CDC. Ever since 1997, we have worked together on a number of CDC-funded projects, two faculty development conferences, several professional association presentations, and were members of the team that

published a statement on college health ecology (NASPA 2004). In my investigation of ACHA and HIV/AIDS, it was only natural that I would ask Rich Keeling to collaborate with me as a research conversation partner. On October 30, 2006, we spoke for close to an hour about the topic and then continued that exchange over electronic mail correspondences through December 2006.

My conversation with Rich Keeling, M.D., started with his recollections of how he first learned of AIDS and HIV. As a practicing physician, he attended to a law student at the University of Virginia student health clinic back in the very early 1980s. This same patient would turn out to be the person who was the very first diagnosis of AIDS in the state, before the disease had even been named as we know it today.

He was the first person recognized with clinical AIDS in the state of Virginia... In the fall of '82 (he had had a rocky spring and summer), [he] dropped out of school for a while and then died in the fall of '82 at the UVA hospital of pneumocystis [pneumonia]. That set me on a clinically motivated, primarily clinically motivated look to see what the heck this was.

Because Rich had been involved with AIDS since its very first occurrence in the state of Virginia, he had been identified very early on as a leader in the work to educate about the disease. He quickly gained prominence in the early to mid-1980s among a small network of college health professionals and then became a leader in the American College Health Association and was elected to the association's presidency in 1988.

Rich's vivid story of this very first encounter with a patient diagnosed with what we now know as AIDS reflects the frenzy back at the dawn of the pandemic caused by a lack of information. The disease and the virus that causes the disease had not yet been identified, so a medical practitioner was left with nothing at his or her disposal to provide care and service for a patient. Rich describes his clinical motivation to figure out what

was causing this man's poor and declining health. That motivation to care for patients became less clinical as knowledge of AIDS developed through the 1990s.

The fast pace of the late 1980s primarily accomplished descriptions of the disease and virus; ... by the early 1990s, I had come to believe that the way I could best contribute to solutions to HIV/AIDS was through prevention, not by treatment; this "fit" with my usual and customary preference for "systems" interventions.

### Theory

I asked Rich about his early involvement with ACHA. He described the association back in the early to mid-1980s as an association undergoing tremendous changes. The association had just changed its bylaws and organizational structure to no longer attempt to look like the American Medical Association (AMA), which it had modeled itself after. The history of the association being created by medical doctors at a time when college health was not yet defined supports this description. Rich describes the early history of the association as "purely a trade association, sort of a professional organization for primarily doctors who worked in college health centers," and not as a leadership or advocacy association. This change in the association came at a time, and was no doubt partially driven by the time, when the membership was changing to include more college health professionals who were not doctors. So the shift in the association to attend to clinical care and medical service but also to include nursing care, health education, psychological services, etc. happened during the same years that the clinical information about HIV and AIDS was being widely publicized and people everywhere started to focus on HIV and AIDS prevention interventions.

By organizing clinical and prevention efforts around HIV and AIDS, the association grew to national prominence and was seen as a very influential force in policy-making decisions on individual campuses. In the late 1980s, ACHA established

its Human Dignity Task Force, following the creation of its AIDS Task Force which had been charged with the production and dissemination of educational and advocacy materials. Interestingly, a major focus of the AIDS Task Force was not in the area of clinical services but in broader human issues. It was this shift in thinking that actually spurred on the creation of the more comprehensively titled Human Dignity Task Force, which was not charged with the production of any materials, but with influencing the overall tone of the association.

...the piece that is connected to the HIV/AIDS work is that one of the things that became very clear in the AIDS work by the mid-80s...was that the major concerns about HIV were not microbiological, and not entirely clinical in college health; they had to do with human rights, relationships among people, and social justice concerns in general... if you approached it simply as an STD, you missed the boat.

As the ascendancy of the association was happening, centered on the issue of HIV and AIDS, a counter-revolution was beginning. Just as the thinking about AIDS became multidisciplinary and not simply biomedical or clinical, a population within ACHA (and in the general public) began to argue that HIV was a moral issue that could be solved if people stopped acting in behaviorally anomalous ways and acted in some kind of universally correct way instead.

Rich Keeling recognizes the broad social realities of AIDS and imagines that in the future, this will be the dominant paradigm for understanding the pandemic.

HIV/AIDS will continue to take advantage of social and cultural contexts that promote illiteracy, undermine women's rights, support poverty, and endorse discrimination against gay and bisexual men. The extent of HIV/AIDS in some countries will be sufficient to undermine social structures and political process; some countries will collapse, causing shifts in the balances of power and national security.

His motivation for continuing to lead work in the college health field of HIV and AIDS is no longer purely clinical, as it was when he first encountered Virginia's first patient with AIDS. I asked him to imagine what he might tell that young man if he were still alive today and this is what he said:

That the struggle to address social justice as an issue in health and health care continues, but that things are better for gay men in America than was the case when he got sick; that we continue to study our own history, and that he is not, therefore, forgotten.

Remembering the dignity of all human life may be the universal ethic that will continue to drive college health into the future. Perhaps the greatest legacy for college health or higher education in general to teach future generations of thoughtful, compassionate, global leaders is the familiar imperative to "never forget."

#### Analysis of Text

When I considered the data in this narrative of the professional association, I was struck with the impact made by the shift in thinking about a health issue as a moral issue, and not as a purely biochemical, or a clinically medical one. This view meant that college students who were at the center of the association's purpose could not just be conceived of as patients who were distant others, but as equal participants in human issues. In our conversation, Rich stated:

So really the HIV work in ACHA rode the tide of feminism, of confrontation of power, of sexuality liberation, of a stronger view of gay rights, of a sense of the need to include people, of compassion, of the development of a more empathic approach related to understanding human behavior problems, plus it also joined with the emergence of health education as a serious field within college health.

Identifying a patient in this way, as an individual interconnected with other communities and individuals, is akin to the critical hermeneutics of Ricoeur (1992).

Ricoeur (1992:18) proposes that the self is never separate from the other, and in fact it is

only in the dialectic relationship of the self and the other that we draw out human meanings. When Rich placed the work of ACHA to respond to the AIDS pandemic within a social, cultural, and political context, he suggested that each patient (the other) and each physician (his self) existed in a dialectic relationship. Ricoeur (1992:18) describes this understanding of the self as an identity that is “bound up with solicitude for one’s neighbor and with justice for each individual.” Foucault (1986:51) wrote that caring for oneself is, in fact, “a true social practice.” This self-and-other orientation carries important ethical implications, especially for health care providers, health promotion specialists, and educators who also work in relationships with individuals and communities.

This same recognition of health as a moral issue with ethical implications for all people subsequently triggered another set of changes in the organization. To hear Rich describe some of these changes:

...after '91, there was a very strong reaction against HIV in ACHA...you began to hear a phrase “one-issue organization.” People had various interpretations of this, but there was one strong view that this was a homophobic reaction that people in the association wanted to take back the organization because it got too liberal and too inclusive, and too “leftish,” and too gay.

What the campus ecology model would identify as environmental factors of political ideology and moral understandings were now meeting with clinical understandings about a disease pandemic that was simultaneously a social phenomenon. The interpretation of what that constructed reality was, and how it should be addressed produced divergent responses. An undercurrent of homophobia (Rich described that the term “gay agenda” was first used within ACHA around the early 1990s in a disparaging way) was swaying the leadership and membership of ACHA away from what had been



its “bread and butter” topic of HIV and AIDS for fear of being associated with that subject alone.

This resulted in small but significant organizational changes as well, which Rich described:

At about the same time, the organization had founded a, a little earlier, a task force, or a caucus or coalition of gay and lesbian people, and that had flourished around '90/'91 and it had to kind of go underground for a few years, '92, '93, '94, because of this shift in the tide, but then it re-established itself and I think it's still going strong now. The Human Dignity Task Force was abolished back then, the HIV Task Force lasted until, I guess, '95, '96 maybe, and then it was merged with another task force on STDs, which is a very interesting development: the fact that they merged those two groups shows the change in the organization that AIDS had become just an STD.

Despite these challenges, the ethical implication to apply medical skill with an orientation towards a process and not any singular individual or individual community is echoed by Arendt (1968a:61) who asserts that we should not be “concerned with single entities or individual occurrences and their special separate causes.” Again, an ecological understanding of public health as promoted by the scientific communities of medicine and public health (Lasker et al. 1997), places the responsibility to act on all interconnected people.

So the college health profession had evolved significantly in less than a century from a medical group that was faced with the clinical mystery of AIDS. When the scientific establishment had solved the mystery and started to offer medical solutions, the college health profession shifted to its prevention and advocacy work that connected a disease pandemic like AIDS to social realities of identity and power (such as homophobia, sexual violence, poverty, etc.). Simultaneous to this broader conceptualization of health as a social justice issue of human dignity, came the backlash

for the association to distance itself from those fearful, marginalizing topics and move back to clinical and biological (or scientifically controllable) paradigms.

Rich stated that the legacies of the work of the AIDS Task Force and the Human Dignity Task Force are still evident in some of ACHA's educational products and membership recognition work, but that overall the organization does not feel like the globally conscious organization that it did in the 1980s and early 1990s.

The association no longer feels, the feeling of ACHA meaning...it feels pretty clinical, pretty managerial. It doesn't have the thrust or tone of social justice or human dignity, it doesn't have the tone of wanting to make its mark on the national stage, it doesn't have the leadership tone that it did in the 80s and 90s. But many of the things put together from the 80s and 90s still survive, even though there isn't much evidence that ACHA is going to do any more with those things, but on the other hand they have not dismantled all the ones that were developed completely.

In fact, around this same time, the fields of medicine and public health were attempting to bridge some of their practical gaps (Lasker et al. 1997) and some of the most prominent work in AIDS education and prevention had shifted to other higher education professional associations, including the CDC-funded project that reacquainted Rich and me in 1996. Rich predicts that ACHA will experience another dramatic growth in its post-ascendancy coming of age: either the health promotion specialists will change memberships to another association, or the tenor of the association will swing back towards conversations of human dignity and social justice in response to the current clinical and medically conservative attitude.

### Implications

In this research conversation, I found three themes to be most compelling: (a) the shift from clinical diagnosis to long-term compassionate care, (b) the power of the

environmental context of fear, and (c) the evolution of a professional association as a living system. I will discuss each implication here.

#### From Clinical Services to Care and Prevention

From its inception as a professional association, the American College Health Association existed primarily as a medical organization. Faced with the medical crisis of AIDS in the 1980s and a broadening of its own membership, the organization began to do more work in health education and health promotion, with an emphasis on advocacy and the universal value for human dignity. This change seems to have happened at the same time that the popular conception of AIDS as a social reality that affected all people and not just those populations segregated to be “at risk” proposed a greater challenge for all people to share the responsibility to address the issue.

When NASPA (2004) published its ecological model of campus health that involved agents and environments (Gladwell 2002), the same project group had also described a model for all social systems (Lewin & Regine 2001). Understanding this interconnected nature of health compelled the association to consider how it could effect changes to enable better health conditions on every campus. Because complex adaptive systems are self-organizing, it is impossible for student affairs educators working as administrators, supervisors, and managers to construct a system according to some externally imposed plan. However, complexity science does suggest some ways in which it might be possible to enhance campus health systems. The ecological model of college health lends itself particularly well to this framework of application and analysis because the goal of any complex adaptive entity is the basic healthy outcome of survival (Thompson 2005 [2003]).

The ecological model allows us to understand the context of health to a deeper degree than the traditional sense of health as a conditioned attributed to individuals only, and understanding that organizational context of health behaviors is vital for the leaders in the system (Pfeffer & Salancik 2005[2003]). Rich Keeling continues to advocate for this paradigm of college health:

A syndemic orientation to medical practice would support interdisciplinary thinking, practice, and research as the basic model of care; it would look for connections to other problems in the assessment of a patient's complaints and concerns; it would anticipate future problems based on syndemic models. College health could (should) lead the development of such an orientation to professional practice.

An ecological understanding of health obligates us to care for each other, recognizing that we are not beings separate from each other (Arendt 1968a), that we exist in a dialectic interconnected relationship with all others (Ricoeur 1992), and that caring for our own health is a distinctly social human activity (Foucault 1986).

### The Politics of Fear

It was the shift from an objective model of delivery of medical health care from an expert clinician to a receptive subject (i.e., the patient) to a more globally conscious model of health for all as a matter of social justice that triggered another change in the American College Health Association. Afraid of being simply dismissed as an organization that could only work with the one issue of AIDS (as multidisciplinary as that may be), the organization dissolved its task forces on AIDS and on Human Dignity. The climate of the organization has once again become clinical, and perhaps as antiseptic as the hospital corridors patrolled by the doctors the ACHA members hope to emulate, as they did earlier in their association's young history. The effect of the environmental factor of fear is markedly described by Rich Keeling in our conversation.

Just when the association had learned that AIDS was not simply a sexually transmitted disease but a pandemic that had as much to do with poverty, war, sexual violence, racism, and homophobia as it had to do with biochemistry, the fear of confronting those newly named issues swung the pendulum of the association back to its clinical origins. It included AIDS in its ongoing work on sexually transmitted diseases and dissolved the task force on human dignity. If nothing else, this tidal change in the association's orientation to social justice is a powerful reminder of the delicate and significant interplay between individuals and their environments. Perhaps it was this recognition of the connection of the association's words (i.e., calling for a social justice understanding) and the issue the association was addressing (i.e., the AIDS pandemic itself) that triggered a social reaction to its progress. Gadamer (1976:77) reminded us of the "interconnection of word and thing" and in this case, redefining a viral pandemic with words of social responsibility signified a fundamental change in the orientation of an expert professional association to an issue that perhaps up until that point, was only viewed from a comfortable distance that limited the association's responsibility to act.

#### The Association as an Evolving Living System

In our conversation about ACHA, Rich Keeling described the fundamental shifts in the organization's tone from clinical services to social justice in the 1980s and 1990s, and a more recent swing back towards a more purely medical attitude. He surmised about the possibility that the association would always remain in flux between those two states (much like a complex adaptive entity might cycle in a pendulum attractor) or if a part of the association (a fractal) might leave the association entirely (effectively dying in one system to gain new life in another). It is this dynamism between static paradigms

that suggests the metaphor of the association as a living system, as a complex adaptive entity.

The stability of a complex adaptive entity can be understood by seeking clarity about the entity itself (Hock 1999; Wheatley 1999). Morgan (1997) suggests that successful management within a complex adaptive entity, such as a campus health system, starts with this kind of clear recognition of the emergent, self-organizing properties of the system. For ACHA, the challenge of this step results in asking deep questions about the mission of the association and what connection it has to individual or community health (Hoban, Ottenritter, Gascoigne, and Kerr 2003). This clarity can be further expressed in mission or purpose statements about inclusion, safety and security, pluralism, respect, access to health or other services, responsibility to the local community, or social justice (Hoban et al. 2003).

As an entire profession, student affairs can begin to shift the paradigm of traditional scientific biomedical thinking by encouraging the application of a systems approach to addressing health issues. By taking responsibility for the health of students away from the sole jurisdiction of the campus health center or clinic, and sharing that responsibility among all constituents of the community, the day to day work of student affairs will be more unified and collaborative and will better represent the networked system.

Another principle of an ecological system is its diversity (Capra 1996). Diversity is a quality of the system that can be supported by management in recognizing the need for and accepting divergent points of view. These divergent possibilities enable the system to adapt and survive at the edge of chaos and order (Capra 1996; Hock 1999;

Lindberg et al. 1998). Student affairs educators may be asked to set the visionary tone or campus life themes for the system's success and survival (perhaps as measured by enrollment, persistence, or graduation rates), and cultivating an appreciation for the value of creative thinking and imagined possibilities is one way of ensuring the system's survival through phase transitions.

Student affairs administration and college health in the ecology model of campus health becomes less about managing a staff and much more about managing (allowing and sustaining) creativity (Amabile 1998). This creativity must be employed in the continuing work to address HIV and AIDS in American higher education. Creative solutions for addressing health issues in higher education may be identified by the critical hermeneutic approach that allows for distancing from the historical record of the conversation text (Ricoeur 1998 [1981]:91). By considering how an interconnected orientation to health might suggest our responsibilities to care for others as we do ourselves, a new world of possible health interventions and possibilities may be opened (Ricoeur 1998 [1981]:91).

### Reflections on the Pilot Study

This pilot study revealed to me several important themes relevant for further exploration. First and foremost, this association of professionals working in college student health had shifted its concept of health as a biomedical and ecological epistemological experience (i.e., a sum of diagnostic parts) to an ontological condition of human dignity and being (i.e., a unified vision of wholeness in life). Then the organization seemed to shift back to its earlier definition in light of sociocultural and political pressures. These changes impressed me like metaphorical tidal shifts in how the

organization defined concepts central to its own existence and how the organization imagined its own place and function in American higher education. The implications for how any organization can imagine and define its purpose, mission, and work in the world suggested the themes to be explored in this research (Ricoeur 1998 [1981]:16).

Conducting the pilot study and subsequently reflecting on the process taught me important lessons about the critical hermeneutic research protocol itself, challenging me to become a better author by living the process (Sischy 2007) and by gaining the opportunity to reflect about the text in the conversation data, the text in my own journal, and the new understandings that those texts might inspire (Gadamer 1976). Most importantly, I remembered the importance of distancing myself from the texts created by conversation (Ricoeur 1998 [1981]:13), interpreting, re-interpreting, and narrating the research instead of simply reporting facts and findings (Ricoeur 1998 [1981]:14-15). This new understanding will influence my future conversations with participants and allow for more playful and constructive conversations with their texts.

#### Background of Researcher

I currently work as a higher education administrator, directing a department at the University of San Francisco. I earned a master's degree in higher education administration over 16 years ago, and many colleagues and friends who know me primarily from my work in residence life always ask me how I came to be so interested in health-related topics. But I remind them that my undergraduate training is in biology and psychology and only after I gave up my dreams of pursuing a career in neurosurgery, did I turn my attention to higher education and student affairs administration. In 1996, when I was appointed to a NASPA national task force that was charged with examining how



higher education administrators had responded to the AIDS pandemic, I felt my two intellectual and professional interests come together for the first time. My work on that task force led to some consulting work with other campuses around the country, the publication of a document about health interventions and health philosophy in higher education, and numerous presentations and workshops, including many collaborations with my research conversation partners.

I always hoped that the research I would undertake for my doctorate degree would contribute to the body of knowledge of the profession that has enriched my life so much. But perhaps more importantly, as a gay man who came out of the closet in my college years of the late 1980s, I feel an additional responsibility to contribute to the community I claim as my own, which is also a community that has been affected by the same pandemic that has been and is being addressed by the association I studied in this research.

### Summary

The story of ACHA and its existence during the time of the AIDS pandemic and its subsequent re-imagined existence is what I studied in this dissertation research. Since I was not involved with ACHA at the dawn of the pandemic in the early 1980s, I turned to the testimony of my research conversation partner(s) to bear witness to what is otherwise an alien experience and to inform my understanding. In telling this story, I hope to "...find the future of the past, the unfulfilled potential of the past" (Ricoeur 1999a:4). Ricoeur stated "Testimony is the ultimate link between imagination and memory, because the witness says 'I was part of the story. I was there'" (1999a:16). Gadamer (1976:xii) explains that "hermeneutics has its origin in breaches in

intersubjectivity” and that “the hermeneutical has to do with bridging the gap between the familiar world in which we stand and the strange meaning that resists assimilation into the horizons of our world. It is vitally important to recognize that the hermeneutical phenomenon encompasses both the alien that we strive to understand and the familiar world that we already understand.” For Gadamer (1976:xix), hermeneutics is a process of making what is “alien” something we can understand, and he states, “the event of understanding can now be seen in its genuine productivity. It is the formation of a comprehensive horizon in which the limited horizons of text and interpreter are fused into a common view of the subject matter --- the meaning --- with which both are concerned.”

Serequeberhan (2000:9) further elucidates Gadamer’s definition of a horizon as everything that can be seen from one particular vantage point and one’s heritage is encompassed within a horizon and discloses other possibilities to consider. For Serequeberhan (2000:23), a fusion of horizons represents not just an opportunity to learn more about and understand what was once alien, but it is the process by which we each develop our own sense of identity: “our identities are neither static nor singular but in a constant process of self-elaboration, always start[ing] from an ‘effective-history,’ and are formulated in terms of possibilities that are grasped in view of a hoped-for future.” Gadamer (1976:8-9) states that “there can be no doubt that the great horizon of the past, out of which our culture and our present live, influences us in everything we want, hope for, or fear in the future. History is only present to us in light of our futurity.”

My pilot study provided me with an opportunity to test my research questions, narrow my research categories, practice this interpretive methodology, and confirmed a general direction for proceeding with more conversations. Using narrative research, I

hope to illustrate how the American college health profession has evolved over time to define its structure, purpose, and strategies within the unfolding context of a global environment that includes HIV and AIDS. The narratives of the research conversation partners will describe the dreams and hopes of the association, providing understanding for the future it will throw itself into. The story of ACHA and the story of AIDS consolidate many different human experiences into a new collective identity as a unified historical community (Kearney 1999:26) and will suggest directions for future movement in public health and education policy. These future directions may move us towards a future where health is not just a diagnosed experience of the privileged few, but recognized as a set of basic human rights for all (Kidder 2004).

## CHAPTER FOUR

### PRESENTATION OF DATA and PRELIMINARY ANALYSIS

#### Introduction

While my pilot study informed me about the narrative identity of an entire professional association that was a relatively new story for me, this research required far more data. The pilot study formed the basis of this study and also prompted me to explore how additional narratives could challenge or expand the discourse. Collecting additional narratives in this anthropological interpretive study grounded in critical hermeneutic theory requires me to interpret meanings and create a new story from the data in the conversations. This act of emplotment (i.e., connecting the characters, choices, actions, memories, hopes, and imaginations of my conversation partners into one cohesive new narrative) “confers an intelligible configuration on a heterogeneous collection composed of intentions, causes, and contingencies” (Ricoeur 2005:100). This newly re-interpreted story will draw from the data presented by each conversation partner, and necessarily, interwoven with my own narrative as the researcher, so that the resulting narrative has a “plot [that] governs the mutual genesis between the development of a character and that of the story told” (Ricoeur 2005:100). The narrative I present here is one of individuals and also one of a professional association, made up of individuals, serving them and others.

Each of the conversations I had with the participant partners in this study began with an exploration of their memories of the past. I asked them to recall their recollections of their first awareness of HIV/AIDS, of their entry into their professional lives, and of their organizational involvement with ACHA (if any). I found that those

memories were powerful and clear and quickly led to a conversation about organizations, and specifically of the concept of the individual within the organization. Finally, I asked my conversation partners to imagine the future implications of the stories we shared and play with the possibilities of applying the lessons of these stories to health and higher education. The themes that emerged included: locating the disease pandemic in the human life-world, defining health in terms of justice, honoring the individual within larger contexts, and teaching future leaders. I will now examine these themes within the context of the research categories.

### Narrative Identity

#### Locating the Disease Pandemic in the Human Life-World

I began each research conversation by asking my conversation partner to recall her or his first memories of HIV and AIDS. I wanted to understand the history, prejudices, and traditions that informed each participant's present. This recollection of past memories in the present helped establish the characters, conflicts, events, and critical incidents that created a narrative of personal identity within the context of the AIDS pandemic.

Almost all of the participants had clear memories of first learning about HIV and AIDS in ways that immediately attached some stigma and emotion, along with an affected population, to the virus and to the disease syndrome and pandemic. Pat Fabiano recalled working as the interim Director of a campus wellness center at a university in the Midwest in the mid-1980s when she was called to a Department of Public Health meeting to be briefed:

about this ‘new and mysterious’ virus and that didn’t really have any meaning for me other than a kind of distant awareness, like bird flu is now: like ‘Okay, I’ll pay attention but it’s not that big of a deal.’

Not all first memories were so distant. Paula Swinford was also working in the Midwest at this time and was told by a coworker, “Gay men are dying in San Francisco.” Sarah Mart recalled being a high school student in Montana during this time:

I remember hearing on TV and in the mass media about “gay cancer,” “ARC,” and “GRID,” any of those first things they called it in the 1980s. My parents only talked about sex with me when I was in 9<sup>th</sup> grade and asked them about how babies were made. I wanted to know what they would say, and kind of dared them, because I honestly didn’t know if they would talk with me about it. We weren’t very free with the sexuality information in my household. I already knew about the “birds and the bees” from reading Judy Blume books and talking with friends, but the information we had was really only about pregnancy, not about sexually transmitted diseases, communicating with sexual partners, or how to make our own informed choices.

The Surgeon General sent a mailing to every household in the U.S. called “Understanding AIDS” in 1988. I still have it in my files at work. It showed up at my house and I read the whole thing. My parents never read it. I just knew that it was important somehow, and I wanted to pay attention to it. I thought that some of my friends, particularly the ones I felt might be gay, could potentially be affected. I knew those friends were a part of the world that was at higher risk of possibly contracting HIV. It felt really important to me; I had a sense of knowing that this would impact important people in my life. I was also aware of the fact that there was major injustice and discrimination going on, against people who had AIDS, and against people who were gay, who others thought were gay, and against people of color too.

Alan Glass and Patricia Marin each remembered hearing news about the “gay cancer” or the “gay disease.” In these first memories, the association of AIDS as a disease affecting one particular population of people was pronounced.

The danger and presumed lethality of the virus or disease was recalled in the memory of Melissa Kenzig, who described her first memory, by way of the evening news:

I was watching TV one night probably mid-'80s, between '85 and '87...and on the nightly news one day they had pictures of someone who had been in a car accident, the scene was all roped off...and they were sending in the HazMat team in the big yellow HazMat outfits. And they said that a man who was known to have AIDS was involved in a car accident so they were sending in the HazMat team, which I couldn't understand why someone who could have something that was a disease that was so bad that they had to send in the HazMat team could even be allowed out in the world. I was very confused by that, I didn't really understand. I remember feeling weird about asking exactly what was going on, but I remember not asking anybody about it. My other recollection was that only men could have AIDS. It had to be a man, because I just knew that only men could get it. I would guess this was 1985 or so.

In Melissa's memory, AIDS was something so life-threatening that a HazMat team (i.e., a Hazardous Materials team) was required to respond. This understanding was then compounded by the early realization that this disease affected only men. In both recollections, I experienced a sense of alienation and distance from the otherness of those affected, along with a disbelief and fear about the danger of the disease.

Pat Fabiano's "distant" feeling about the "new and mysterious" disease did not last long. In her words:

And then a young man walked into the Wellness Center and he introduced himself and he was very warmly welcomed, as was anybody at the time, and he was asked a set of routine questions about why he was there and if he was a student, etc. And it turned out he was not a student. He was from Cape Girardeau, Missouri, which was across the Illinois-Missouri border. He had come to Carbondale because he had hoped that at the university he would find resources that he couldn't get in Cape Girardeau. And he said that he had been thrown out of his house by his parents and that when the local authorities heard he had this mysterious virus, he was banned from the mall and wasn't even allowed to go shopping in public. I just remember being horrified, absolutely horrified by this story. And it was my first understanding that this wasn't just a virus, that it was a virus that had sociopolitical dimensions to it.

This was perhaps an extreme extension of the quizzical response that Melissa had to the news of the HazMat team – in this memory, the barrier separating people was not the fabric of a protective yellow suit, but a complete separation, isolation, and a prohibitive

order that prevented someone from participating in public life. All of these early memories clearly placed AIDS in the realm of the dangerous, and squarely in the communities of men, and specifically gay men.

Even when gay men were not the clearly identified community most directly affected by AIDS in these early memories, the feeling of fear, especially fear of some other populations was inescapable for many of my conversation partners. Patricia Marin told me that by the time she was in college, the “public understanding became that it wasn’t just about the gay community...we also knew that the way it was transmitted was through IV drug users and syringes.” Ric Underhile described the pervasive emotional atmosphere in this way: “...there was no real public health message back then...it was just over-the-top, almost hysteria, naming Hispanic, Haitian, and homosexual communities that were affected.” Alan Glass also described a growing sense of dread and foreboding, combined with uncertainty: “...you see, the whole thing seemed like it was evolving: at first it was 20% fatal, and then 40%, and then 100% so it all just seemed unknown and nobody knew anything.” Alan went on to describe his own internalized fear in his earliest memories of AIDS, a fear that he said lasted “throughout [his] entire 30s:”

I was scared to death that I would get it. ...I know that many of my friends, even me, a lot of people responded by stopping doing anything sexually. That was a piece of all of our lives. ...So in that sense, I remember being afraid. ...So pretty much through my 30s and maybe even 40s, any kind of physical change in my body I just thought was the beginning of the end. ...So I think a lot of people in my generation just lived through a couple decades of fear. And a related thing is that it’s only very recently that I’ve started to be concerned about dying of the things that middle-aged men die of (like heart disease and all that), because all through my 20s and 30s, I was convinced that I would die young, before middle age, of AIDS because all of my friends did. But now I’m starting to worry about the other stuff.



What struck me about this memory is that Alan is a medical doctor who was describing decades of how this disease had created a tradition in his past that colored his present-time assessment of his own health: a bias so powerful that it affected his concern about other health risks and health issues that might affect him.

In a story of perhaps the most fearful response of the virus, Alan recalled having to utilize the kind of barrier protective measures that Melissa had seen on television:

...when I was a pediatric intern at Cincinnati Children's Hospital/University of Cincinnati in Ohio. We had a baby born to an HIV-infected mother. Actually, the mother must have had AIDS, because the HIV test was not yet really available. So we had this baby born, and I remember waiting on the availability of the test so that we could actually see if this infant was infected with HIV. And the baby was isolated, you had to 'gown and glove' to go in and even touch the baby on rounds, they really limited all contact with the baby.

Alan remembered that his emotional response to this was empathy for the baby, and he thought "at the time how awful it was that we had to treat the baby that way, because the baby didn't look any different from any other baby."

These memories continued to demonstrate what Luoluo Hong identified as the "marginalization" that was happening as different affected populations were being identified. The feeling that HIV was affecting other, distant communities was narrated by Jenny Haubenreiser who first thought of "AIDS as some disease that was in some remote place affecting some remote population." What Luoluo referred to as the marginalization of communities in the messages they were receiving included this phenomenon of naming populations of people that were never the majority population.

A final message common to the memories of several participants was that AIDS was connected to sexual behavior and that a healthy response to AIDS involved protecting oneself. Katrina Rodriguez remembered first learning about AIDS as a

“disease that was sexually transmitted” and then thought of the urgency of protecting herself from becoming infected with HIV because “this was something serious.” Melissa Kenzig’s first memories of AIDS included the suspicion that the disease had to do with sex, and because of its connection to the taboo topic of sex, it was not to be discussed, even in the privacy of a family home. Later as a high school student, she experienced a confirmation of this suspicion when a paper she wrote for an advanced placement biology class was returned to her by a teacher who told her that because her report included mention of sex between men, it was inappropriate and could not be turned in.

...I was told that was inappropriate, it was inappropriate content for a high school student to be writing a report on [gay people], and I was not allowed to write or submit a report on that topic at all. ...And I knew doing that was not okay, and just because I wrote about gay people having HIV, I was not okay with not being able to do that, even though in 1990 it was an established fact. There was nothing to quibble with. I had just literally written what I’m sure was just a silly 10<sup>th</sup> grade book report on HIV, but the fact that I was talking about HIV being transmitted via sex and the primary community that had it was gay men – he was not okay with that.

When she insisted on submitting the paper because it was a report of the medical facts that were being released at the time, she received no credit for the paper (and a grade of D in the class) – a decision that clearly communicated how any engagement of the topic of AIDS, even its most basic facts that may have been communicated in the popular media, was unwanted and unacceptable (and academically damaging). Finally, Karen Moses shared her earliest memories of AIDS with me in professional and personal stories that linked AIDS with condoms, the need to be careful and protect oneself, and a degree of sexual promiscuity among gay men.

## Oneself as Another

### Defining Health in Terms of Justice

In many of the narratives of the research conversation partners, a re-orientation of the individual self interconnected and interrelated to many others was often evidenced. This dialectic relationship of oneself as another helped formulate the themes of defining health in terms of social justice for all, and relocating the individual within any larger context, such as that of an organization.

The themes of these early memories were perhaps most easily summarized in my conversation with Paula Swinford who told me that early in her professional awareness of AIDS, she and a colleague linked AIDS with the topics that they termed, “The Big Three:” death, drugs, and sex. These three issues elevated the enormity of AIDS to the level of much more universally understood human experiences, and less marginalized human populations. As Katrina Rodriguez recalled, “...once the heterosexual community became affected, people paid attention.”

The fact that death, drugs, and sex affect the heterosexual majority, as well as any other human population was clear. But those three issues might still feel intellectually or emotionally distant. Several participants named motion pictures (e.g., the motion pictures, “And The Band Played On” and “Philadelphia,” and the staged theatrical play, “Angels In America”) as their experiences that really helped interpret what may have been a detached intellectual knowledge of AIDS as a disease, transformed into an appreciation of how the disease affected people in real life. Katrina Rodriguez said (of “Angels In America”), “...when I saw these personal narratives of how the disease affects people’s lives...that’s when I knew: oh my goodness, this is serious and we need

to all think about this, and this is real.” Jenny Haubenreiser said that the movie “And The Band Played On” served to personalize her knowledge of AIDS, as well as connect AIDS to the concepts of epidemiology, social networks, systems and networks, including the roles of people “beyond the medical professional.” She also said that watching that movie was the first time she thought, “AIDS is a really important issue...certainly the human cost and suffering is something that is all of our responsibility.” The connection of AIDS to a universal human experience was clearly a significant effect of seeing the movie, which Karen Moses also identified as a “profound learning experience.”

As the AIDS pandemic grew to be a disease experience that could be artistically and metaphorically connected to all human experience, the conversation partners who work in college health now and who were involved in a health profession during the 1980s and 1990s, also described growth in the public health and health promotion fields that started to re-define health far beyond the strictly biomedical paradigm.

Paula Swinford explained to me that prior to 1976, there was no organized group within the American College Health Association for people who worked in health education or health promotion. Pat Fabiano described how she and the rest of the health promotion profession had to learn and adapt and apply new knowledge very quickly and in rapid succession of new information being released very quickly as the virus and the epidemic were studied and became better understood. She vividly recalled the energy of working with colleagues at this time, when they had to “take risks with active learning and experiential education” so frequently and so vigorously, that she believes “the HIV/AIDS phenomenon contributed to the growth of health education on college campuses as we today know it.”

I asked my conversation partners to consider this story: the coming of age and the growing up of an entire profession. What many of them described was the evolution of thinking that health was not just a combination of symptoms or the absence of symptoms but as a much broader conception of the human condition. Pat Fabiano described students at Stanford who were HIV-positive or who had AIDS as “warriors” who were doing nothing less than “fighting for their rights” to simply attend classes or live in university housing despite the fear of their diagnoses. One of her memories was about:

...students who were not going to be assigned to some lower rung of Dante’s Inferno. And they were awesome. I can remember students dragging themselves to meetings, literally half-dead, to make the point with an administrator about the treatment that they were getting at the university. It was truly inspiring to not talk about social justice or advocate for social justice but to work every day for social justice for an entire group of people.

The activism that she described was considerably different from the work of teaching students to train for distance running or teaching them first aid, which were the early professional experiences that Paula Swinford described from the decade or so prior to Pat’s time at Stanford. To be sure, Pat later also told me, “I believe HIV/AIDS...in the early ‘90s...made us all courageous.” This refigured concept of health as a social process and as engaged activism moves health beyond the limits of the biomedical clinical experience.

For Sarah Mart, her personal understanding of health reflected the evolution of thought that was happening in her profession:

...“health education” is often very narrow and focused just on educational process. Often health education is not defined or practiced as John Dewey or Paulo Freire might think of education as experiential education and education for freedom, it’s just giving people more information about a certain medical topic. We also know that that is not enough; that in and of itself, information does not create healthy individuals or healthy communities. So my understanding of the term “health education” is included as part of the “health promotion” piece that

also includes public policy, activism, and environmental management – looking at all the different factors (in the community, environment, and society) surrounding an individual and taking appropriate action to change those factors in order to promote health. Health promotion is not just educating about a topic. The intent of health promotion is to increase the health of people, college students, specifically, in this case.

Ric Underhile shared his understanding that health education should “increase the quality of life for all members of the community.” This changing definition of health was also narrated by Rich Keeling in my pilot study, who identified that by the mid-1980s, there was a growing sense that “concerns about HIV were not microbiological...they had to do with human rights, relationships among people, and social justice concerns in general.” Paula Swinford also reflected on the intersection of HIV and human dignity, as typified in the ACHA task forces that carried those names, and referred to it as the “very big definition of health.” Alan Glass stated his belief that the future of college health would certainly include this broad definition that includes, but is not limited to, medical health services, and includes mental health and health promotion, among other things.

Ric Underhile told me that in the 1990s, “ACHA was bold and innovative, and some people were really pushing it to stay ahead of the curve.” But he also told me that he thought “associations – any association, including ACHA – are very conservative by their nature I think they promote ideas but only when it’s comfortable for everyone.” He described a lesson he has learned from serving in various leadership capacities within the association that the leadership and governance of a professional association must balance “what members need, with what members like.” It is this balancing act between the discomfort that accompanies some of the best learning and the comfort that comes with the complacency of maintaining a safe distance from new or bold ideas that may have contributed to the changes in how ACHA addressed HIV/AIDS.

Interestingly, Paula Swinford identified a “very core issue” for the American College Health Association, which is that the association itself “doesn’t have a guiding statement with regard to the definition of ‘college’ or ‘health’.” This lack of an accepted definition of the population and purpose that the association would presumably serve opened the conversation with Paula to consider how the philosophical orientation of the association could change from a biomedical definition of health to a social justice definition of health and back again:

Well, the association regresses back to mediocrity. It’s easier for health to be only about medicine and it’s very difficult to maintain the complexity of the issues that actually affect our health like what we put into our food, and what our public transportation is like, and where we build housing, and it’s easier to mix some chemicals together and medicate someone.

#### Honoring the Individual within Larger Contexts

Pat Fabiano’s early experience meeting a man who was literally ostracized and expelled from his community because he was infected with HIV taught her that “this wasn’t just a virus...it was a virus that had sociopolitical dimensions to it.” She came to this understanding through her encounter with just one individual. This was perhaps a similar revelation to those described by Jenny Haubenreiser, Katrina Rodriguez, and Karen Moses: each saw individual characters performed on stage or in a motion picture and the greater sociopolitical and human experience dimensions of AIDS became realized. Karen in particular named a “profoundly depressed” emotional response that accompanied her first viewing of the movie “And The Band Played On” because it gave her “a better understanding of the deception and the politics...documented in the context of HIV/AIDS, but it certainly plays out in many of the health issues that we work on: the politics of public health.”

Jenny Haubenreiser's earliest memory of AIDS was also watching the movie "And The Band Played On" which not only piqued her initial interest in a health profession, but also served to "personalize" the disease for her because in order to understand the disease, she learned that "you had to understand people's social networks." In the timespan of a few years, the narrative identities in the data moved from distance from (and barriers between) people to the interconnectedness of people in social networks. In terms of public policy and health, Jenny articulated her experience as a policy advocate that even in light of research and data, legislators will respond best to an individual who can provide personal testimony about an experience or a health issue. She also likened this to health crises of our time such as the genocide in Darfur or AIDS and said that "[p]eople are more likely to respond to faces they can see and relate to."

Finally, in terms of organizations like professional associations or college/university campuses, many of my conversation partners commented about the value of individuals and personal connections. Several participants told me stories about how they were mentored into the association and encouraged to assume more and more volunteer leadership within the association. Luoluo Hong very emphatically stated that she had grown up (chronologically and professionally) in her professional association. And in light of her years of experience with the organization that included increasingly influential leadership positions, she returned to the value of the personal network of connections to other individuals such involvement can cultivate: "...when the going gets tough on your home campus, you can turn to your colleagues in a professional association." Patricia Marin described the process of how an entire organization was developed over time as the work of two dedicated professionals, who then "started to



network people together and pull people together.” And Jenny Haubenreiser reflected on the various benefits that one might receive from a professional association like ACHA but settled on “...the friendships – that’s what’s important. And that’s what’s helpful for people in the association: sharing ideas and common values.”

Recognizing that an organization like ACHA is no separate other from the individuals in the organization also raises other complications. Alan Glass acknowledged that the organization “is a very diverse association” and that many of the conversation partners involved with my research quite probably shared similar political views that might not be reflected in other communities within the association. When considering the structural changes to the association that had first generated my interest in this research, Pat Fabiano stated that the association “did what organizations do: it destroys what it doesn’t understand.” Paula Swinford explained the changes by telling me that “the association regresses back to mediocrity. It’s easier for health to be only about medicine and it’s very difficult to maintain the complexity of the issues that actually affect our health...” However, Pat also acknowledged that if I talked with different people in ACHA about those same historical events, “they will not only have no organizational memory about this, but they will of course have an entirely different story about this...the story [will be] given a different title, [have] different characters, the plot will be different...”

Whether the narrative is a health issue or an entire organization, the stories of the participants refocused the value of community contexts and global environments on the individuals and personal relationships.

## Mimesis and Imagination

### Teaching Future Leaders

Because my research began with the story of organizational changes in the American College Health Association, some of the implications my conversation partners focused on was what to teach future professionals. Bringing the past into the present in order to imagine future actions is the mimetic process of this research and has great bearing on leadership development and education. Paula Swinford admitted her bias that this might have been reinforced by her family's own sense of professionalism getting involved with a professional association was simply "giving back... [and] part of being a professional and having a career." This action of getting involved was balanced with Luoluo Hong's words that future leaders cannot simply "do;" they must also be deeply reflective, critical thinkers. Melissa Kenzig stated sharply that in a combined total of nine years of graduate studies (at the master's degree and the doctoral degree levels), "nobody has ever taught me how to be a good professional!" She elaborated by describing essential professional skills such as conducting a good interview, juggling administrative tasks, managing interpersonal dynamics, and understanding that personal beliefs cannot be compartmentalized away in someone's narrative and will therefore affect anyone's professional life. When I reflected that story back to other conversation partners, several agreed. Karen Moses considered all of the lessons she had learned over years of experience and so many of the important skills she has developed have to do with managing processes and effectively networking coalitions: "things that we are not taught in school." Luoluo emphatically agreed that "all the unwritten stuff, the soft

skills” were extremely important to teach to future leaders, but are also the lessons that are not currently addressed in the higher education experience.

In addition to possible lessons to teach future leaders that could be gleaned from the organizational changes that have occurred within ACHA, the participants also easily imagined lessons to be learned from HIV/AIDS and the way in which the pandemic had helped to redefine health. Sarah Mart understood the reality of the AIDS pandemic in a literal and metaphorical sense: “...the issue itself (HIV as a virus, as a disease, and an infection is important) but also...the broader implications and the learning opportunities for students themselves and for professionals in the field.” When I asked her to consider what the college health promotion could do to apply this perspective to its work, she said:

I really wish the focus would be on the big issues, the process and the work of public policy and environmental management – not only improving health for individual college students and college student populations, but also supporting, encouraging, teaching, and providing students with what they need to create healthy communities and environments after they leave college – to *be health* in their communities, and to be involved in their communities. I wish for all of our programs to be developmentally appropriate, to be very integrated and intertwined with the learning mission, and to be research-based.

One insight that Karen Moses gained from the movie “And The Band Played On” was the “politics of public health.” She later reflected on the kind of marginalization that the communities first identified as most affected by HIV/AIDS and said:

...should we even pay attention to this disease because it is affecting a population that we don’t care about [?] And for me, issues that break my heart and that bother me to the depth of my being, are the ones that we think don’t matter because it’s not about people we care about. I mean, should there even be a population of people we don’t care about? What’s wrong with that thinking? It’s pretty evil.

Her heartfelt sentiment suggests an implication for higher education: the urgency of preparing leaders to care about all people, no matter how seemingly distant or

disenfranchised. When I asked Karen to imagine how we could change higher education to promote that value, she posited that the purpose of higher education needs to be defined on a timeline that goes beyond graduation:

Isn't college training people to become professionals in a working world? So the grades and education they get here really isn't about "here," it's about what happens after. So I started asking why we had to confine the health promotion work to their experience here. I mean, it's one thing to not have your academic progress impeded by drinking, sure, but why can't we ask while students are here, can they learn healthy lifestyle practices that will carry them through life as community leaders or workplace leaders or family leaders – because of the work that we do here with them now. Did they learn to be better people because of us?

Similarly, Ric Underhile stated that health issues as complex as HIV/AIDS necessarily involve human systems and are correspondingly complex. He stated that “human systems are not nice and simple, and that’s what any health issue, certainly one like HIV/AIDS, teaches us.” He went on to say that the challenge facing higher education is to take on large-scale approaches to care for students and also “manage some social and cultural changes.” Luoluo Hong stated directly:

I think colleges and other educational institutions have to take a more concerted effort to make sure that our students are engaged with and have a more globalized or international perspective and I think education needs to cultivate the understanding that we are more mutually interdependent than we think we are.

Later in our conversation, Luoluo also commented more specifically on the student affairs profession as “the human development profession” which led her to conclude that it should also be the “social justice profession.”

Luoluo also opened a new understanding that is a lesson for future leaders of ACHA that might address the fear-based actions of the organization to do away with the HIV/AIDS Task Force and the Task Force on Human Dignity. This lesson came from my reimagining of Luoluo’s story of how she disengaged from the association when she

became dissatisfied with it, even as she attained more highly elevated leadership positions within the organization. Luoluo regrets that she did not speak up sooner and agitate faster. Paula Swinford remembered the association president who was “gutsy” and got lucky when she appointed Rich Keeling to boldly lead the HIV/AIDS Task Force who moved in the right direction and knew that the association needed to “get [itself] together, medically.” Jenny Haubenreiser described her growing discontent with the association when she said that she saw “no growth, no vision, no development of a profession” until the Health Promotion section within the association took on those tasks. This reflected earlier actions of the section when Paula described the health promotion professionals deciding, “This association is not going to do what it needs to do for us. We need to start doing it for ourselves.” While this did serve the Health Promotion section well and created lucrative and helpful new tools and projects, this type of concerted effort must be combined with the kind of engagement (especially with leadership) that Luoluo regrets not taking. The structural changes within the association may have indeed been an effective way of increasing the efficiency of a large volunteer organization, but an equally effective future narrative of ACHA must combine bold vision with articulated advocacy and agitation to stir new ideas and avoid any disengagement from within its membership.

### Summary

The categories that emerged from the narrative texts of data provided by the participants in our shared research conversations include: how the disease pandemic is articulated in terms of our human experience, how we can define health broadly and expansively, how we can refocus on the individual within larger contexts, and how we

can teach future leaders to be and act in professions, organizations, and throughout our life-world. These categories are further explored in the next chapter.

## CHAPTER FIVE

### SECONDARY ANALYSIS

#### Introduction

This critical hermeneutic inquiry must include reflections about the meaning interpreted, or laid open, before the text (Ricoeur 1988). Hermeneutics recognizes that “when we use language, we are already interpreting the world, not literally as if it possessed a single transparent meaning, but figuratively in terms of allegory, symbol, metaphor, myth, and analogy” (Kearney 2004:20).

Thus far, the conversations I had in both the pilot study and in the full research protocol have converged on the following themes within the research categories: how disease (HIV/AIDS or any other) is named and affected populations identified (categories of mimesis and oneself as another), how health can be defined in broader ontological (and not merely clinical) terms (categories of oneself as another and imagination), how we can refocus attentions on the individual within larger contexts such as organizations (categories of oneself as another and imagination), and how higher education can prepare the leaders of tomorrow (category of mimesis and imagination).

This secondary analysis required moving between the chapters of literature and conversation data for a deeper theoretical understanding of the research. Discovering meaning from the texts of the research conversations is a process that Kearney (2004:31) described as “to arrive in the middle of a dialogue which has already begun and in which we try to orient ourselves in order to make some new sense out of it.” This dialectic process is what Kearney (2004:32) pointed out as the true power of stories to “transcend...subjective intentions” and open “a world of possible meanings, to new

modes of being-in-the-world and of being-interpreted.” This process also engages the imagination as the “very instrument of the critique of reality [that] simultaneously [juxtaposes] two different worlds” to produce new meanings, and thus shape “new worlds” (Kearney 2004:35, 38). By engaging my imagination in the narrated pasts and simultaneously being outside those narratives, I could imagine myself and imagine other possibilities (Kearney 2004:73). Kearney (1999:87) also describes the transaction that occurs for the imagination to take action “toward realizing what is desirable and reasonable.” In this chapter, my imagination will employ language so that “new meanings [can] come into being...in the form of new verbal images” (Kearney 2004:40).

As I moved between these texts, I became most attuned to the critical hermeneutics related to the ecology. Gadamer (1996:79) traces the root of the word to the Greek *oikos*, meaning the domestic house or the household. But in addition to the meaning of “keeping house with the means, energy and time that are available,” he provides the additional definition of “not only the ability to manage one’s self, but also the ability to manage along with other people.” Bowers (1993) writes similarly about an ecological orientation that includes cultural and spiritual dimensions of interconnectedness. I kept coming back to these concepts in particular because so much of what my conversation partners narrated to me was about the interrelatedness of people, issues, and disciplines. Expanding my awareness as a locality of understanding within the larger and more diverse human context that Geertz (2000a:16) termed “local knowledge” also permitted me to play with different ways of knowing, as engaging with the narrative texts permitted a socially constructed experience to share new ways of seeing (Bateson 1994).



Treating the conversation texts as data also employed the “hermeneutic disclosure of possible worlds which are suppressed in our present reality and whose very otherness provides alternatives to the established order” (Kearney 2004:68). The research conversations and the narrative data they produced illustrate how “exposure to new possibilities of being refigures our everyday being-in-the-world...so that when we return from the story-world to the real world, our sensibility is enriched and amplified in important aspects” (Kearney 2002:132-133). This was my hope and my aim as the researcher in this study.

### Narrative Identity

The construct of identity proposed by Ricoeur (1992) is an orientation to self that considers the dialectic relationship of Sameness (*idem*) and Selfhood (*ipse*). In Ricoeur’s terms, *ipse* (the characteristics unique to each individual) defines identity as much as *idem* (that which we recognize in others that is like the self). The dynamic nature of identity holds at its core this duality of oneself as another: the understanding of the one term necessarily involves a relationship to the other term. Ricoeur (1992:3) wrote that “from the outset...the selfhood of oneself implies otherness to such an intimate degree that one cannot be thought of without the other, that instead one passes into the other.” The data presented in the previous chapter included the memories of research participants that defined health in terms of multidirectional relationships between people, manifesting this kind of inward-outward dialectic. In order to make meaning of the multiplicity of dialectic identities in the human experience, Ricoeur identified narrative identity: the emplotment of characters, events, journeys, experiences in a meaningful story. Ricoeur (1992:178) explained that the “notion of narrative unity places its accent on the

organization of intention, causes, and change that we find in all stories.” An epidemiologist might describe the AIDS pandemic in terms of infectious routes and networks of viral transmission. In the data of these research conversations, the AIDS pandemic unfolded as a narrative that connected the horizon of public health to the construct of health identity as an experience of oneself as another: a story that ultimately moved public health from the tradition of diagnosis and treatment to a future of well being, justice, and dignity for all.

#### The Pandemic as a Multidisciplinary Narrative of Human Dignity

I began my conversations exploring the memories of the research participants: asking them to configure in the present those histories and traditions that were prefigured in their pasts. Ricoeur (2004:23) described the importance of memories:

We say that we remember what we have done, experienced, or learned in a particular instance...the singular faces of our loved ones, words heard according to their manner of utterance each time new, more or less memorable meetings. ...Things and people do not simply appear, they reappear as being the same, and it is in accordance with this sameness of reappearing that we remember them.

My conversation partners were certainly able to remember meetings and words, but more importantly, their narratives allowed people to reappear for me in a new text.

Jenny Haubenreiser’s earliest memories of AIDS included an awareness that understanding the pandemic would require an understanding of “systems and networks” and “groups” of people, not simply infected or affected individuals. Sarah Mart also described the need to address AIDS both as “the disease itself” and also as “the implications of it on our communities and our populations.” Jenny named this shift in thinking when she realized that AIDS “...wasn’t just a medical experience [but that] there were emotions and social experiences as well.” Scheper-Hughes and Lock

(1987:30) describe the emerging field of medical anthropology “as providing the key toward the development of a new epistemology and metaphysics of the mindful body and the emotional, social, and political sources of illness and healing.” Garro and Mattingly (2000) concurred that an anthropological application of narratives in medicine (and, I would add, in health) helps describe the illness experience through characters and action. It is this process of emplotment that is central to Ricoeur’s (1992) theory of the dialectic of the self and the other in a life-world. These texts all suggested a more expansive view of health, education, and leadership.

A broad, multidisciplinary approach to health naturally leads to the position that health and human dignity must be understood together. In fact, another medical doctor has written that the classical positivist view of the world is no longer supported by a societal view that everything cannot be comprehended by rational thought alone, and that science has passed into a more metaphorical and poetic mythology (Dossey 1982:200-201). Dossey (1982) argues that this emergent mythology of science is one that unifies all the previous separated human experiences (e.g., physical and mental) into a single cohesive and more authentic whole. This reflects what Kearney (2004:29) referred to as “a genuine hope” in which purpose is aligned with action, in this case for the purpose and in the action of caring for all.

Professor Jonathan Mann, the founding director of the Global Programme on AIDS of the World Health Organization was quoted in the *The Globe and Mail* on May 25, 1995 saying (cited by The Noah’s Ark-Red Cross Foundation 2002):

Because the marginal and disenfranchised in society are most vulnerable to disease, promoting human rights is an essential component of the strategy to fight HIV/AIDS and other epidemics. Human rights provide the guide for the kind and

direction of society transformation which is needed, because the realization of human rights and dignity is the societal precondition for health.

Recent recommendations for health and HIV/AIDS initiatives also advocate for an integrated approach that includes education, prevention, counseling, testing, and care not just for those infected with HIV or with AIDS, but for their communities (Milstein 2008; Robert, Booske, Rigby, & Rohan 2008; United States President's Emergency Plan for AIDS Relief 2007; W. H. Kellogg Foundation 2002). A similar, integrated, multidimensional approach to fostering health in higher education has also been proposed (Association of Canadian Community Colleges 2008). There is also a hermeneutic basis for this refiguration of health as social justice. Ricoeur (1992) wrote that a just institution was a historical community that lives together and is bound by common mores with the ethical aim of equality (an extension of his concept of sollicitude). If we understand that the health of oneself is the health of another, then we can see that a human community must orient itself towards the justice of equal health.

The narrative of the health promotion profession to define health broadly was stated by Alan Glass, Sarah Mart, Paula Swinford, Jenny Haubenreiser, and Ric Underhile, along with Rich Keeling. When she told me about one of her early memories in ACHA, Pat Fabiano recalled the time she commented to Rich Keeling, "You're not asking us to deal with HIV; you're asking us to change society." Rich affirmed that conclusion, but the texts of health education, health promotion, and even the public policy response to AIDS also concur that the issue is too large, too connected to the totality of the human experience and the entire human community, to warrant solely a biomedical response. This perspective honors Ricoeur's "dialectic of self" (1992:3) by

eliminating the separation of oneself (such as the health promotion professional) from another (such as anyone affected by HIV).

Recall that Rich, a medical doctor, recalled his first memory of AIDS as his diagnosis and treatment of the very first person recognized with clinical AIDS in the state of Virginia. His work then required him to respond as a medical clinician. Rich said that “by the early 1990s, I had come to believe that the way I could best contribute to solutions to HIV/AIDS was through prevention, not by treatment.” This was his turning point from a biomedical orientation to the disease to something much more broadly defined. His work for ACHA then included publishing policy recommendations that included “[higher education] institutions [should] provide humane and caring services, avoid discrimination, seek opportunities for effective prevention, and provide students with HIV/AIDS every possible chance [to complete] their academic work.” These recommendations signify a marked shift from protective barriers and isolation measures that were present in the stories of many of the participants’ early biomedical memories of AIDS. During my conversation with Sarah Mart, she remembered being inspired by the brilliance of this “social justice standpoint and the necessity of addressing HIV/AIDS not only as the issue itself (HIV as a virus, a disease, an infection), but also as the broader implications and learning opportunities for students, and for professionals in the field.” What Sarah appreciated about this generalized and globalized perspective on HIV/AIDS as a human experience was its understanding that HIV/AIDS was not just an infection or a disease, but a pandemic with implications for all communities and populations.

Susan Sontag (1988, 1989) positioned AIDS in several metaphors that can also help narrate the texts of the research conversations. In a military metaphor (Sontag 1998,

1989), HIV invades the body and people must defend themselves from infection with barriers or fight off the progression of the disease syndrome with medication. This metaphor was described in the stories of Patricia Marin, Karen Moses, and Katrina Rodriguez, who each narrated memories that involved being careful to protect themselves or others they cared about with birth control and condoms. Karen even described the “big process” she had to coordinate with the student government on her campus to get condom-dispensing machines installed on her campus. In a plague metaphor (Sontag 1988, 1989), populations are identified to be feared and avoided or quarantined. These themes were evident in the memories of Paula Swinford and Pat Fabiano, who both encountered individuals who searched for a safe place to go for help, support, resources, and treatment, and in the narrative of Luoluo Hong, who described the process of marginalization in the identification of affected communities. In a catastrophe or cataclysm metaphor (Sontag 1988, 1989), there is an added dimension of judging the affected populations as fundamentally wrong or sinful, and certainly less valued than the majority population that is saved or favored. These value judgments were reflected in the stories of Patricia Marin, and Melissa Kenzig. The judgments that fuel stigma and discrimination were also discussed in global public health documents addressing HIV-related intolerance (UNAIDS 2001). Additionally, the fatality of judgment was echoed in the memories of Alan Glass and Ric Underhile. Alan emphatically told me that he “was scared to death” that he would become infected with HIV, and that fear influenced his life for the better part of two decades.

One consequence of these metaphors becomes a desire to return to what Sontag (1988, 1989:78) identifies as “conventions,” which she describes as stricter controls on

conduct in personal life, panic over sexuality, and the limiting of social contact. Again, the young men whom Pat Fabiano and Paula Swinford encountered far from their communities were driven from their homes as the extreme result of strict controls. Biomedical controls were employed by the HazMat team responding to a car crash witnessed by Melissa Kenzig and by the hospital protocols that required Alan Glass to don protective gear to hold a baby. Finally, the panic over sexuality was not only witnessed by Alan Glass and Ric Underhile, it affected their personal identity development. Ric told me the story that gay baths in Atlanta were being shut down even when “there didn’t seem to be anything really concrete about that.” Their stories, along with Rich Keeling’s and that of Sullivan (1996), are perhaps the narratives that best demonstrate Melissa Kenzig’s statement that “the personal is political,” and further corroborating data to support the multidisciplinary approach to health.

In his global historical narrative of AIDS, Jonathan Engel (2006:16-17) corroborates these personal narratives and reports that in the 1980s, the average number of sex partners reported by gay men dropped by almost half, while nationwide condom sales in the United States almost doubled to an annual business of \$338 million by 1985. He also notes that the public policy decision to close gay baths in many cities during this time was an action that equated disease transmission with places and not with activities, making individual health behaviors inseparable from identity with an entire community (Engel 2006:18-19).

Finally, the dialectic between medicine (which cares for the individual patient) and public health or health promotion (which cares for populations) (The New York Academy of Medicine 1996) is reminiscent of the dialectic of self and other described by

Ricoeur (1992). The movement from one to anyone is the process that can sustain the validity of both medicine and public health, a partnership in health suggested in the narratives of Alan Glass, Jenny Haubenreiser, and Sarah Mart. For example, Jenny identified possibilities for true working partnerships between the usually disconnected fields of nursing and health promotion, and between health care administration and health promotion. Mirroring the narrative of Paula Swinford who described how health and hygiene officers eventually transformed into the health promotion section of ACHA that she came to lead at one time, a report described the past of the “‘great sanitary awakening’ of the 19<sup>th</sup> century” that isolated individuals and then gave rise to public health as a social responsibility of collective actions (W. K. Kellogg Foundation 1996:1). Such policy reports have focused not on biomedical diagnostics or epidemiological statistics, but instead have emphasized the need for much more humanly real foci such as sustained leadership, diverse partnerships, social and economic community development, and networking and communication (W. K. Kellogg Foundation 1996, 2003). These concepts may be broad, but they still humanize the pandemic in ways that one can imagine would permit the fusion of horizons and new imagined futures.

Re-orienting health towards the full dignity of the individual remembers the argument that an understanding of self “is tightly bound up with solicitude for one’s neighbor and with justice for each individual” (Ricoeur 1992:18). Kearney (2004:26) stated, “...we can only hope to recover this ontological desire to be by first understanding ourselves as we exist outside of ourselves.” Ricoeur (1992:193) adds that “solicitude adds the dimension of value, whereby each person is irreplaceable in our affection and our esteem.” He also wrote that solicitude informs us “through the transfer of the other



onto ourselves, the irreplaceable character of our own life” (Ricoeur 1992:193).

Demonstrations of this acknowledgement of oneself as another came in the story that Alan Glass told me of holding an HIV-infected baby and feeling a connection with the baby, despite the physical barriers that separated them.

In my own narrative, this re-interpretation of the text from the value of solicitude allowed me to configure my memories of the AIDS memorial quilt, imagining my connection to and passing into the other (the passing acquaintance who was memorialized in a quilt panel at my feet). Imagined in this way, I understand that my identity includes my health, and that my health is also defined by the health of all others. Ricoeur (1992:193) wrote of a similar connectedness when he defined similitude as the force that “authorizes us to say that I cannot myself have self-esteem unless I esteem others as myself.” In the social justice orientation towards health that is maintained by the ACHA members with whom I spoke, the understanding of solicitude (i.e., esteem and affection for the other that is irreplaceable) leads one directly to the awareness of similitude of health (i.e., that I cannot claim to be a healthy individual if others I esteem are unable to do so). Heidegger (1962) also identified care and identity as the essential components of the ontological nature of humans. For Heidegger, one’s identity (i.e., “Being”) is inseparable from one’s care for the other (i.e., “Being-with”).

### Oneself as Another

The identity of oneself as another was helpful not only for the hermeneutic understanding of what the participants described as the expanded definition of health as an orientation to justice for all, but also for understanding the individual in larger contexts. Within the organization under study, the data presented in this research often

stated a recommitment to honoring the whole person in each individual member of the organization: sometimes to varying degrees of dignity. Ricoeur's (1992:183) definition of solicitude as the genuine esteem, friendship, and respect in which "each loves each other" has similar bearing on this analysis of health as human dignity and the health organization as human individuals. This hermeneutic analysis of the conversation data thus reveals a new ethical orientation for understanding and caring for and with others.

### Remembering the Individual

Many of the participants identified the primary importance of the individual, both in health, and also in organizations. The attention paid to the individual need not contradict the universality of the definition of health proposed above. Indeed, in his hermeneutic dialectic, Ricoeur (1992:37-38), identifies "oneself" as the physical and psychic natures that allow us to ascribe meaning to anyone. In this way, Ricoeur offers a narrative that supports a definition of health grounded in the interrelatedness of all people, by naming a unifying condition of the human experience. Ricoeur (2004:210) further stated that "space is continuous" so, indeed, there can be no separation between oneself and another.

Habermas (1996:365) stated that "Problems voiced in the public sphere first become visible when they are mirrored in personal life experiences." In terms of health and health promotion, Katrina Rodriguez, Karen Moses, and Jenny Haubenreiser each narrated a story of realizing the human dimension of AIDS when they witnessed performances of individual characters in entertainment media. Karen Moses, Pat Fabiano, and Jenny Haubenreiser also told stories of the impact that a single person telling a personal story can have in education and policy-making/decision-making. Recent

evidence suggests that the peer-to-peer intervention may still have the best impact in educational interventions, especially in targeted contexts (Johnson 2006).

Within the construct of the organization, Ric Underhile also emphasized the value of the individual and individual conversations and stories, separate from the artificial boundaries of position or title. As he put it, “everybody benefits from a conversation.” Indeed, in critical hermeneutics, it is the relationship between two individuals that allows for “the possibility of seeing and understanding the world, and therefore one’s self, differently” (Herda 1999:7). Furthermore, “...a conversation characterized by genuine interpretive listening, both/all persons participate in the ongoing process of constituting meanings” (Stewart 1983:383). Perhaps this is the hermeneutic reason why so many of the participants in this study identified the support and development they experience in their individual relationships within the organization.

Remembering the power of the individual is also important in the text that discussed the public policy ramifications of personal testimony. Pat Fabiano and Jenny Haubenreiser offered specific stories of individuals describing their own personal experiences in order to lobby for changes. The hermeneutics of testimony has been described by Gadamer (1976:xv) when he identified that “...the past has a truly pervasive power in the phenomenon of understanding.” When Karen Moses described her process of finding allies, building networks of commitment, and when Patricia Marin described an organization building itself through networks of researchers and activists, surely the power of narratives of individual pasts could be more than helpful.

As stated in Chapter Three, some of the documents reviewed for data in this study could have been provided or identified by the participants. During my conversation with

Katrina Rodriguez, she remembered being moved by a book that included collected stories written by and about women living with HIV/AIDS. I procured a copy of this book and its historical overview of the pandemic recalls the complex nature of focusing on individuals: at the onset of the pandemic, individual communities were named and blamed for the spread of the virus (a memory shared by several participants), and that stigma created the notion of “‘deserving’ victims” (Lather and Smithies 1997:143). That same historical account also describes the political agendas, bureaucratic agencies, in scientific quarreling that have now come to be as much a part of our understanding of the pandemic as its biomedical facts (Lather and Smithies 1997:144). Finally, the authors describe a tradition in the history of HIV/AIDS that dichotomous stereotypes such as the “ordinary woman,” contrasted to the “female sex worker” (Lather and Smithies 1997:144). In my research conversations, several participants reflected this tradition in their memories of understanding who AIDS affected, which was usually a distant other “them” and then later, the more self-identified “us” or “all.”

#### Mimesis and Imagination

Understanding the data in this research is an act of mimesis, which Ricoeur (1984) identified as the construction or creation of reality, not the simple duplication of reality. Understanding the stories of individuals (or of an individual organization such as ACHA) requires a connection to those narratives, which in turn affects and informs one’s own narrative (Kearney 2002, 2003). Gadamer (1988) supported this view that a present meaning is derived from past contexts. From this mimetic action, we can construct narrative identities. Heidegger (1962:203-204) identified a purpose to these narratives with his concept of *dasein*, or the authentic being that is “always, already in a definite

world.” Within this definite world, we can now imagine future ethical actions in what Kearney (1999:38) refers to as the “horizon of the possible.” Kearney (1999:106) wrote that this narrative imagination has

A singular capacity to commit us to a dimension of otherness beyond ourselves – a commitment that, in the moment of decision, invites the self to imagine itself as another and to imagine the other as other. Were we devoid of such narrative imagining, we would be devoid not only of poetic freedom but also, in the long run, of ethical judgment.

In the research conversations of this study, I engaged the participants in imaginative inquiries about the ethical judgments that would be possible in the futures of their professions.

#### Professional Education

One of the common goals of higher education, found in many vision and mission statements of colleges and universities is to educate a citizen, a leader, a professional, an adult. Several of the participants easily imagined implications of the ACHA story as they relate to health. Similarly, many were able to imagine implications of the same story as they relate to the education of all professionals.

From Melissa Kenzig’s story that nobody in nine years of graduate education had ever taught her how to be a professional, to Luoluo Hong’s story of working with staff and supervisors who were only equipped to do or act, without regard for critical thinking, and without a social justice orientation, the narratives of my conversation partners offered evidence of an incomplete higher education.

Bowers (1993) reminds educators of the need for the advancement of critical pedagogy: to challenge students to identify the forms of power and control in their lives. This revealed understanding might address the concern stated by Melissa Kenzig that

professionals need to understand the social and political realities of their work. Bowers (1993) also advocates for a form of spiritual self-reflection that illuminates one's traditions and cultures. This could address the need for a globalized, interdependent perspective that Luoluo Hong spoke of, or the capacity to lead as better people, as Karen Moses imagined.

Parker Palmer (2007) states that nowadays, a professional is usually understood to be the person who possesses knowledge and techniques that other people do not understand and who claim to be value-free. This is the kind of overly educated worker described by Melissa Kenzig and Luoluo Hong. He goes on to propose a new interpretation of the professional being someone with “ethical autonomy and the courage to act on it” (Palmer 2007:7): a person who combines knowledge and skill with a grounding in self-aware identity.

Additional implications for higher education pedagogy will be explored in the next chapter.

### Summary

As I developed my own understanding of these interconnected themes of human dignity, health as social justice, individual action and character within organizations, and teaching leadership for the betterment of all people, I fondly remembered that day in 1996 when I stood on the National Mall in Washington, DC, surrounded by people and surrounded by memorials to people in the NAMES Project AIDS Memorial Quilt. The Quilt has been described in narrative terms “as one of the great epics of time” (Connor, 2000:48) that is at once political art and a “sacred space where individual stories can be told and heard” (Connor 2000:48). This art form fittingly reflects Ricoeur's point that

tradition serves as "...a living passing-on of innovation which can always be re-activated by a return to the most creative moments of the poetic composition" (Ricoeur 1991b:429). Ricoeur (1999a:17) also said that "Expression and discussion are ways of healing" and certainly the Quilt serves to achieve expressions of grief and loss and remembrance and love in its many panels (designed to be three feet wide by six feet long – the dimensions of most adult graves). Heidegger (1971:78) commented that "art is by nature an origin: a distinctive way in which truth comes into being, that is, becomes historical." The Quilt preserves "the relation of the present to the past" (Ricoeur 1999b:10) and puts "memories before our eyes" (Ricoeur 1999b:15) and we who witness it become heirs to those memories, free to imagine a future of better possibilities.

On June 1, 2009 (nearly 13 years after my trip to see the Quilt in Washington, DC), I heard Cleve Jones, who created the Quilt in the mid-1980s, speak at The Commonwealth Club in San Francisco, CA. He said that "our struggle with AIDS informs everything else" (Jones, public address, June 1, 2009). His comment brought me back to Paula Swinford's conceptualization of AIDS as a pandemic that was about the "Big Three" issues of death, drugs, and sex. While one might be able to distance one's self from drugs and sex, all human beings share the trait of mortality. Gadamer (1996:62) states that "the experience of death occupies a central place in the history of humankind." Cleve Jones's work created a medium to narrate the stories of many lives, without becoming the author of those lives or of the work (Ricoeur 1991:437).

As I stood in that sacred space back in 1996, the enormity of the Quilt was eclipsed by those individual panels, I understood how the individual and the (global) community were intertwined like fabric, challenging and informing my own identity as a

person and a professional. Without planning or predicting it, those moments remembering an “other” from my past, would have bearing on myself in the present. Perhaps that reflection of the personal in the landscape of political art is one example of the global breadth of health as human dignity. The AIDS Quilt has managed to meet the challenge of leadership in the face of the AIDS pandemic to create the capacity to act and then allow the work to be self-sustained without continued intervention. The dual political nature of social movements that are described by Cohen and Arato (Habermas 1996:365) is also a part of the narrative of The Quilt. The Quilt offensively brings forward issues relevant to the entire human population, supplies new information by humanizing the epidemiological numbers of the pandemic, and criticizes health care policies, health care industries, and social apathy. Defensively, the Quilt consolidates the many different human lives it narrates in its panels into a new collective identity as a unified historical community (Kearney 1999:26). The Quilt offers artistic testimony to the pandemic. Ricoeur (1999a:16) stated, “Testimony is the ultimate link between imagination and memory, because the witness says, ‘I was part of the story. I was there.’”

My memory of participating in that final display of the AIDS Quilt in its entirety in 1996 is an event in my own past. The Quilt in 1996 still represented only 1 in 8 Americans who had died of AIDS (Jones 2000:261-262) and was still the largest AIDS awareness event in history. Because I can always claim that I was a part of the story and that I was there, that event in my past is now my responsibility for continued action in the present. I hope I will continue to imagine ways of contributing to what many hope will be a fitting probable future in this pandemic: an imagined future where the Quilt no



longer grows and when it can finally be folded up tightly and placed lovingly into the cedar chests of our collective memory.

However, until such a time comes into our present day, the reality of HIV/AIDS will continue to call for concerted attention and action. After hearing the story that Rich Keeling told me about that man who was the very first diagnosis of AIDS in the state of Virginia (a law student named Michael), I asked him to imagine what he would want to tell Michael in this research now. Rich told me that he would want to say:

That the struggle to address social justice as an issue in health and health care continues, but that things are better for gay men in America than was the case when he got sick; that we continue to study our own history; and that he is not, therefore, forgotten.

Pat Fabiano recalled an emotionally similar story to me as we closed our conversation about one of the “warrior students” she worked with and advocated with in the mid-1990s. Pat told me that Sergio became more and more sick and was eventually admitted into the university hospital and Pat visited him there:

...he handed me a poem that he had written. Of course I wish I had it to read to you. I don't. But I remember that it said he felt like an astronaut who had been forgotten in orbit and [he wished for] somebody [to] please come up and get him back to earth.

The final human act of the NAMES Project AIDS Memorial Quilt serves a purpose for both Michael and Sergio, whether or not they have panels enmeshed in those many square miles of fabric. One panel in The Quilt includes a letter that asks, “After all, isn't that what each of us wants? Not to be leveled into facelessness but to be treated as a unique, inimitable person?” (Brown 1992). Perhaps we can imagine a future to answer this memorial plea.

## CHAPTER SIX

### SUMMARY AND CONCLUSIONS

#### Introduction

This research required entering into a relationship with the text of conversations. That relationship opened me for a fusion of horizons which can better inform my own present and imagined future. This interpretive research also carries an ethical imperative to state those new understandings, new meanings, new actions, and possible new futures into text. As Herda (1999:131) writes, “To change our lives and our understanding is more a responsibility than our right. When people demand their rights to gain a better life, they are relying on others to do it for them. ...In the end, it is our responsibility to think differently, to learn, and to act differently.” Ricoeur (1995:373) also stated that “the relation between imagination and the world of possibilities is a relation to an unreality that becomes real in the act of transforming the world.” The responsibility of understanding and the hope of transforming the world are what frame this concluding chapter of my study.

As a result of the research conversations, what began as my exploration into the changes in organizational structures within a professional association for college health developed into an intersection of narratives about health, human dignity, organizational politics, individual identity, personal relationships, professional training, and higher education. The narrative data from the participant conversations seemed to converge in one similar direction as far as college health promotion was concerned: as that profession came of age in the time of AIDS, it has adopted an orientation to health that identifies the purpose of the profession as the obligation to “increase the quality of life for all,” as Ric

Underhile commented. This definition has been codified in an accepted set of standards for the profession (a guiding document that Karen Moses named as essential for strategic leadership), and it informs a nationally implemented survey to collect data that can be used to further inform decisions into the future. What also emerged from this research was a wealth of suggestions and implications for the future directions of at least two other professional fields: student affairs and undergraduate/graduate education in general. I offer some thoughtful descriptions of those implications here.

### Implications for Student Affairs

#### Suggestions for Graduate Preparation Programs

Student Affairs, the profession that has been my career and vocational home since 1993, is charged with educating the student outside of the classroom, in all possible developmental and learning processes. As educators of whole human beings (Keeling n.d.), this charge encompasses every facet of a student's life. Thinking beyond health issues, Ric Underhile stated that that one challenge we will face is to take large-scale approaches to address all "the developmental needs of college students." He also acknowledges that taking a large-scale approach will require a full appreciation of the complexity of issues. It is this complexity and interrelatedness of systems that Karen Moses also described in her story that required the enormous input of resources to develop coalitions that could manage the environmental contexts of individuals. Ric commented that this level of complexity of human systems cannot be addressed with easy answers. Unfortunately, as several participants pointed out, student affairs graduate preparation programs typically produce a new professional who is most trained to do tasks, and move from topic to topic. Even more strikingly, very few are trained about

college health, and almost assuredly not from the perspective that health is the capacity for all people to feel dignity and freedom. As the language of student affairs gradually develops around the concepts of sustainability and social justice, there may be newly emerging opportunities to enlarge those conversations to include an appreciation of health as a necessary condition for student success and human achievement. Indeed, one of the leading professional associations for student affairs called for universities to adopt systems approaches to complex problems, and consider them in inclusive and interrelated ways (College Student Educators International 2008).

Certainly, some formal training in health topics could be helpful for the student affairs professional, as Alan Glass told me. But as the data revealed, even more important might be the creation of better networks of individuals. While students who serve their campuses as peer health educators have the opportunity to experience individual relationships with the professional staff in health promotion, no other mentoring system is in place for students or professionals to benefit from the kind of “real life” conversations Ric Underhile described that are free from the artificial constructs of job title, positional authority and power, or even office location.

Melissa Kenzig and Luoluo Hong clearly suggested that future leaders in student affairs should also ground their work in an understanding of the social and political dimensions of the professional life-world, in both workplaces and in professional associations. Employing the dialectic of oneself as another proposed by Ricoeur (1992), it is possible to imagine how this intelligence about the sociopolitical external to someone can be cultivated with the appreciation one’s own sense of tradition, culture, politics, values, and beliefs. Here is where student affairs may utilize an advantage.

Traditionally, student affairs professionals are well versed or at least quite familiar with the narratives of multiculturalism and social justice. A health promotion initiative that has been proposed focuses on teaching the “intersectionality” of personal identities (UNAIDS 2001:8). The curriculum in graduate preparation programs and in professional development programs already typically includes identity development theory, so this could be easily expanded to include a dimension of self-reflection in the intersectionality of identities.

In our work as educators functioning outside of traditional classrooms and laboratories, student affairs staff members engage students in critical thinking and self-reflection to develop skills in empathy and understanding, and this same educational practice could be applied to teaching about health. In the words of another writer, the “ability to empathize with the plight of others is what keeps us human. And our humanity increases the more we talk to each other” (Sischy 2006:66). Connecting the edges of social justice narratives and health narratives may yield great educational promise because it is “...at the edge that we see new horizons” (Sischy 2006:66). The student affairs profession has always accepted the challenges of educating on these boundaries and on the topic of HIV/AIDS, it must again live on that edge.

#### Suggestions for Professional Development

I believe that professionals who are trained or accustomed to doing tasks, and usually multiple tasks at any one time, are likely to fall into the trap of following plans of action and blueprints for decisions, without engaging issues and playing with ideas in conversations with others. In my conversations with Paula Swinford, Karen Moses, and Jenny Haubenreiser, they each asked clarifying questions that serve as models for future

practice narratives in student affairs, so I will restate them here for their application to all of the work of student affairs, what Paula described as a strategic process (instead of a strategic plan):

- Do I have data that identify this issue on my campus?
- Are there tools in the literature that suggest the issue can be addressed?
- Does my profession or professional association suggest standards or best practices to guide my work on this issue?
- Does this issue affect students' ability to succeed today?
- What is the benefit of this decision or course of action?

To all of those questions in a strategic process, Paula suggested a more pragmatic question typical of under-resourced operations: If I can only do a few things, what will I choose to do well?

As Alan Glass pointed out, student affairs administrators are often coworkers (and sometimes supervisors) of health promotion departments and programs. That organizational structure obligates the student affairs professional to know about health. Even more importantly, it requires student affairs professionals to partner with health promotion in the recognition that not everything can be solved with medicine or counseling: the capacity to be free from illness is cultivated by the skillful coordination of complex, interrelated systems in multiple processes. If the most impactful health message can still be carried by the individual (or the “oneself”), then student affairs professionals need to see themselves as the health promotion “other,” and vice versa. The work of working across the disciplinary silos that Jenny Haubenreiser and Ric Underhile described needs to start at that individual level.

Finally, it is essential for student affairs practitioners and health promotion professionals to apply a paradigmatic shift to their work and understand that effective AIDS education is one and the same with comprehensive health promotion (Gould and Keeling 1992). This requires that the work operate from the understanding that information dissemination or risk reduction are both important but are not enough to promote healthy communities by themselves (Gould and Keeling 1992). Effective health promotion is also no longer the sole responsibility of the staff in the health, wellness, counseling, or related departments. Student affairs administrators (and entire campus communities) share this responsibility. However, student affairs may be uniquely poised within the horizon of the lived student experience to organize the institution effectively around policies, protocols, and programs to connect people and communities and advocate for health for all (Keeling and Engstrom 1992a). This shift into a universal advocacy perspective would also move higher education one step towards the vision of accepting health as a condition for (student) success and lifelong well-being (a vision that was similarly reflected in the narratives of Sarah Mart and Karen Moses). Another professor of public health put it this way:

...health itself is an instrumental value that gets you to something else that is more important, to an ultimate value. ...when you frame the health issue, it ought to be in the sense of the benefit and the value added that it gives to the purpose and progress of education. (Kreuter, n.d.)

### Implications for Higher Education

#### Suggestions for Re-Imagining the Teaching Reference of HIV/AIDS

The implications I describe here can apply to undergraduate education as well as graduate and professional education. The message from the participants was clear: post-secondary education needs to continue to rise to the challenge of educating not simply

lifelong learners, or global citizens, or ethical professionals, but all of the above, and then some. The purpose of higher education needs to be re-imagined to include the successful development of ethical, self-reflective adults who can improve the health of their communities as much as they elevate their own dignity. Bowers (1993:167-168) suggests revitalizing the curriculum to teach: “an awareness of continuities with the past, ...the restriction of self for the sake of others” so that oneself does not benefit at the expense of another, the interdependence of all humans and all life, the validity of multiple ways of knowing, and sensitivity towards the environment (which could also be interpreted as care for the context of the community or care for the organization around the individual). To that list, I would add continued reflection on one’s own values and beliefs (as suggested by Melissa Kenzig) and the opportunity to name one’s own fears (as suggested by Pat Fabiano).

Specific to higher education in the health professions, the advancement of medical anthropology and the expansive worldview of health promotion described in this study, combined with the growing sensitivity to the fact that patient narratives are not just a set of symptoms that can be diagnosed in 15-minute appointments, really points to the direction in cross-disciplinary collaborations. The clinical view that health promotion and health education just manage programs in lifestyle and hygiene is perhaps now as outdated as the health promotion view that medicine is of primary importance to the health of individuals and communities. The shift in medicine towards health care, nursing, and health administration is already eroding that cherished enclave of thought. Philip Alcabes, an associate professor of urban public health at the Hunter College School of Health Sciences of the City University of New York wrote:



Health officials are not pushing for social fixes that would have even more powerful effects by limiting inequalities in wealth or their health-impairing correlates. ...while changing your behavior can make an appreciable difference to *your* health, it doesn't necessarily make any difference to *society's* health... In the new public health, where behavior is scrutinized and social vulnerability replaced with victimhood, other groups become races and take their place in the hierarchy of the Worthy: Hispanics (diabetes), gays (AIDS, syphilis), and now fat people (heart disease) are inked with the mark of disease risk. Social reform, that old thing, won't help; race is imprinted in the genes. ...We have to develop curricula that face the vexatious positioning of health as a moral issue (Alcabes 2007:B6).

Together with better informed partners in student affairs, perhaps we will all manage a shift not just in thinking and teaching but also in the resources allocated to achieve these imagined futures of health, most broadly understood, including in its important ethical dimension. Instead of defining enemies in other disciplines, we can all see ourselves as the other and work to improve the professional and personal experiences of everyone.

Finally, in higher education, HIV/AIDS emerges as a teaching tool that fits into most curricula. Beyond the obvious teaching applications in biology, genetics, psychology, or communication (the courses that I recall from my undergraduate days as ones that referenced HIV/AIDS), there are far broader teaching and learning opportunities presented by the horizon of HIV/AIDS. With specific reference to the early memories that several participants shared with me, the subject of HIV/AIDS can provide new horizons in the arts, humanities, social sciences, and business curricula. Several participants recalled vivid memories that involved some performance (theater or motion picture) that personalized AIDS as a human experience and not a statistical report of worldwide epidemiology. These days, the "face" of AIDS that I see most often in the mass media are the happy and healthy faces of people surviving with an HIV-positive diagnosis and living with AIDS as a chronic condition, managed by advertised

pharmaceutical products. Although this is a worthy narrative of survival and one that may confer hope, the reality of the pandemic has been relegated again to the faceless “others” located in faraway places. Reconfiguring this message to make HIV/AIDS once again relevant to the discourse of leadership development in higher education will require curricular infusion in many more disciplines.

Jonathan Engel frames these implications in the following way:

AIDS demonstrates our own fundamental inhumanity; AIDS defines a world in which we refuse to take essential responsibility for our fellow human beings; AIDS is what happens when people refuse to care – about themselves, their lovers, their friends, their compatriots, their fellow denizens of the earth. ...But if AIDS is not moral, it is certainly political. From its onset, the disease has invited abuse and exploitation for political gain, whether from conservatives who labored to portray it as divine intervention, or from liberals who used it to illustrate the primacy of civil rights.

...Many AIDS experts have declared a vaccine the only answer. But if a vaccine is one answer, women’s education is the second. ...The West faces a conundrum. Having essentially solved its own AIDS problem, it now faces a humanitarian disaster produced largely by the countries in question. AIDS has become a uniquely third-world disaster, stemming from preindustrial social and sexual norms, in which marriage, monogamy, and sex education are deemphasized and sexual expression is valued. While the West can provide money and medicine, and perhaps some unwanted advice, it cannot change whole societies. These must change on their own, and all evidence points to the process being slow and attenuated. At best, the West can lead by example, demonstrating to the third world the advantages of gender equity, universal literacy, and mandatory education. (Engel 2006:321-322, 324-325)

While one might disagree with some of Engel’s tone or language, he is clearly making the case that AIDS, the disease, is also a mirror of our own societies, especially the faults that betray our own health. He also connects the health promotion benefits of not only money and medicine, but also of gender equity, literacy to participate as a full citizen, and access to education for all. Hiltz (2005) also points out that where HIV/AIDS is concerned it is not just the virus that is killing us, but our behavior toward each other.

The mandate for higher education in general, and student affairs specifically, is thus to teach and develop adults to live with civility in diverse communities together, with reflection and practice informing our behavior toward each other. As a teaching tool, the subject of AIDS holds tremendous promise for developing the minds and hearts and an educated citizenry that is the promise of higher education, and often the stated mission or vision of higher education institutions.

### Suggestions for Higher Education Organizations

For organizations such as those professional associations who serve any population in higher education, there are additional implications that follow from the concepts of self-reflection and leadership development discussed here and in conversations with the participants. Most professional associations depend upon a small national office, a member-elected leadership that changes after a time-limited term, and an enormous amount of volunteer leadership. In my own experience with ACHA and other professional associations, I have witnessed the kind of complacency and inertia that several participants identified. I have also witnessed that the time and space for individual conversations at professional association meetings is not provided, and has to be sought out by those individuals who are largely already networked. I can imagine (albeit with some difficulty because the enormity of achieving this change seems too far from the history of traditions in my professional associations): the great reduction in scheduled workshops and presentations and the inclusion of conversation circles for both peers and also across disciplines, in the free space that Ric Underhile identified. Perhaps a starting point for such conversations would be the question that Karen Moses asked, “How can we change the world?”

### Implications for the American College Health Association (ACHA)

In some ways I still feel like an “outsider” within ACHA, despite my meager contributions of volunteer leadership over a few short years. It is still not the professional that I would call my first and foremost “home,” unlike some of my conversation partners. But since my research interest started with this association, it is a new “home” for an entire history of traditions in constructed narratives for me now. In the previous chapter, I interwove the narratives of several conversation partners to imagine an association future that could function with efficiency in structure and boldness in vision.

The membership of ACHA and the Health Promotion section in particular, might benefit from imagining their future place within a larger evolving medical narrative. Recent publications have documented that “social mobilization” and “urgent intervention” are required for effective AIDS interventions (Epstein 2007:254). To organize these comprehensive social movements, it will be important to remember the five claims of communicative competence described by Habermas (1985). The research paradigm of critical hermeneutics demonstrates that there is great power in narratives and stories. Epstein (2007:261) identifies that positive actions “start with ideas that get people talking and they develop into social movements that change things for the better.”

Hilts (2005) illustrates examples of successful interventions such as the nationwide campaign in Botswana, a country where 40% of the adult populations was infected with HIV in 2000. The plan in Botswana was to provide drug therapy to every infected person. This medical intervention was implemented by an international team of experts working with local recruited volunteers that went out to all populations in the country and understood the social structures, physical environments, traditions, and

relationships in that country. The comprehensive plan included the medical treatment, combined with outreach and education, palliative care, job placement, monitored compliance with prescription instructions, and testing. The lesson from this program is that “patients will spend ninety-nine percent of their lives in their communities, not at a hospital or a health facility” (Hilts 2005:159).

Speaking about the economic, political, and social implications of pandemic, Julio Frenk, Dean of the Harvard School of Public Health (and former Minister of Health for Mexico and former Executive Director for Policy at the World Health Organization), applied the example of the H1N1 influenza pandemic and said: “This pandemic is clearly showing us that in health matters, the world has become a single neighborhood, and that the consequences of actions that take place far away show up, literally, at our doorsteps” (Frenk 2010:48). Although his remarks focused on H1N1 influenza, he discussed the global health agenda as one that “has moved from the exclusive domain of experts to take center stage in the most pressing global issues of our times: global security, sustainable economic development and democratic governance” (Frenk 2010:50) in a new health security perspective that must be grounded in an ethic of universal human rights (Frenk 2010). Surely, based on the narratives collected in my research, the multidimensional imperatives of HIV/AIDS on the human condition and the global community can also be highlighted in connection to a health security agenda.

Another published article that describes how we can address obesity and improve cardiac health in the United States does not simply state the traditional diagnostics of diet and exercise. The article recommends interventions in product packaging of cigarettes, financial incentives for smoking cessation programs, healthy dietary choices that can be

paid for in food stamps, reduction of salt intake, physical education in childhood achievement measures, and federally funded sidewalks and bike paths (Willett and Underwood 2010). Similarly, the United States Surgeon General's report that addressed obesity focused on critical interventions in the home, in child care, in schools, in the workplace, in health care, and in local communities to address diet, behavior, and lifestyle (U. S. Department of Health and Human Services 2010). Returning to the argument proposed in the introduction to *Grays Anatomy*, that we "only begin to know who we are once we understand what we are" (Grotta-Kurska 1974:ii) this critical hermeneutic investigation can imagine the retort that what we are is our full and complete essence of being; and if our being is what we are, then we must know who we are, but we are not acting in an ethical orientation to be both who and what we are in the future.

The understanding revealed in these medical narratives is that medicine alone does not produce success: program work because of a combination of professions such as medicine and administration, or health promotion and policymakers. Informed by its own past of changed task forces and examinations of increasing the effectiveness of its own volunteer leadership, ACHA should also remain mindful that within its own existing organizational structure are these diverse populations of different but connected professions: doctors, nurses, psychologists, social workers, pharmacists, administrators, and health promotion professionals. The question remains: what future can ACHA imagine that interconnects these communities? Also, how might ACHA follow the lead of a medical establishment that is increasingly aware of the need to manage the health not just of individual patients, but of entire communities? Moving beyond the organization as oneself, another question for ACHA is: what "other" associations that may currently

exist in silos, are possible partners in ACHA endeavors in its imagined future? These questions and no doubt countless others may be explored in genuine conversations when the space is created for discussion and discourse.

### Suggestions for Continued Research

As far-reaching as the conversations in this study may be, there are always more conversations to be had, more ideas to explore, and more possibilities to imagine. Some suggestions I propose for future research are:

1. I acknowledge that my investigations were prompted by my personal connection to the association under study and the participants I invited and worked with throughout this research process. Conversations with individuals in entirely different professional associations (or from different sections of the American College Health Association) could reveal new or convergent themes.
2. Similarly, conversations with the association members who are not yet involved with the organization (the “90%” that Karen Moses identified) would be another approach.
3. Future researchers could also scan the professional literature for the emergence of these such as human dignity or social justice and pursue a study about that organizational enhancement (whereas this study originated with what I identified as an organizational loss).
4. A critical hermeneutic examination of the narratives of medical anthropology and health ecology could open different horizons that apply to new understandings of HIV/AIDS or any other public health issue.

One story that Pat Fabiano shared with me was about her visit to a student dying of AIDS in the Stanford University hospital. I believe that the emotional impact and importance of this story deserves to be re-told here. This student wrote a poem that expressed his feeling like an astronaut who had been forgotten in orbit and all he wanted was someone to come get him and bring him back to earth. I hope future research, especially research in the critical hermeneutic paradigm, can always examine the experiences that bring people back to us.

#### Researcher's Reflections

When I began this research, I assumed that I would co-construct narratives that revealed personal political agendas for changes that occurred in a professional association. Instead the research stretched my imagination and challenged me to consider my understandings of health, human dignity, professional preparation, and individual leadership. My starting point for this research was HIV/AIDS and the topic had enough personal connection to me and my community that it sustained my energy through the course of the study. However the metaphor of HIV/AIDS as a disease pandemic that has infected all of human existence also helped keep my thinking both broad and also focused. The intersections of the personal and political, of the individual and the community, of the privilege of health and the experience of illness, always helped fuel my play of ideas. The unexpected outcome for me doing this research was that I believe the process of this hermeneutic examination of these human issues has changed me to think more critically, feel more deeply, and commit myself to a greater sense of professionalism as an educator than ever before.



Over the time of this study, I attended a performance of the play, “The Time of Your Life,” by William Saroyan (1939). The play begins with this text (which was projected onto the stage at the production I attended, casting its words onto the San Francisco set below):

In the time of your life, live – so that in the good time there shall be no ugliness or death for yourself or for any life your life touches. Seek goodness everywhere, and when it is found, bring it out of its hiding-place and let it be free and unashamed. Place in matter and in flesh the least of the values, for these are the things that hold death and must pass away. Discover in all things that which shines and is beyond corruption. Encourage virtue in whatever heart it may have been driven into secrecy and sorrow by the shame and terror of the world. Ignore the obvious, for it is unworthy of the clear eye and the kindly heart. Be the inferior of no man, nor of any man be the superior. Remember that every man is a variation of yourself. No man’s guilt is not yours, nor is any man’s innocence a thing apart. Despise evil and ungodliness, but not men of ungodliness or evil. These, understand. Have no shame in being kindly and gentle, but if the time comes in the time of your life to kill, kill and have no regret. In the time of your life, live – so that in the wondrous time you shall not add to the misery and sorrow of the world, but shall smile to the infinite delight and mystery of it.

Completing this dissertation and progressing through this entire degree program has certainly been the time of my life; sometimes feeling like it had consumed all of my time and all of my life. I hope this work has revealed goodness and encouraged virtue in the face of shame or terror. I hope this work has ignored the obvious and provided text for new fusions of horizons. I hope this work has illuminated the idea that we are all variations of each other, and therefore more connected than not. I hope this work has been kind and gentle, while promoting understanding. And I hope that when all is said and done, I will still be smiling at the delight and mystery of life.

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## **Appendix A**

### **Brief History of the American College Health Association**

The research site for this study is the professional association, the American College Health Association, or “ACHA.” This association has existed for less than 100 years and serves as a leadership and advocacy organizations for college and university health (ACHA n.d.). Individuals working in the field of college health can join this association as individual members and they represent a wide array of different professions ranging from medicine to nursing, from health promotion to business administration, from dieticians to exercise physiologists, and from mental health providers to pharmacists. Entire college or university campuses may also join as institutional members, and private companies and other organizations may join as sustaining members. The association publishes a quarterly newsletter, a bimonthly peer-reviewed academic journal, collects data and supports research in the field of college health (most notably with an ongoing nationally coordinated health assessment survey project), and provides plentiful volunteer leadership opportunities to its members (ACHA n.d.).

In the 86 years since its founding in 1920, there have been 72 presidents of the American College Health Association, and just under 78% of those presidents (56 out of 72) have been medical doctors with at least the M.D. degree. The history of the association also reveals a strong connection to medical science. Prior to World War I, most American colleges and universities lacked college health programs completely (Boynton 1971). What is generally recognized to be the first college health service was established at Amherst College in 1861 (ACHA 2006). Those campuses that were more

fully developed usually had an academic department for the study of physical education, and a physician was directing a separate college health program (Boynton 1971). During World War I and immediately after the war, the federal government launched campaigns to reduce the high incidence of venereal disease in the armed forces. This appropriation was led by a professor and Director of Hygiene at the City College of New York, Dr. Thomas A. Storey (Boynton 1971). After the war, drawing from his experience, Dr. Storey was appointed to a presidential committee on college hygiene and the American Social Hygiene Association was organized, with Dr. Storey appointed to the position of Executive Secretary to both organizations (Boynton 1971). At the same time, the number of higher education institutions that were organizing health services on their campuses was growing, and most of these programs were being directed by physicians or nurses (in the cases of smaller campuses). These doctors and nurses realized that they had no formal way of organizing and were often left attend meetings for the professional associations of physical education, athletics, social hygiene, or the general science (Boynton 1971).

In 1920, a group representing 20 colleges and universities met to create what was first named the American Student Health Association. As the appointed leadership worked to draft the association's constitution and bylaws, its membership increased the following year to 65 campuses. By the time of its ninth meeting in 1928, the new association had started to organize itself into committees that addressed different functional areas of college health and on campuses throughout the country, college health centers were starting to be housed in their own buildings (Boynton 1971; Christmas 1992). The association's annual report also stated a need to earn the support of campuses

and the public with evidence of effective interventions. Through the 1920s, the association began to develop standards for college health hygiene and in 1932 they addressed the important issue of tuberculosis in the higher education community. Regional affiliates were organized in the 1930s, and the association's news publications began to take shape (Boynton 1971). In 1937, the association voted that they no longer needed to schedule their annual meetings to coincide with those of two athletic associations. In 1939, the association voted that "Negro colleges" (Boynton 1971:274) would have to form their own organization to support their college health efforts, a decision that was reversed a few years later with the integration of Negro colleges into the American Student Health Association (Boynton 1971). Through World War II, many American colleges and universities were busy assisting with the military efforts and the association only had one general meeting in 1944 but continued its education and epidemiological monitoring work of tuberculosis (Boynton 1971). The influx of war veterans into American higher education after 1946 required the association to address new topics such as malaria and tropical diseases and married family health, so campus health centers began to collaborate with local community agencies and private-practice physicians to provide the necessary care (Boynton 1971). In 1948, the association officially changed its name to the American College Health Association so that its acronym would not be confused with the newly renamed American School Health Association (an organization for school physicians) and so that its membership would not be mistaken to be current students (Boynton 1971).

Through the early 1950s, association proceedings were mailed not only to the campus health services offices, but also to member institutions' libraries, thus centering

the work of the association in the academic life of each campus (Boynton 1971). Partly as a result of its annual conferences, the association's national reputation was growing. In 1957, the association's basic functional organization as it exists today was formulated to include sections for: administration, environmental health and safety, health education, medical service, mental health, nursing service, research, and tuberculosis control (Boynton 1971; Christmas 1992). Additional changes in the bylaws allowed for sections to be created later. Through the later 1950s, the association undertook fundraising activities to sustain their efforts and to establish a permanent national office and staff, which changed locations through the years until finally taking up residence in Maryland in 1979 (ACHA 2006). The association continued to grow through the 1960s and in 1961 it published the first *Recommended Standards and Practices for a College Health Program* (Boynton 1971). The *Journal of the American College Health Association* was drafted into its current form in 1962, and the association also developed working partnerships with the Peace Corps to establish their medical standards. Through the 1960s, the association's focus on public health issues affecting college students led to initiatives in alcoholism, accidental injuries, and smoking (Boynton 1971).

The current organization structure of ACHA was most recently adopted in 1987 (Christmas 1992). The association changed from its 1970s structure into a much more streamlined one with leadership identified in a Board of Directors, made up of elected representatives from each of its geographic regions (Christmas 1992). In 1984, ACHA established its AIDS Task Force, and two years later it received its first HIV-related cooperative agreement from the CDC. In 1994, the association established its own non-profit fundraising foundation and adopted its first strategic plan by 1995, later revised in

1999 (ACHA 2006). In 2004, a new section for advanced practice clinicians was created, and by 2005, ACHA's membership had grown to include more than 2,600 individuals, 925 institutions, and 17 other organizations (ACHA 2006).

## **Appendix B**

### **Letter of Invitation and Research Questions**

Date

Participant's Name and Title  
Company or Organization  
Address

Dear Mr./Ms./Dr.:

Thank you for agreeing to participate in an exploration of my dissertation topic. As we discussed, my study examines the organizational evolution of the American College Health Association in response to, and continuing during the AIDS pandemic. It is my intention that this research will reflect critical issues and will propose subsequent policy recommendations for the American College Health Association and for health in American higher education.

Your participation in this research is contingent upon your signing a consent form, a copy of which you will keep. By signing, you will be granting me permission to audio record and transcribe our conversation(s). In this way, our conversation(s) will provide data for the analysis of the subject I have described. Once transcribed, I will provide you with a copy of our conversation for your review, comments, and editing. You may add to or delete any section of the conversation at that time. Once I have received your approval of the transcript, I will proceed with the work of analyzing our conversation. Your name and affiliation, the data you contribute, and the date of our conversation will not be held confidential.

While the conversations and transcripts in this research are collaborative, the writing that comes from them will be my product, and may include some of your editing. You therefore consent to forgo anonymity under these conditions. You acknowledge that you have been given complete and clear information about this research, and it is your option to make the decision at the outset about whether to participate or not, and can withdraw at any time without any adverse consequences.

Below you will find a series of proposed questions. These questions are intended as guidelines to direct our conversation(s). I would like to emphasize that I am seeking stories that reflect your personal history and experience with the topic at hand. My hope is that our conversation will provide an opportunity for us both to reach new understandings.

Reflecting upon your experience with the American College Health Association, the AIDS pandemic, and American higher education, please consider the following research questions:

- What are your earliest memories of AIDS?
- What has been your experience with the American College Health Association?
- How have responses to AIDS developed and changed over the course of the pandemic?
- How do you define “health?”
- What role does fear have in the AIDS pandemic? What role does fear have in an organization?
- What do you think is the future for American college health in higher education?
- What gives an organization legitimacy?
- What implications do you suggest for any campus working on “health?”

Thank you again for your willingness to participate. I look forward to our conversation(s).

Sincerely,

Mr. Ray Quirolgico  
Doctoral Student  
University of San Francisco  
School of Education  
Organization and Leadership



**Appendix C**  
**Letter of Confirmation**

Date

Participant's Name and Title  
Company or Organization  
Address

Dear Mr./Ms./Dr.:

Thank you very much for allowing me the opportunity to have a conversation with you about your experiences and reflections on the AIDS pandemic and on health in American higher education. I am confirming our meeting on [day, date, time]. Please let me know if something requires you to change our arranged date, time, or place.

With your permission, I will audio record our conversation, transcribe the recording into a written text, and submit it to you for review. After you have reviewed the text, I would like to discuss our conversation again and include any follow-up thoughts and comments you might have. Please know that the data for this research are not confidential.

The exchange of ideas in conversation is the format for participatory research. This process encourages you to comment upon, add to, or delete portions of the transcript. In addition, this process allows you to reflect upon our conversation(s). Only after you have approved the transcript will I proceed to analyze the text of our conversation.

Again, thank you for your willingness to participate. I look forward to our conversation(s).

Sincerely,

Mr. Ray Quirolgico  
Doctoral Student  
University of San Francisco  
School of Education  
Organization and Leadership





**Appendix D**  
**Thank You and Follow-Up Letter**

Date

Participant's Name and Title  
Company or Organization  
Address

Dear Mr./Ms./Dr.:

Thank you for taking the time to meet with me on [day, date, time]. I appreciate your willingness to participate in my research. I believe our conversation will be valuable to my dissertation.

I have attached a copy of our transcribed conversation for your review and approval. The transcript, once reviewed and approved by you, will provide the basis for my data analysis. As we have discussed, data from this research are not confidential.

Please review the attached transcript and add changes or clarifying comments you deem appropriate.

Again, thank you for your generous participation.

Sincerely,

Mr. Ray Quirolgico  
Doctoral Student  
University of San Francisco  
School of Education  
Organization and Leadership



## **Appendix E**

### **Journal Excerpts**

September 15, 2004

Thinking of topics that I feel passion for: enough to sustain a year or two of research and writing: health and higher education. Use experiences with NASPA Project to build a topic.

October 18, 2004

Too much research in health education and behavior change: nothing new. Maybe efficacy of existing interventions?

January 4, 2005

Use the framework of a viral/epidemiological life cycle as the structure for telling a story?

March 12, 2005

Talked with Rich today about dissertation topic ideas. Brainstormed HIV and AIDS issues like fear, perception, panic, oppression, and access (to health care). He mentioned some of the early ACHA task forces (one on HIV and one on human dignity: both got disbanded when the organization grew fearful of being called a “gay group”). Use this (i.e., college health) as a model for public health?

April 3, 2005

Need to be careful of scope of topic: have to find something manageable and not too large or else it will never get done!

May 12, 2006

Legitimation of Power class project: NAMES Project as a grassroots effort with large scale, lasting cultural effect. What’s the connection to a larger social fabric?

August 2, 2006

Talked with Sarah this afternoon about possible topics. We discussed some kind of retrospective: what have we learned in 25 years of the AIDS epidemic? I like it, but I need to put it into context.

October 21, 2006

Looked back at journal entries from this summer and what feels most alive to me is some kind of work on college health, social justice, and HIV/AIDS.

October 30, 2006

Preparing for interview with Rich. Possible conversation starters:

What do you remember about the “dawn” of AIDS?

What was college health/ACHA like back then?

What is it like now? Why?

What future do you imagine for college health? ...for AIDS?  
What were you researching/studying/reading about when you were first aware of AIDS? (Look for an arts context.)

January 19, 2007

Pilot study needs major revisions. I just figured it out in Guim's class: I need to narrate a story, not just report the facts/findings/conclusions. Need to play with conversations more (don't stick to a script but interpret and re-interpret while it's happening). Another possible conversation starter:

Once upon a time there was an organization known as ACHA, and it...

February 12, 2007

Try to connect the more broad-based thinking of public health as "everything" to the expansive hermeneutic view of health: oneself as other, etc. Play with this as an educational implication for preparing students to lead in a global community. Propose an ethic of health or an ethic of care? – Public health as social justice.

March 2, 2007

From Intersession class: work with people who don't all think alike. Possible "outlier" conversation partners: Katrina or Patricia --- ask for reflections on insights so far. (Alison or Free? --- Might be too removed from higher education or policy implications.) Might have to go back and ask Rich for possible follow-up leads. Use these "outside" perspectives to draw out what is the "same" and what is "different."

April 1, 2007

Play with themes:

- Fear
- Perception
- Isolation
- Panic
- Oppression: especially naming the "other" people affected
- Access
- Dignity
- Social fabric (NAMES Project?)

May 14, 2007

Annette Benning in conversation with Steven Winn at the American Conservatory Theater in San Francisco, CA:

"You don't need to worry about the next 10 years or the next 5 years; you just have to do the next chunk, the next choice."

"Learn to have a life while you're living it."

May 18, 2007

William Saroyan's "In The Time Of Your Life" – closing framework?

June 11, 2007

Possible (personal) narrative thread: Once upon a time there was a sidewalk vendor who sold pretzels and lemonade on Main Street...

Who was he? How was he connected? How many lives had he touched?

August 3, 2007

Conversation with Katrina Rodriguez: re-conceive health as privilege.

August 7, 2007

Pat Fabiano's e-mail signature line: "When there is no vision, the people perish."

September 9, 2007

Informal conversation with Gabe Olszewski: In higher education, we don't have any more conversations. If we know things don't work, why don't we try to do something about it instead of wasting time quantifying and qualifying the issue to death?

August 5, 2008

The question is not how we discuss HIV/AIDS, but why: what is the relevance?

January 4, 2009

Acknowledgements

- Family
- Friends
- Conversation Partners: one attribute from each
- USF Colleagues
- Committee

June 1, 2009

Cleve Jones speaking at the Commonwealth Club in San Francisco, CA:

"We should question the pessimistic forecasts of our future."

"There is no such thing as a fraction of equality: you're equal, or you're not. There is no subjectivity or compromise about it."

"So many people are entrenched in the old strategy that they can't think in any other way."

"Our struggle with AIDS informs everything else: caring for a dying person makes you "family" and makes it real."

"We must make a single overarching demand for full equality."

When I asked, "What are you most proud of?" he responded: "In most cases it was other people who did the work. I'm proud of enduring. I'm proud of my friends, proud of the young people I meet every day, proud to still be here. I'm really lucky."

Connect this to Pat Fabiano's conversation.

July 4, 2009

Metaphor of HIV: infection, adaptation, hiding/lurking.

October 1, 2009

Re-reading transcripts: shouldn't health be about lifting up the most disadvantaged and the most disenfranchised?

Christmas 2009

Make the dissertation presentation personal. How personal?

Personal journey: connection to the issue by way of identifying with a community; learning about (and distancing from) all other affected communities; trying to teach about the universality of the pandemic.

## **Appendix F Pilot Study and Transcription**

The following pilot study conversation was conducted with Rich Keeling, M.D. on October 30, 2006, with a follow-up exchange of additional ideas conducted via electronic mail correspondence after inviting him to check the transcript for accuracy. (My words are printed here in boldface and his words are in plain text.) The pilot study allowed me to test some of my research questions and play with the process of constructing a narrative based on new understandings that developed as a result of the conversation.

So tell me about this paper, and it's part of your dissertation, right?

**My working title of my dissertation is "Re-Imagining American College Health as Social Justice." That's just an early draft; it will probably change and evolve over time. This project is the pilot study, if you will, that will become the proposal next semester and then the big thing after that.**

Re-Imagining college health as social justice? I'm just making a few notes here too.

**What I'm looking at is how ACHA has changed in the last 25 years from the basic biomedical health education to the recent thinking of the Health Promotion section that includes standards defining health as a social justice issue (like if anyone in the world is unhealthy, then ultimately I am unhealthy). I'm curious about how the entire profession or professional association has changed over time. The Standards statement seems to cover so much more than just college health and it's so radically different than even what I knew of ACHA when I was first introduced to the association a few years ago. The "imagination" part of the title comes from critical hermeneutics: in the class I am taking now (and this is the final project for it) we are studying the presupposition that an orientation to an imagined future is a powerful part of how we represent our past in the present. I'm thinking of having conversations with different folks from ACHA to talk about how they have been involved with all this.**

Okay, that sounds great. How do you want to start?

**Well, I'd like to know about how you got started with this. What do you remember about the start of "dawn" of AIDS? What are your earliest memories of AIDS?**

Wow. What I remember is related to a patient actually. I was in 1982 running the health center at UVA. We still had the old health center. As you remember, the health center at UVA took care of students in the professional schools and graduate schools as well as the undergraduate schools. I was asked by one of the other physicians (I still remember who that was, a physician named Barbara Berk, M.D., to see a patient she had seen the week before). She had seen a law student named Michael who had come to her with a cough and fever and she thought he had bronchitis. She had actually X-rayed his chest and he had some fluffy stuff in his X-ray, but she was uncertain what to do because he hadn't gotten better in a week and she had treated him with typical broad-spectrum antibiotics. She asked me to see him. I saw him, and he was quite ill. He was sick from his cough, but he was also feverish, he didn't look well, and he kept talking about being, not so much short of breath, but not having as much below his usual reserve capacity. I worried about that. I changed his antibiotics. He was only 23 or 24, whatever a typical law student is. I remember going home that night with him on my mind, thinking there was something weird about this, wondering if I had missed something because it was unusual. And he was back, literally, the next day. And he was worse. So I admitted him to the hospital. People who saw him at the hospital called me later and said he was really very ill and asked me to come over. They said we don't know what this is, you don't know what this is, but it's serious. Make a long story short, he ended up having a biopsy done that night and he was diagnosed with pneumocystis pneumonia. And we could not figure out why a 22-year old/23-year old law student had pneumocystis pneumonia. And that set us off on a search for any other documented cases of young people with pneumocystis pneumonia, which eventually turned up the CDC case reports of clusters of young gay men in Los Angeles and San Francisco turning up with pneumocystis pneumonia. This young man was obviously in Charlottesville, Virginia and that led us back into a series of questions into how he was connected with San Francisco, or Los Angeles and if he was gay. And we learned he was gay, he was actually from Los Angeles, went to school at San Jose State, had friends in San Francisco, and you can see where that led to from there. He was the first person recognized with clinical AIDS in the state of Virginia.

**The first person in the whole state? What year was that again?**

Yeah, the first. This was sometime early '82. In the fall of '82 (he had had a rocky spring and summer), dropped out of school for a while and then died in the fall of '82 at the UVA hospital of pneumocystis. That set me on a clinically motivated, primarily clinically motivated look to see what the heck this was. By then there were other cases being reported in other places, by then the CDC had begun calling it GRID, you know: Gay-Related Immune Deficiency, public health departments had begun to make it reportable, there was a lot of regulatory activity related to it, and a little bit of clinical activity with people mostly saying they didn't know what to do. But, most of the research that clarified the cause and origin of all that had not yet been done. So all we knew was that this guy had, what was that called? G.R.I.D.?, and he died and his partner got sick shortly thereafter at that time also.

**Is your motivation still clinical these days?**

No; by the early 1990s, I had come to believe that the way I could best contribute to solutions to HIV/AIDS was through prevention, not by treatment; this "fit" with my usual and customary preference for "systems" interventions. I still cared for patients with HIV/AIDS until I moved to New York in 1999, though.

**Was his partner also at UVA?**

Partner was also at UVA, a law student, yes. And I remember, I'm pretty sure this was late fall in 1982 or early 1983, being asked for the very first time ever, to come to a meeting of the "10% Society" at UVA, or the, I'm not sure that was the right name, but the gay and lesbian association at UVA and answer questions about what they began to regard as a serious threat. And at that time I remember sitting in this little meeting over in the old Westley Foundation, over in the Dell, across from Newcomb Hall? Sat in a room with, I don't know, maybe 20 people who were, frankly, terrified. I didn't have much that would help them and I decided after that experience that I needed to know more about transmission, and that's how I got interested in the science of it and as '83 went on, I eventually went to a couple of conferences in the summer of '83 that focused on HIV and special briefings of the state medical bureau society and things like that. So that by the end of 1983 or '84, I knew a lot about HIV and AIDS. I had seen a few other patients by then. Most of them were not UVA students. And in April of 1984, I gave my first talk at a convention that I ever did about AIDS, and that was at the American Council on Education's meeting which was either December of '83 or January '84, I can't remember, but anyway early/mid 80s, which is significant because that was the first big conference presentation about AIDS in higher education. And from there, in '85, I got appointed chair of the task force on AIDS for ACHA and that led to 5 years or 6 years worth of work that the task force did which really set the standard for how higher education would respond to AIDS. That's how I got into it.

**So within a year or so of your encounter with the very first patient with AIDS in Virginia, it seems like things happened quickly in the medical world and what was GRID was now AIDS. Do you recall how you felt about the speed of the research that identified the virus and the disease and all that? Do you think everything about AIDS has happened with that fast pace in the 25 years or so of the pandemic?**

If anything, it felt slow to me; I was impatient to know what caused this illness, what the nature and characteristics of the virus were, how the virus behaved and might be attacked through pharmaceuticals, and what we should tell people who were infected. The fast pace of the late 1980s primarily accomplished descriptions of the disease and virus; in the 1990s, there was a similarly fast pace in developing pharmaceuticals to treat HIV infection or its infectious complications. Since the 1990s the pace has slowed in all areas.

**So, that first talk in '83 or '84 was for ACE. Had you previously been involved with ACE and ACHA?**



No. I was a member of ACHA and had been to a couple of meetings somewhere around there, about that same time, of the Mid-Atlantic College Health group, which was the regional affiliate of ACHA. They had created a task force on AIDS, and I got appointed to that and that task force had met, I don't know, maybe 4 or 5 times but it really didn't have much of a mandate and it, like many regional task forces, was made up of people who were awfully busy, and it was hard to find time to come together, so there was a lot that did not happen. But it was my connection with that task force that got me up in the mind of ACE because somebody from ACE trying to find a speaker about AIDS to put up on the program of their annual meeting, which I remember was in Miami, actually called (I'm pretty sure now it was January of '84), they called ACHA. And said we need a speaker who knows something about HIV and AIDS, and they said, well the only person we know is this guy Keeling at UVA. And so they called me, flew me down there, and that began a very good and multi-year collaboration with ACE. I did a number of things for them after that. They introduced me to someone at the Association of Governing Boards who had me write a couple of booklets for them about what governing board members needed to know about HIV in terms of primarily policy questions.

**What would be your policy-related recommendations now, if you could rewrite those booklets?**

I wouldn't change anything, believe it or not. We recommended that institutions provide humane and caring services, avoid discrimination, seek opportunities for effective prevention, and provide students with HIV/AIDS every possible chance at completing their academic work. I'd still say all of that today.

**Can I go back to that first meeting of the society at UVA?**

Sure.

**The twenty or so people who you said were looking for answers to questions and they were terrified, did they all know the two young men who died?**

No. I'm not sure any of them did. The two law students who died, as far as I know, they never disclosed to others what had happened to them; just that they dropped out of school.

**How do you think those 20 people started to feel this sense of terror?**

They had seen press coverage. Things like, I don't remember if Rock Hudson's death had occurred by then or not, I can't remember what year he died, but he may have died in '83 or '84. By then, there had been significant public attention to deaths of young gay men with AIDS. It was particularly associated back then with San Francisco and New York, and Los Angeles had kind of fallen out of it for a while, but UVA had many students who came from New York and Long Island. They had heard about AIDS up north, but I don't think there had been any attention to AIDS in the Charlottesville newspaper at all and I don't think the public health people in Virginia had done at that

point anything about AIDS either. So I think most of their knowledge, most of their fear, was based on media reports about people in other cities.

**So even from the time that Barbara had asked you to see this patient, some time in '82, in two years or less, then there was some kind of huge media blitz on this.**

Oh yeah.

**So it actually didn't take very long for the press coverage to escalate to the general knowledge, even if it was misinformed or terror-based.**

No. And in fact, it was very much fed by media accounts which were quite terror-based. The impression you got from most of the news magazines, remember this was before the Internet, what most people got was primarily from newsmagazines and television news. And it was all really terrifying. I mean, I remember there were cover stories in *Time* and *Newsweek* back then with really frightening photographs of people dying of AIDS.

**I remember that. I remember seeing lots of photos and colored images of electron micrographs of white blood cells and red blood cells and reading about people not knowing what was happening.**

Absolutely.

**Now, the work with the regional task force. Was that with other directors of health centers?**

They were all people from other health centers; they weren't all directors. I remember there was one physician from the University of Pennsylvania, and there was a health educator, Annie Lomax, from the University of Delaware, and me, and a guy named Jeff Gould, a graduate student who worked for Annie at the University of Delaware health center, and then there was a nurse from University of Maryland – Baltimore County. I don't remember her, but I remember she was there. And there were just 5 of us. We met at Delaware once, and UMBC once, at Penn once, and then at Virginia once.

**Did any of those other four have experience with actually clinically diagnosed patients?**

No.

**Oh, so they were also responding to what was in the medical literature at the time plus what was in the general public media and press. And you were the only one with direct experience with a patient.**

Yeah. And I think that had a lot to do with why I kept getting put center on these things. People felt that I was grounded by the fact of having actually provided, or having cared for someone. And most college health people still have not done that in 2006.

**Did AIDS ever terrify you? How did news of Rock Hudson affect you?**

I was worried (not terrified, though), especially before the value of universal precautions against transmission of HIV in health care settings was proven. The news of Rock Hudson's illness and death filled me with questions; I wondered how his life had been, where and how he had been himself, how awful it must have been to die mostly alone.

**You amended a statement above. First you said that their knowledge (those 20 students you met with) was based on the media reports, and then you said it was their fear. When educators talk about oppression (at least in my world), they say that students fear what they do not know, what they are ignorant about. Do you think someone can have knowledge and still be fearful? Is it fear of another kind of unknown?**

I think you can fear what you don't know, and you can fear what you aren't sure you can control -- such as your own risk.

**How is the media these days handling AIDS?**

It's handled as an ordinary health reporting matter, mostly, except when occasional government reports or actions focus attention on some aspect of it, such as the threat to the security of African nations.

**So thinking back to '82, '83, '84, what was college health like back then, in general?**

It was an interesting time in college health. There was a significant revolution occurring at the time, primarily related to governance and demographics. ACHA up to then had been modeled after the American Medical Association, and had a governance structure that had, without going into too much detail, suffice to say, it had a governance structure that looked exactly like the AMA. Part of that was done originally when ACHA was founded to give it legitimacy, you know: "Look, we're just like AMA." And part of it was just the way that physician-members of big organizations tend to do things. They tend to do things in a complex, bureaucratic way, and that happened in ACHA. Now the revolution was, even though for years and years and years, since it was founded in 1920, by 1980, there had never been a non-physician president of ACHA. Everybody had been a doctor, first of all. And second, there had been very few women who had been presidents of ACHA. Around 1980, '82, '83, there had been a revolution in the demographics of the association in the disciplinary mix of the association and in the governance, and women had been elected to leadership positions starting in the late 70s/early 80s, and there were fewer physicians represented and more nurses, nurse practitioners represented in the organization. And about the same time, they did this enormous revision of the governance structure that required constitutional amendments and bylaws votes by the membership, and all that, which had significantly changed the structure of the association so that it did not look like the AMA and instead it looked

tremendously more agile and flexible. All of that was happening at the same time that HIV and AIDS was going on. Most people thought those things taken together, that is the work we were doing in HIV and AIDS plus those changes in the association were, the phrase you often heard was, “putting ACHA on the map.” ACHA had been regarded as a kind of sleepy, second-line association in higher education, but that with the big issue of AIDS to focus on and with leadership on that issue that was unquestionable and a shift in the tone of the organization away from the stuffiness of the AMA model, that ACHA was finally waking up, coming into its own. So, especially up until the late 80s, that whole period from ‘82/’83 up until ‘88/’89 was a period of great ascendancy for ACHA. They grew lots of new members, they had lots of schools join, they had a very active Board of Directors, they made a tremendous amount of money on the sale of materials, which were primarily AIDS-related prevention materials: pamphlets, videos, things like that, that were focused on HIV Prevention. The association became extremely strong, set up a foundation by the end of the 80s, and really identified itself with leadership, as opposed to just representation. The other interesting change happening around then was the beginning of a focus on human dignity as a concern in a health organization. The woman who was president of the association after me, the woman who succeeded me, Barbara Driscoll, was the head of the health center at Wooster, created a task force on human dignity, which I think was the first structural way that ACHA recognized the importance of dealing with social justice questions in the association. That task force was responsible and the piece that is connected to the HIV/AIDS work is that one of the things that became very clear in the AIDS work by the mid-80s (‘86/’87) was that the major concerns about HIV were not microbiological, and not entirely clinical in college health; they had to do with human rights, relationships among people, and social justice concerns in general. That link had been made by the HIV/AIDS task force that I chaired and then Barbara took it further by naming it as the Task Force on Human Dignity. So we continued to have the AIDS Task Force, but then there was this task force on human dignity and her presidency (which would have been ’89-’90) was focused entirely on social justice.

**You have at least two Barbaras in your life that are significant in this story already.**

Exactly.

**What was the connection between the two task forces: HIV/AIDS and Human Dignity? Were there members on both?**

Yeah, there was significant overlap. There were, I can’t remember... The AIDS Task Force was very large and at one point we got to be 18 or 20 people and it was the only task force in a professional association I have ever seen where there were people applying to be on it and being turned down because there just were not enough spots; we were just too many. It was regarded as a very productive group, and it was. It produced that whole book, that ACHA produced, the “yellow book” back in ’89-’90 that recommended standards for institutions’ response to AIDS, it produced 7 or 8 brochures, a couple of videotapes, the policy statements, it had two big CDC-funded research studies, it was the center for the CDC grants on teacher education for prevention in schools. So there was a

lot going on and the task force was established really to manage all that. The Human Dignity Task Force on the other hand, did not have the mandate to produce products. It was more supposed to influence the tone of the organization and what it was trying to do.

**I want to go back now. You said ACHA was founded in the 1920s?**

I think it was founded in 1920.

**So from 1920, so for 60 years, it really had no public platform, it wasn't recognized for anything, it wasn't until AIDS?**

Yeah, if you look back, we actually looked into this back in the period of the task force because we looked for past examples of other instances when the association had spoken out publicly on a topic, and there were none. It had been purely a trade association, sort of a professional organization for primarily doctors who worked in college health centers.

**What do you think was the shift that led to people applying to be on the AIDS Task Force and then being turned away just a few years after this predominant sense of fear?**

In the initial year or two of the task force, which would have been '85 or '86, it wasn't so easy to get people to serve on the task force. People were concerned about the issue, they saw it as an important issue in higher education, but people actually feared what would happen to them in terms of reputation, especially for men. We had no trouble getting women but the few men I approached to work on it were reluctant because they thought working on a task force dealing with AIDS would label them as gay. I had several who, frankly are still around in the field of college health today, turned us down because they were afraid that would happen.

**Were they afraid of being labeled "gay" or labeled "HIV-positive?"**

Being labeled as gay.

**I'm assuming then that was one of factors that led to the conclusion that this was more than just a clinical diagnosis problem.**

Absolutely. And the formulation of HIV in the association, and I had a lot to do with it, the formulation was as June Osborn famously said, "multidisciplinary trouble." It was, if you approached it simply as an STD, you missed the boat. That formulation became persuasive and there was still some reluctance up until the late 80s among some people in college health who thought of HIV as a moral issue and who felt that the association was overstepping or putting too much of its time and effort into this, which was primarily a, as people would say, a "behavioral anomaly" and if people would just behave more right and rationally they wouldn't have HIV and AIDS so why was ACHA putting all this time and effort into it? So we spent a lot of time confronting that kind of stuff and since we were working on those kinds of issues and this was also at the time when the women's

movement and feminism had begun to explore women's sexuality as a response to the topic, so it came at the confluence of a lot of these liberating messages, but also during the presidency of Ronald Reagan, so there was a sense of something to fight against. There was a sense that we had this repressive presidential administration, that people who cared about young people would have to challenge the Reagan administration, the whole speak-truth-to-power thing came up back then. So really the HIV work in ACHA rode the tide of feminism, of confrontation of power, of sexuality liberation, of a stronger view of gay rights, of a sense of the need to include people, of compassion, of the development of a more empathic approach related to understanding human behavior problems, plus it also joined with the emergence of health education as a serious field within college health. And so with HIV and AIDS, if you couldn't do anything with that clinically, then the power came in health education, because all you could do was prevent it. So health educators who had previously been pretty marginalized with HIV/AIDS came front and center. And it was seen again as something that made the association a lot of money and brought a great deal of positive prominence. So for about 4 or 5 years, say '85-'86 all the way up to '90-'91, HIV was really the bread and butter of the American College Health Association.

### **Do you think people remember that now?**

People who are still around probably do, and they certainly in the Health Education section of ACHA, the legacy of that is certainly clear. That was the time in which health educators began to have power, recognition, and status in the organization and I think they know that's when it started. But on the other hand, after '91, there was a very strong reaction against HIV in ACHA. I think it was '91 or '92, that there was a change in the tenor of discussions on the Board, and there was a change in presidential leadership, a change in board members, and you began to hear a phrase "one-issue organization." People had various interpretations of this, but there was one strong view that this was a homophobic reaction that people in the association wanted to take back the organization because it got too liberal and too inclusive, and too "leftish," and too gay. And another view was that the HIV group, as it was often called, had become too powerful and had become too famous, and we had sort of gotten too big for our britches. Thirdly, there was a feeling that HIV and AIDS were marginal issues that didn't affect that many college students so why was the association spending so much time and money on it? And all these things came together around '91/'92, about the time I was leaving UVA, and by the time I left UVA, the HIV Task Force had begun to go into decline. I don't think there were any new products, any major conferences, after '92. Around '92 we released another paper that had to do with recognition and treatment of AIDS in college health centers in a clinical focus. After that, ACHA really softened its approach to AIDS a lot and in that set of transition, some individuals got badly damaged. I got beat up some back then. But I stayed with the organization. I kept going to meetings, I was editor of the journal, or I guess I was consulting editor to the journal at that time, but I continued my engagement with ACHA even though they pretty much pulled back from the HIV stuff. But [Wm.] David Burns who had allied himself with the AIDS Task Force and the Human Dignity efforts under Driscoll got thrown out, basically. He was Vice President and Vice Presidents were almost routinely elected Presidents and he was not. There was

a strong reaction against David Burns, back in '92, and people felt that he was just going to continue the “gay agenda” – they started to use that phrase, gay agenda, at ACHA. At about the same time, the organization had founded a, a little earlier, a task force, or a caucus or coalition of gay and lesbian people, and that had flourished around '90/'91 and it had to kind of go underground for a few years, '92, '93, '94, because of this shift in the tide, but then it re-established itself and I think it's still going strong now. The Human Dignity Task Force was abolished back then, the HIV Task Force lasted until, I guess, '95, '96 maybe, and then it was merged with another task force on STDs, which is a very interesting development: the fact that they merged those two groups shows the change in the organization that AIDS had become just an STD.

**For me, that means that HIV became just another biological phenomenon.**

That's correct. And when that happened, the focus of broader thinking about AIDS and HIV left ACHA completely and went to other organizations like NASPA a little bit, pre-dating the campus ecology work which started in '97/'98. That picked it up. The project on AIDS in higher education, David Burns's project in AAC&U, picked it up. There was a little project at NAFEO and another little project at ACTE, the Association of College and Teacher Education. Interestingly enough, the leadership for HIV/AIDS and higher education in ACHA passed away 10 years ago, even though it was ACHA that established it, largely for reasons within ACHA. The other trends that happened about the same time were the attempted take-back of the association by physicians. Even though physicians had not been presidents of ACHA much through the 90s, for the past 5 or 6 years, they have been physicians again. So physicians reasserted their dominance or prominence in ACHA, they reasserted control. The idea of ACHA as being a kind of all-on-the-same-footing resource for anyone from a health center pretty much went away in the 90s. Having said all that, regardless of the fact that the tone changed and the focus changed, two or three things were preserved through all this. One is that the little caucus, whatever it is, this grouping of LGBT people has survived. Second, we had established an award called the Miguel Garcia-Tunon Award on Human Dignity, which was actually funded by David Burns and me through donations to ACHA. That award, which was named in memory of an ACHA staff member who died, he was a UVA student actually, he had been a patient of mine, and then worked for ACHA later in the 80s running the seroprevalence study. Anyway, he died in '89, and in response to his death and in honor of his contributions, Burns and I gave money to ACHA to establish this award and that award still survives. They don't give it every year, but they give it most years. And then third, this kind of statement that you're talking about earlier which speaks about the global consciousness of the health of all survives in the Standards. So some of the legacy of the work done in the mid- to late-80s and early 90s is still around, even though the organization doesn't feel that way anymore.

**Is that award on human dignity funded by the foundation now?**

It's funded by the foundation but it's given by the association itself.

**You said there are remnants of the work done in the 80s and 90s even though the association doesn't feel like that anymore.**

The association no longer feels, the feeling of ACHA meaning...it feels pretty clinical pretty managerial. It doesn't have the thrust or tone of social justice or human dignity, it doesn't have the tone of wanting to make its mark on the national stage, it doesn't have the leadership tone that it did in the 80s and 90s. But many of the things put together from the 80s and 90s still survive, even though there isn't much evidence that ACHA is going to do any more with those things, but on the other hand they have not dismantled all the ones that were developed completely.

**So what do you think is in the future for college health?**

I think that's a really interesting question. The big question that college health in general will have to answer that has to do with everything we've talked about is, "What will college health mean in the future?" There was a time when what it meant was a clinic on campus or a place where students who were sick could get put back together again so they could go to classes. And in the late 70s through the early 90s, there was a very different view of college health that was enunciated, which said college health is not just about treating sick students; it's about preserving learning capacity, and it's about health in the broadest sense, the same analysis that the campus ecology group would have said. So it's about understanding all the determinants of health and then responding to those equally and many of the determinants of health are not clinical. So this new definition of health was responsible for bringing into ACHA a new bigger group of people who were not doctors or even nurses many times: so lots of health educators and social workers began joining ACHA.

**And pharmacologists and psychologists and family therapists...**

Right. So what has happened more recently is a return to a more limited vision where it's primarily clinical and managerial. So the question as you look into the future is, "What will college health be 10 years from now?" And there are two completely different predictions about that. The negative prediction, and this you'll hear this from Paula [Swinford] if you talk with Paula, is that it's going to split: that everything we think of as prevention, social justice, positive social change, support for students as learners, all of that is going to leave ACHA, move to NASPA or ACPA or both, become part of what we think of as student development, and that everything we thought of as the clinical work of college health is going to remain in ACHA until more institutions decide that they don't need to run their own health clinics anyway: in places where there are private medical facilities across the street or down the road, those institutions will just stop operating health centers, or offer just very minimal health centers or triage and referral places, because health centers are expensive. And I think Paula would probably be the most outspoken advocate of that view. The alternate view is that this continual struggle for balance for power and focus will just continue, and that we will go through another phase sometime soon: another phase of ascendancy, of social justice, of a focus on prevention, and a non-clinical approach to college health and that 5 or 8 years later, there will be



another phase after that. In other words, we may just see another swing of the pendulum. And that whatever the issue is will carry over time, but that more or less we will just continue the way it is. There are arguments that favor either one of those views, and there are probably other interpretations. My own view is that Paula is probably closer to “right.” I think her vision is a little more Armageddon-ish than what will actually happen: I don’t think you’re going to see wholesale closures of health centers. But I do think you’re going to see this split where the non-clinical parts of college health are going to go to other organizations. That is happening; you can already see that happening, and I think that will happen more in the future.

**Does Paula have a counterpart in the other view? Who tends to be the more vocal person of the “we’ll just ride it out” feeling and then we’ll swing back in 6 years or so?**

You know Ric Underhile? I think Ric takes a more balanced view than Paula, although I’m not sure it’s an advocacy thing on his part. Ric takes the view that yeah, there are going to be some changes and probably some health centers are going to get split up or will close, and there will certainly be this association membership shift that we talked about, but mostly college health is just going to go along the way it is, and ACHA will go on. And I’m sure he would be happy to talk with you too if you wanted to chat with him.

**You mentioned this balance of power will either split or swing back like a pendulum. And I find that interesting because both of those are concepts in complexity science, and we’ve talked about my interest in that as well. There are pendulum attractors and some fractals just die because death is part of a natural living system anyway.**

If you stood outside college health and looked at it from another association’s point of view or from medicine’s point of view, what they would have said about it back in 1980 is that it was either unknown or irrelevant. Accordingly, ACHA has never been a member of the Secretariat of Washington higher education associations because the other organizations have never regarded ACHA as needing a place at the table. They’ve always regarded ACHA as a subsidiary student personnel association, like NACADA or college unions. If you had asked that question in 1990, everyone would have heard of ACHA: the CDC had ACHA representative on almost every task force, college health people were being brought in on television and newspaper stories talking about common issues in young adult, suicide for example, eating disorders was another one. There were college health people on every one of those representational groups. And then if you look at 2000-2002, it’s back to the way it was in 1980: a lot of people haven’t heard of ACHA, ACHA is no longer asked to be represented on task forces and things, ACHA is no longer the go-to group for media comments on young adult issues. If you read any of the stories in *The New Yorker*, *The New York Times*, *Harper’s*, *The Atlantic Monthly*, about youth suicide for example, they never quote anyone representing ACHA; they go to individual universities and quote a psychiatrist in this or that place. There’s no longer a sense that ACHA represents the best in thinking in the field.

**Thanks you've given me a lot to start with!**

I've probably said more than you wanted.

**No, no, I've set up all my notes pages and you actually answered some of the other questions that I prepared to ask you, but this is all good stuff. I get a sense of organizational evolution, and you've touched on some of the external and internal factors, so I've got a lot to comb through.**

Fabulous. And I want to add that I would be happy to do this, or some portion of this again.

**Thanks. I think I told you that this pilot study will get developed into the proposal and then the dissertation, so I would love more conversations with you and now actually some of the people you named. I was already thinking of Pat Fabiano, Paula Swinford, Karen Moses, maybe some other newer folks in the field.**

I think it would be interesting to talk with them. Actually, Paula would be a good person to talk to about the future. Pat is a better person to talk to about the past because she lived through it all. I would suggest you talk with David Burns too, except you would never get him on the phone. Alright, my friend, good luck and thanks.

**And I will keep you posted!**

**You said ACHA modeled its early governance structure after AMA. What do you think gives anything legitimacy (if not a governance structure)?**

Legitimacy is established by the quality of the work you do and the influence you have, not by any specific governance structure; legitimacy by imitation (which is what ACHA tried to do for many years) doesn't work in today's intellectual and professional marketplace of ideas.

**You're doing some work these days on what the CDC calls "syndemics," which looks at interconnections. Some of my research calls that "complex systems." You said physicians tend to do things in complex, bureaucratic ways. If they really did work in complex ways (as suggested by syndemics, not bureaucracies), what do you imagine medicine or college health would look like?**

A syndemic orientation to medical practice would support interdisciplinary thinking, practice, and research as the basic model of care; it would look for connections to other problems in the assessment of a patient's complaints and concerns; it would anticipate future problems based on syndemic models. College health could (should) lead the development of such an orientation to professional practice.

**What is college health like now? Why?**

College health remains a very diverse group of professions and practices -- including everything from one-nurse triage operations to complex, comprehensive health centers with multiple specialists. The unifying focus is the learning and development of students of any age; what holds the field together is the population it serves, not the methods through which it does so. You'll hear reference to "the college health model" -- but there really isn't one, or, rather, there are many of them.

**What future do you imagine for AIDS? Why?**

HIV/AIDS will continue to take advantage of social and cultural contexts that promote illiteracy, undermine women's rights, support poverty, and endorse discrimination against gay and bisexual men. The extent of HIV/AIDS in some countries will be sufficient to undermine social structures and political process; some countries will collapse, causing shifts in the balances of power and national security.

**What were you studying/learning/teaching/reading/researching about when you first were aware of AIDS?**

I was practicing and teaching hematology and clinical immunology in the medical school at U.Va., and directing their student health center.

**What do you remember about literature/arts related to AIDS during the whole span of the pandemic?**

There was an exuberant outpouring of art, poetry, and music linked to the human experience of HIV/AIDS. I still have several books of poetry and a photobook of the art produced in the mid-1980s. While public and media attention have flagged, there are still wonderful works of art being produced with HIV/AIDS as a theme.

**You live in New York now, one of those early sites of the epidemic, at least here in the U.S. Do you see any effects of AIDS now in that city? Beyond the commercial campaigns I might see on the other side of the country, I mean.**

Yes; AIDS is a constant presence in NYC -- not so much in the way it used to be, when there were, visibly, large numbers of affected people, but more in the sense of its being a given, part of the foundation/crust of the city/'s structure.

**If you could tell that law student Michael something about this research project of mine, what would you want to be able to say?**

That the struggle to address social justice as an issue in health and health care continues, but that things are better for gay men in America than was the case when he got sick; that we continue to study our own history, and that he is not, therefore, forgotten.