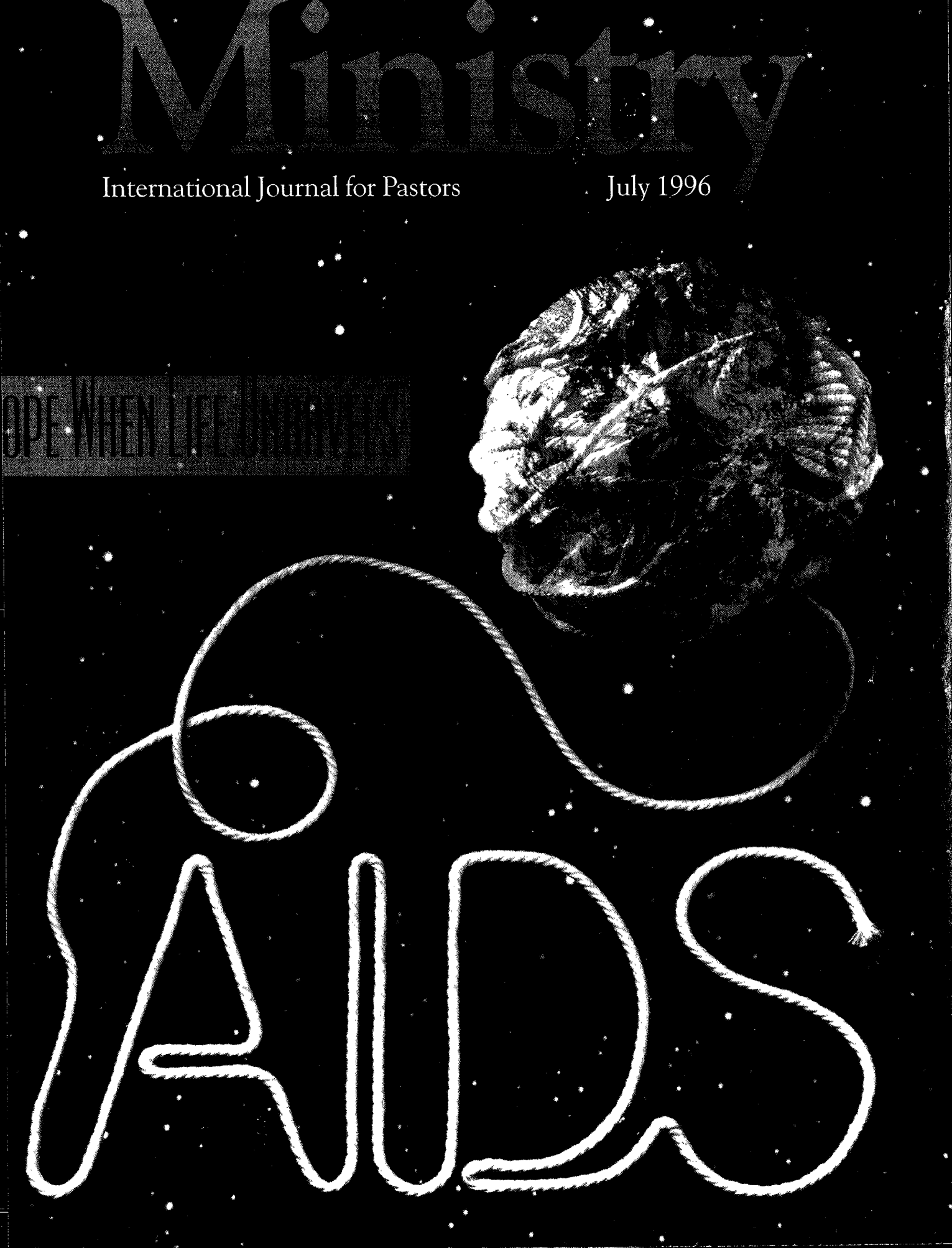
Ministry

International Journal for Pastors July 1996



Letters

Proving more than intended

George Knight [March 1996] brings to mind a statement from *The Great Controversy*: "Before accepting any doctrine or precept, we should demand a plain 'thus saith the Lord' in its support" (p. 595). Why would anyone consider it unfair or unreasonable to follow this advice? What better counsel could we have received? The following is another statement expressing a similar idea: "The Bible with its precious gems of truth was not written for the scholar alone. On the contrary, it was designed for the common people; and the interpretation given by the common people, when aided by the Holy Spirit, accords best with the truth as it is in Jesus. The great truths necessary for salvation are made clear as the noonday, and none will mistake and lose their way except those who follow their own judgment instead of the plainly revealed will of God" (*Testimonies,* vol. 5, p. 331).—Frank W. Hardy, Westminster, Maryland

■ I am not a minister or a theologian, but I read with interest George Knight's article. I was surprised by his disagreement with the hermeneutical principle "The Word of God is infallible; accept it as it reads." I thought this was the rule of interpretation that Adventists adhered to. In *A Symposium on Biblical Interpretation*, the late Gerhard Hasel states that "the basic principle of biblical interpretation is to take words always in their literal sense unless there is an unmistakable contextual indication to the contrary," and then we take them as they read in context.

The Bible harmonizes so beautifully when we take it as it reads. I don't know why anyone would want to impugn that.—Dwight Seek, Omaha, Nebraska

■ I refuse to recognize George Knight's real meaning when he stated that Ellen G. White "was (and is) the most 'authoritative' minister the Seventh-day Adventist Church has ever had." Why? Because he was mixing truth with error. He was taking the fact that Ellen G. White was the most "authoritative" voice that the SDA Church ever had and placed that truth in the framework, or setting, of an ordained minister.

Knowing very little about Ellen G. White, or of her work and position in the Adventist Church, nonmembers would believe that our church accepts the ordination of women to the gospel ministry. And the suggestion that she was "the most 'authoritative' minister" would lead them to believe that she was a minister. Knight also states, "she exercised spiritual authority." A much more appropriate word would be "guidance." She exercised spiritual *guidance*—not authority! She commanded no person to obey her words.—Frank G. Sharp, Escondido, California

■ I was delighted to read George Knight's "Proving More Than Intended." I agree with Knight when he writes, "My point has to do with the proper use of Scripture."

Why do we have so many problems in our churches? Because some think that the Bible needs no interpretation, and those who think so do not perceive that they put their own interpretation in the Bible (and in the writings of E. G. White).

I wonder how we can tolerate in our theological seminaries and leading positions people belonging to a society that rejects "the use of any form of 'the historical-critical' method in biblical study" (see Robert McIver, "The Historical-Critical Method: The Adventist Debate").

Are we returning to fundamentalism, or do we really search with the help of the Holy Spirit for a proper use of Scripture? I hope to read more of this kind of articles in *Ministry*.—Emanuel Zolliker, Switzerland

George Knight responds

I always find it interesting to see how many readers miss my point. It is also fascinating to discover how many of those same individuals can divine *what I don't believe* based on their reading.

Part of what I *did* say regarding 1 Timothy 2:11, 12 was that (1) it *does not* mention ordination, (2) it *does* explicitly state that women should not speak in church, and (3) those SDAs who say we shouldn't contextualize or interpret the passage have put themselves in an awkward position.

Those who opt for a *plain reading* of what the text says without any interpretation or contextualization and yet accept Ellen G. White as a prophet, and also conclude that Paul is talking about the ordination of women, have read a great deal more into the plain teaching of the text than those who argue for ordination.

My argument, of course, was not an argument either for or against the ordination of women. Rather it was a plea to use the Bible in a consistent manner and to follow our methodology to its natural conclusions.

Christian belief should be based on a plain "thus saith the Lord," but we need to be certain that we are truly hearing the Lord and not just echoes of our own preconceptions. I would agree with the letter from F. W. Hardy (cited above) that it is the "'great truths necessary for salvation [that] are made as clear as the noonday.'" But it is one of the great tragedies of history that churches spend the bulk of their time arguing over those things not essential for salvation. But if I were the devil, that is how I would engineer the shape of Christian dialogue.—George Knight, Berrien Springs, Michigan

First Glance

Last January, after more than a third of a century's absence, I visited the small town of my birth. Gweru, Zimbabwe, is now distinctly postcolonial Africa, and part of a nation moving inexorably into an identity distinctly its own.

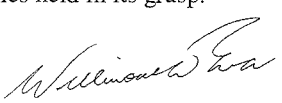
Something unforgettable happened when we stopped at a supermarket. As we got out of the car, a host of small boys gathered about us, offering to "watch our car" while we went shopping. I decided to commission a particularly engaging 8- or 10-year-old to take on this responsibility. When we returned to the car we found our man definitely on duty. I asked him how much he expected to be paid for his work. "Anything you would like to give me, sir" was his reply.

His encounter with me was clearly a major happening in his day. But there was an unmistakable shadow of chronic desperation about him, and his features were subtly lined with a caliber of fear that one simply denies could possibly be part of the world of such a beautiful boy. I gave him what was to him a handsome payment. For his eyes got all the brighter, and he danced with joy as both his hands took the offering. Who was he, and what was his story?

Later, while reading Saleem Farag and Joel Musvosvi's article, "AIDS and the Church in Africa," it dawned on me that the boy I met on the street of my town was almost certainly one of the 50,000 Zimbabwe AIDS orphans.

Along with the revelation of this possibility came the realization that distant as Africa is to most of us, this boy could actually have been on any street, either now or in our future.

The articles of this issue are dedicated almost exclusively to the grotesque horrors of AIDS, what it is and does, and how we may pastor the people and families held in its grasp.



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Volume 69 **Number 7**

Write for *Ministry!*

Will Eva

Have you thought seriously about writing for *Ministry*? What keeps you from doing it?

You may feel that you would like to write, but can't find the time to do something that is not crucial to all you are called upon to do. Another restraint may be your private misgivings that what you have to say might not be worthy of publication. You may feel that your ideas are a bit far to the right for some, or a little left for others, or, worst of all, irrelevant. There may be some procedural questions that stand in the way of writing, such as: What does *Ministry* actually want by way of subject matter? How many words should I write? What will they do with what I submit? Will I be turned down? What will I be paid?

Stripped down to its essence, *Ministry* is simply a forum for the exchange of our best thoughts and ideas. To me, the subject matter we all look for falls into three categories: inspiration, information, and issues. In a given monthly issue we usually have three or four articles on the theme of that month, with the remaining articles covering other pastoral concerns. We always seek to publish articles that are practical to the daily life of pastors all over the world.

Suggested themes

Please take a look at the following themes and see if you find one or two you would like to write about during the next two years: Seventh-day Adventists and the Second Coming of Christ. The pastor's personal budget, especially in high cost areas. Youth and young adult ministry. The pastor as a leader. The Sabbath and Seventh-day Adventists today. Ministerial marriage and family. Diversity of church practice in time and place. The pastor and the Holy Spirit. What is an effective church? The essential characteristics of a successful pastor. Renewing the call to ministry. Pastoring in multiple-church districts. Pastors as keepers of the soul. Pastoring in small churches. Divorce and remarriage. A pastorally oriented view of the issues of salvation. The pastor and his or her preparation for retirement. Homiletics—preaching the Bible with meaning. Dealing with difficult people. Speaking to the secular mind. Interdenominational relationships. The development of doctrine in the SDA Church. Forgiveness.

Besides articles, we look forward to receiving any ideas at all for the improvement of the journal. As always, Shop Talk ideas are very welcome. We plan to expand this column starting next January. We are also eager to receive articles from all our readers regardless of denominational background. We are especially in need of articles from outside the Americans context.

Some guidelines for writing

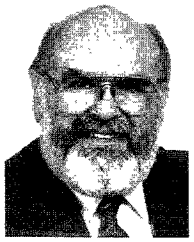
When it comes to actually sitting down to write, here are some important considerations:

- Query before writing. Contact the editorial office with your topic, outline, qualifications for writing. If available, send a sample of your writing.
- Write with an international awareness.
- Articles with 1,500 to 2,500 words are preferred.
- Manuscripts should be typed, double-spaced in average-sized font, with numbered pages. If possible, articles should be sent on a diskette in WordPerfect format together with a hard copy.
- Use endnotes rather than footnotes. For legal reasons, all endnotes must be verified by our editorial staff, so please include a photocopy of all citations and bibliographic information.
- Name, address, telephone and fax numbers, social security number (if appropriate) should be on the first page.
- Enclose a self-addressed, stamped envelope if you would like your manuscript returned (if not accepted). Non-United States authors should enclose self-addressed envelope only.
- Payment for articles is carefully considered, but subjective and usually around US$150.

If you have further questions about writing for the journal, just let us know and we will send you our pamphlet, "Writer's Guidelines."

When we receive your manuscript, we will be as prompt as possible in acknowledging it and getting you a response about its acceptance or rejection. If accepted, please understand that it is often difficult to schedule an article for publication as early as you might expect it to appear.

So, go for it! Write for the glory of God! There are pastors all over the world who will benefit from your insight and experience. ■



Dealing with AIDS!

Bruce C. Moyer

It is a disease that calls upon Christians to demonstrate compassion, love, and personal acceptance.

AIDS is not the sort of thing we want to talk about at the table over supper. We don't want to admit that this kind of thing affects us as Christians. But it does affect us, and we must talk about it.

The bad news is that HIV/AIDS is an equal opportunity pandemic. The HIV virus does not ask questions about our religion, age, sex, lifestyle, or sexual preference. It crosses all social, political, and economic lines. *The good news* is that AIDS can be avoided. But we must begin by not avoiding it. That is, we must face it, and talk about it. We must talk about it at church, at our schools, and in our homes. We cannot close our eyes and ears hoping that it will go away. It won't! We cannot assume that our children and youth are immune. They are not!

A number of Adventists have been doing battle with this infection for a number of years. The church has not been silent, but the voices of those who have spoken have been partially muted by widespread denial. In the past year a number of these people, including some of the authors in this issue, have formed the Adventist AIDS Network. This is a network of Adventists who are concerned about and involved in a compassionate response to HIV/AIDS, and the prevention of its spread. For further information about this network please contact the Adventist AIDS Network, Sutherland House, Andrews University, Berrien Springs, Michigan 49103. The network can be reached on CompuServe at 74617,2465.

The articles in this issue have been carefully and prayerfully written and call for a new and clarion realization that we are dealing with a pandemic that has infected and is terrorizing millions of men, women, and children in every part of the world. This is a disease that easily has the potential of eclipsing the Black Death of Europe.

AIDS has been called, by some, the leprosy of the late twentieth century. It is a disease that calls upon Christians to demonstrate compassion, love, and personal acceptance. It calls us to reach out, as Jesus did, to the lepers of His day, touching people with healing, forgiveness, and practical demonstrations of compassionate ministry and inclusiveness. ■

Bruce C. Moyer, S.T.D., is the associate director of the Institute of World Mission at Andrews University in Berrien Springs, Michigan. He formerly worked as the Senior Advisor on AIDS for ADRA International.

AIDS: fear and compassion

Harvey A. Elder, M.D.

Reducing irrational fears. Opening our hearts. Understanding how AIDS is and is not communicated.

Harvey A. Elder, M.D., is professor of medicine, Loma Linda University School of Medicine, Loma Linda, California.

"I'd like to be her friend, but I think she has AIDS in her family."

"No, I'm not going to a church that accepts people with AIDS. What kind of people do you think we are?"

"He has AIDS. He should not hold a church office."

"I don't want to wash his feet. I could get AIDS."

"I don't want to baptize her. I'm afraid of catching AIDS from her."

AIDS. Even the word brings fear to the hearts of brave people. We avoid it. But AIDS is! It is more than just four letters. It is a powerful word. AIDS powerfully affects *people*. Many of us transfer our fear of AIDS to people who may have, or who we suspect may have, AIDS. In doing this we create *the problem*: "How, as compassionate people, do we deal with our fears, without abandoning people with AIDS and without abandoning people with high-risk behaviors who may yet get AIDS?"

Information dispels fear. Factual information allows us to separate valid concerns from irrational fears. Let's examine the facts about AIDS, its cause, and methods of transmission. Then we can know when we are at risk and when we are not. With well-gathered information we can respond intelligently to valid concerns while quieting our irrational fears. Acting on factual information makes us able to minister to those affected by HIV without being limited by irrational fears of contracting AIDS ourselves.

How HIV/AIDS functions in the human body

HIV (human immunodeficiency virus) causes AIDS (acquired immune deficiency syndrome). The documentation for this fact is stronger, better established, and more persuasive than the support for any other theory or belief regarding the cause for this disease. A virus "lives" only in a living cell. Outside the cell it is just a collection of inert molecules. A virus acquires "life" only as its molecules bind to a living cell allowing the virus to enter and capture the cell. Once it enters, the virus forces the cell to do its bidding. Most viruses are very "particular," binding only to certain cells. Virus binding depends upon a certain match.

The binding molecules of a virus fit only certain molecular arrangements, similar to a key and lock. The virus "key" molecule fits only certain molecular "locks." Only a critical molecular arrangement on the cell surface matches the virus. A virus must contact the molecular "lock" that fits its molecular "key" so the virus can bind, enter, and grow. This becomes clearer when we look at HIV. HIV remains lifeless unless it enters one of the cells with a matching molecular lock. When exposed to air, HIV and its surrounding fluid dries and gradually loses its ability to bind to a living cell.[1] It dies!

HIV, being the human variety of immunodeficiency virus, must find a human cell. It cannot live and multiply in cells of other animals or insects. Only humans can acquire and transmit HIV. Animals and insects play no role.

HIV does not bind to just any human cell; it binds to cells that have the CD^4 marker[2] as their molecular lock. If we identify which human cells have CD^4 markers and how HIV gets to these cells, we can develop a prevention plan.

Scientists found CD^4 markers on only a few human cells.[3]

1. Certain lymphocytes called "T-helper cells" have CD^4 binding sites. These cells inhabit lymph nodes and wander through the blood vessels to tissue and, via lymphatic vessels, meander back to lymph nodes. They are also present in a few body fluids such as pus, semen, vaginal secretions, spinal fluid, and human milk.

2. We have a group of "garbage collector" cells called "macrophages." These large cells wander through the body "eating" and destroying tissue debris, cancer cells, and many kinds of infectious organisms. These cells are also present in blood, pus, and injured tissue.

HIV multiplies rapidly in a T-helper lymphocyte. In this way, in less than 48 hours, thousands of new HIV can be released![4] These released HIV attach to CD^4 binding sites of new T-helper lymphocytes and repeat the cycle. With this kind of com-pounded multiplication, within a few weeks of first meeting HIV, the infected human will be producing more than one billion new HIV every day!

The body fluids in which HIV lives and moves (such as the blood and bloody fluids, pus, semen, vaginal secretions, human milk, and cerebral spinal fluid mentioned above) often contain the HIV in T-helper lymphocytes. If these are fluids from recently infected people, they contain large numbers of HIV. Within a few months of infection the person's immune system acquires the ability to partially control the multiplication of HIV. Then HIV multiplication slows, and these fluids come to contain fewer HIV. However, as persistent HIV infection progressively destroys the immune system, patients become symptomatic, and the blood level of HIV rises again. With advanced AIDS, HIV multiplies faster.

HIV does not "take over" all body fluids. Most body fluids other than blood, pus, semen, vaginal secretions, human milk, and cerebral spinal fluid have no HIV or very low levels. Certain body fluids, such as saliva, actually kill HIV.[5] We know which fluids contain HIV and which do not.

As we minister to others, He transforms us into ministers of His peace. In all this we live for the praise of His glory.

How HIV is spread

How does HIV spread? To answer this question we need to look at activities that transmit HIV.

1. Certain sexual activities transmit HIV. Sexual intercourse, whether heterosexual or homosexual, transmits microbes from partner to partner. These microorganisms may persist in their host for years. Thus the genitalia of sexually active people can carry the genital microbes of all their sexual partners during the previous five years. These microbes can be HIV, or agents for other sexually transmitted diseases.

The sexual activity that stretches the anus tears the lining mucosa and exposes cells with CD^4 markers. This makes anal sex the most efficient way of transmitting HIV. However, all forms of intercourse, regardless of the body orifice used, can transmit HIV.

2. Blood transmits HIV. Blood and blood products from the United States, northern Europe, Australia, and New Zealand are very (but not absolutely) safe.[6] Reused needles and syringes for drug use carry blood from previous users; hence, these frequently transmit HIV.

3. About one fourth of the babies of HIV-infected mothers in the United States develop HIV infections. The fetus can be exposed to HIV while developing in the uterus or during delivery. The newborn may also acquire HIV through its mother's milk.

4. HIV crosses diseased or cut skin, and causes infection by attaching to cells in the deepest skin layer. HIV has not been shown to cross normal skin.

Conditions that do not transmit HIV/AIDS

By 1984 epidemiologists had identified the first three of the above four routes for the spread of HIV/AIDS. During the subsequent 12 years, despite intense research, no additional routes have been discovered. Only rarely has HIV crossed skin broken by disease or trauma and initiated HIV infection.[7] Still other methods of transmission may exist, but if they do, they occur very rarely.

These logical arguments have been empirically documented by laboratory and epidemiological studies. For example, people who live with "people with AIDS" (PWA) do not acquire HIV infection unless they are sex partners or share needles and syringes. Family members sharing kitchen, bathrooms, the same dishes and dishwater, even without special disinfection do not get HIV infection. Eating food prepared by PWA does not transmit the virus. The same question goes for washing family laundry with laundry from a PWA. Even sharing the same toothbrush and razor, though this is not recommended regardless of HIV status, has not transmitted HIV. Though kissing on the cheek or lips does not spread HIV, deep kissing can. Mosquitoes

and other biting insects do not transmit HIV.[8] (Some authorities believe HIV can be transmitted through insect bites.)

Ministering without fear

Let us return to our first question: "How, as compassionate people, do we deal with our fears? How do we deal with fear without abandoning people with AIDS?

The following facts can dispel most of our fears.

1. Sex with an HIV-infected partner transmits 75 percent of AIDS in the United States and 80 percent of AIDS globally. Sex in the sanctity of marriage between two who are HIV-free and who have been and are committed to lifelong monogamy is absolutely safe.

2. Intervenous injection drug use transmits 23 percent of AIDS in the U.S. and 6 percent of AIDS worldwide. We minister best to those with drug habits by encouraging them to enter treatment programs. "Tough love" is the most compassionate ministry for a person still using drugs. Until they are "clean and sober" for more than a month, verbal ministries and acts of compassion only encourage addiction.

3. Blood transmits about 1 percent of AIDS in the U.S. and 6 percent of AIDS globally. While receiving blood has some risk, it is absolutely safe to donate blood in most countries. We who have no risk behaviors may minister in lifesaving ways when we systematically donate blood as often as every two months.

4. Maternal-fetal transmission accounts for 1 percent of U.S. AIDS cases and 8 percent of global AIDS cases. Today this transmission can be decreased by expensive drug therapy for the mother and the newborn.[9]

Showing care and compassion

How can we show care and compassion to those who are HIV/AIDS positive? By doing the things loving people do. We can bring them to church, sit with them, and invite them to our potluck dinners. And we can eat some of the food they bring! They can serve and be served during the ordinance of humility. Pastors can safely enter the baptismal font with them.[10] We need to have people who are affected and those who are infected by HIV as integral parts of our parishes.

We can invite them to our homes. They can use our bathroom facilities. They can safely hold our children if the child does not have an infection. When our hands have no obvious cuts or eczema, we may touch them. We may touch them on the arm or shoulder, in areas where their skin has no obvious cuts or other lesions. We may hug them and kiss them on the cheek.

We and our churches are called by God to be incarnational centers of redemption. When we follow Jesus' charge to "go and make disciples," some of them will be infected with HIV, some with other loathsome diseases. There are no exceptions to our marching orders. The people Christ welcomes into His arms are those who feed the hungry, give drink to the thirsty, take in strangers, clothe the naked, care for the sick with acts of kindness, and visit those in prison. However, these people are precious to God. God's children have many maladies. Some have AIDS and are dying. We have the privilege of loving and caring for them.

God, us, and AIDS victims

We serve those with HIV infection and AIDS because we ourselves know something of brokenness. We know the hopelessness and despair of deserved lostness. We know that God, who showed us mercy, gives mercy to the undeserving. We, just as they, have never deserved God's grace. We must all come and fall before God in adoration and praise. He loved us! He wanted us! He found us! He saved us when we were rebels deserving death! God lavished us with His incomparable love. Dazzled by His incomprehensible mercy, we serve those with HIV infection and AIDS. They, as we were, are broken and suffer. Daily they suffer as we suffered. Gratitude demands that we serve those who are as we were; we can do no less. We are constrained to extravagantly lavish His grace on others without restraint.

In obedience we confront our fears. In obedience we experience God's greatness as He disarms our fears. Caring for those affected by HIV, we meet Christ ministering to their loss and grief. We see Him as the one who never leaves or abandons. Looking back, we realize that His compassion created our caring, His love formed our love. As we share, our gifts are anointed by His Spirit. Taking steps of service, we walk His path. In reaching out to touch, we find His hand guides our fingers. When speaking, His voice speaks tender words through our mouth. He takes our imperfect, conditional, broken love and uses it to heal the suffering of others. As we minister to others, He transforms us into ministers of His peace. In all this we live for the praise of His glory. ■

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[1] L. Resnick, K. Veren, Z. Salahuddin, et al. "Stability and Inactivation of HTLV-III/LAV Under Clinical and Laboratory Environments." *Journal of American Medical Association* 255:1887-1891.

[2] J. N. Weber, R. A. Weiss, "HIV Infection: The Cellular Picture," *Scientific American* 259: 101-109.

[3] R. A. Weiss, "How Does HIV Cause AIDS?" *Science* 260: 1273-1279.

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[5] D. H. Coppenhaver, P. Sriyuktasuth-Woo, S. Baron, et al. "Correlation of Nonspecific Antiviral Activity With the Ability to Isolate Infectious HIV-1 From Saliva," *New England Journal of Medicine* 330: 1314, 1315.

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[7] Centers for Disease Control and Prevention. "Update: Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients," *Morbidity and Mortality Weekly Reports* 36: 285-289.

[8] L. Mike, *Do Insects Transmit AIDS?* Office of Technology Assessment, Congress of the United States. Superintendent of Documents, Sept. 1987.

[9] E. M. Connor, R. S. Sperling, R. Gelber, et al. "Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 With Zidovudine Treatment," *New England Journal of Medicine* 331: 1173-1180.

[10] B. C. Moyer, "The Caring Church and HIV; Special Issues of Concern to Pastors," in *Compassion in a Time of AIDS: A Resource Manual* (Lincoln, Nebr.: Church Resources Distribution Center, 1994), pp. 39-55.

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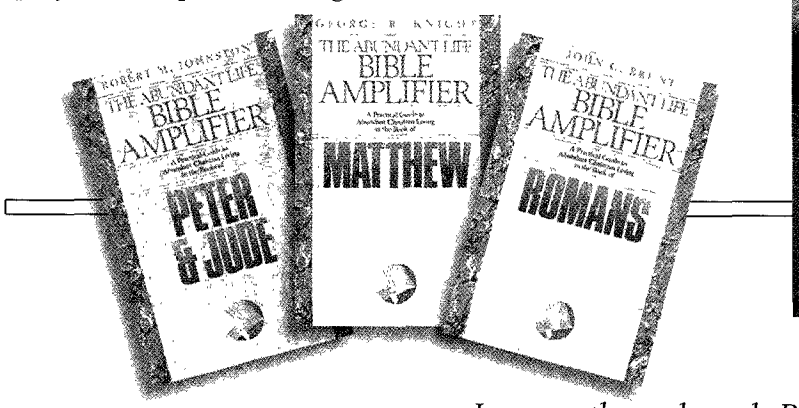

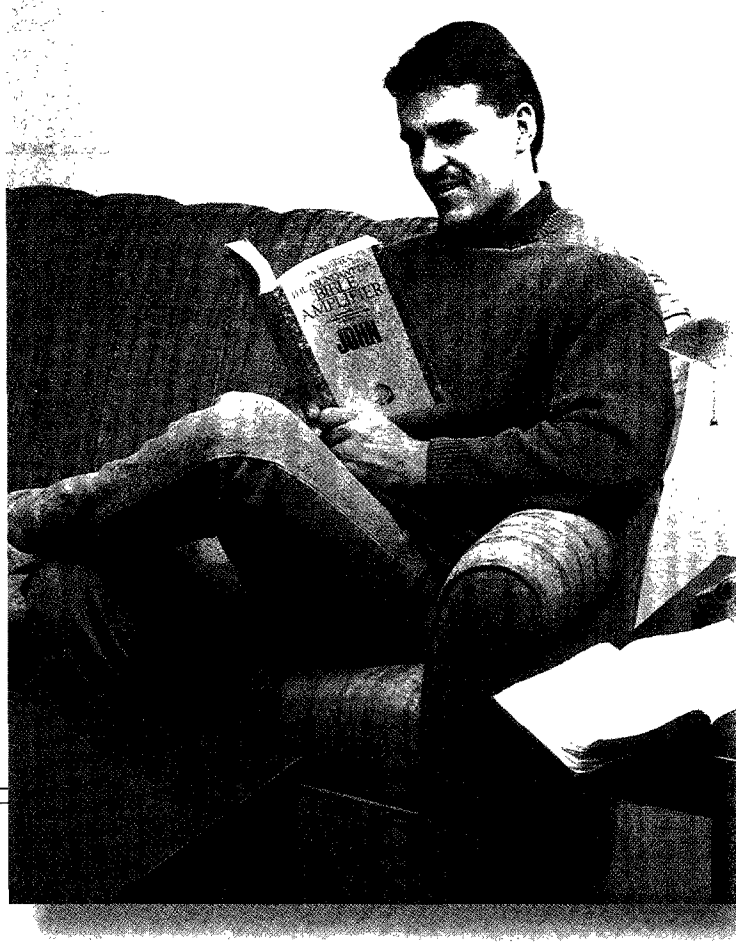

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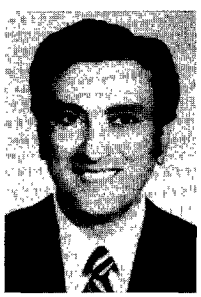
AIDS and the church in Africa

Saleem A. Farag and Joel N. Musvosvi

Practical implications for the church worldwide



Saleem A. Farag, Ph.D., is chair of the Interdenominational AIDS Committee in Harare, Zimbabwe.

Joel N. Musvosvi, Ph.D., is the ministerial secretary of the Eastern Africa Division of Seventh-day Adventists, Harare, Zimbabwe.

United States or Uganda. India or Zimbabwe. Taiwan or Argentina. AIDS has become a worldwide scourge. No country is immune to its ravages. No community is free from its devastating effects. Spiritually, emotionally, physically, and medically it is one of the deadliest diseases, if not the deadliest, ever to strike the human race. In Zimbabwe one person dies of AIDS or AIDS-related diseases every half hour. A 1995 World Health Organization survey estimated that HIV infections worldwide stood at 17 million, with approximately 12 million cases located in sub-Saharan Africa, followed by South and Southeast Asia, with about 3 million. Inaccurate diagnoses, along with incomplete and delayed reporting, have kept this figure much lower than it probably is in actuality. Further, in 50 countries outside the sub-Sahara region, the estimated HIV prevalence rate was 5 per 10,000 sexually active adults, while in 15 sub-Saharan countries the rate was 500 per 10,000, or 100 times as many.[1]

"Ironically this disease [AIDS] is essentially preventable. The abandonment of sexual promiscuity, homosexuality, and drug abuse could eventually stop it in its tracks, though that is hardly likely to prove an acceptable or practical solution."[2] If sexual promiscuity was not endemic, AIDS would not be pandemic.

AIDS and the breakdown of society

All over the world AIDS seems to have people in its grasp. It is destroying not only bodies but also the very social structures, such as the family, that have contributed to the maintenance of morality throughout the centuries.

Consider the agony of Africa. Poverty, the economic exploitation of many by few, and political instability have created a social situation in which bare existence has become a debilitating impossibility. In the wake of AIDS millions of children go hungry each night and suffer from severe malnutrition. As a result, numerous women have resorted to prostitution to feed their families. The result? HIV has significantly affected Africa's female population. As Professor McCeen Ankrah of Makerere University, Uganda, says: "The use of sex to generate income places increasing numbers of young women at risk of HIV infection and transmission." "I did not sell my daughter," Ankrah quotes a parent. "She saw me suffering and wanted to help." Such tragic situations are confined not only to the poor and illiterate but to out-of-work graduates as well.

The human tragedy of AIDS

This is not to say that HIV/AIDS is simply a problem of poorer countries. The disease does not recognize political boundaries, economic status, race, or creed. It is a lifestyle malady, and it affects people everywhere, whether they choose such a lifestyle out of economic desperation or sheer abandon.

AIDS presents itself not only as a personal and family tragedy, but also as a national one. The majority of people who die of AIDS are between the ages of 15 and 35. This age group

represents the most economically productive sector of a society. These are also the ones in whom educational resources have been invested. Their death leaves a country economically and socially depleted. In the developing countries, where there is a shortage of skilled personnel, this is a particularly devastating phenomenon.

The tragedy is compounded when one considers that most of these developing countries hardly have the resources to care for AIDS-afflicted patients. Economic realities force these countries to cut the "soft" areas of health care and education in favor of defense, agriculture, mining, and business. The health budget of many of the developing countries is about US$3 per person per year. How could such countries afford expensive AIDS treatments?

In the United States the average cost of caring for an AIDS patient is approximately US$32,000 per year, as compared to less than $400 in sub-Saharan Africa. Even though Africa has approximately 70 percent of the world's HIV infections, it has attracted only 2.8 percent of the US$1.2 billion spent on HIV prevention programs. Ready access to good health care is one of the main factors determining long-term survival for HIV-infected people. While in Western countries people with HIV survive for 10 or more years, the average patient in Africa has only 15 months to live. The difference is the availability and affordability of good health care.[3]

The human tragedy of AIDS does not end with the death of the patient, but transfers to an entire generation of orphaned children. Zimbabwe alone estimates an orphan population of 50,000 as a direct result of AIDS. Almost overnight these children find themselves on the streets having to fend for themselves. By the year 2000 it is estimated that HIV infections worldwide could be around 40 million, one fourth being children.[4]

Traditionally African society had no such thing as an orphan. When the social structure was intact, the extended family immediately adopted any child who lost his or her parents. In many African countries economic turmoil and civil unrest have severely disrupted these structures. The traditional concept of an extended family has come under so much stress that societies have not been able to deal with the problem of orphans, especially in the numbers generated by the multitude of parental deaths caused by AIDS. Thus the thousands of defenseless children who now make the street their home.

The church must see that the story of AIDS is not about epidemiology, economics, or statistics. Rather it is the story of pain, anguish, fear, and neglect.

Aids: the challenge to the church

The ultimate test of the church is the spiritual maturity of its people. Nowhere is this maturity more tried than in the way the church responds to the cry of suffering human beings in and around it. In today's context, AIDS represents the ultimate cry of suffering. Upsetting as it might be, when it comes to AIDS many church members, ministers, and leaders have chosen to look the other way, as did the priest and the Levite on the Jericho road.

One area in which the church has no excuse is the area of proclamation. The church exists to proclaim. We all know that AIDS can be prevented by living with chastity before marriage and fidelity in marriage. Yet both chastity and fidelity have been largely ignored in the rhetoric of societies as they expound on the AIDS issue. In all of this the church, reflecting societal ambivalence, has generally been almost as tentative. In the United States 74.4 percent of girls and 90 percent of boys have had sex outside of marriage before the age of 18. Instead of upholding the divine principles of morality and relational integrity, the church, in the name of love, has at least tacitly agreed with the customs and values of what societies generally advocate.

The church must see that the story of AIDS is not about epidemiology, economics, or statistics. Rather it is the story of pain, anguish, fear, and neglect.

World culture, the sexual revolution, and AIDS

In the past, African culture and morality sustained itself around two great traditional pillars, both rooted in the family and culture. One was premarital chastity, with no sanction for sexual contact before marriage. The other was marital faithfulness, with no room for extramarital sexual expression. Tribal, cultural, ethical, and religious forces supported these values in much of Africa.

A fourfold fear also supported these values: fear of what the tribe, the family, friends, and relatives might say; fear of God, because religion was still an active force in society; fear of unwanted pregnancy that would bring shame to the family and the tribe; and fear of sexually transmitted diseases.

A sexual revolution has swept Africa. As the many forms of technology have moved rather suddenly onto the African scene, traditional African values have been shaken. Western sexual perspectives, along with movies, pop music, discos, videos, alcohol, free drug use, and the products of the "sexual revolution"

have all had their impact. Other causes include the breakdown of parental control and increasing urbanization. The "free love" philosophy has replaced traditional African sexual mores and behavior.

Most African tribal cultures are profertility and prosexuality, but within strictly defined limits. However, with urbanization, technological development, and independence such limits lost their bearings, widening the road for promiscuous sexual behavior and AIDS. Added to the cultural breakdown and the invasion of a morally loose lifestyle came tentative political and governmental action against AIDS. This hesitation, along with economic limitations, exacerbated the AIDS problem in many African countries.

In some Western countries children may be given explicit sex education, and may even be introduced to the use of pills and condoms, but for a multitude of reasons African tradition and culture do not make such sex education and AIDS prevention programs easily available. Materials provided under Western auspices are often so explicit that many African communities consider them pornographic. Bitter protests from families have led to the removal of such sex education from school curricula.

Never before have family values been more seriously challenged. The United Nations Declarations of the Rights of the Child and the Rights of the Adolescent, including the advocacy of highly controversial sexual and reproductive rights, have challenged the foundation of Christian and traditional African homes in which morality, fidelity, and the heterosexual family unit have been so strong, and in which appropriate parental authority and influence have been maintained.

In a rapidly evolving world under a "new moral world order" many in very influential places, such as the United Nations, are attempting a redefinition of family. According to them, family may be defined as two men, two women, a man and a woman, or a man or a woman. In this family, adolescents and children have "sexual rights" and can make choices including having access to contraceptives and abortion, with or without parental consent, if they so choose. Thus sex is finally separated from the serious business of morality, marriage, reproduction, and family.

The majority of people who die of AIDS are between the ages of 15 and 35.

The challenge to the church

Against such powerful and worldwide trends, the church has the formidable task of championing chastity before marriage and fidelity in marriage. It must find ways of effectively crying aloud and sparing not, particularly when it comes to maintaining high moral and spiritual standards in human sexuality. Pastors, evangelists, teachers, youth leaders, and others must rediscover the positive discipline of life as it is in Christ so that we will not be pressured into embracing destructive "new" morality trends. We need a spiritual awakening that will enlighten us about the forces that exist to squeeze and conform us into destructive philosophies and behaviors.

What should the Seventh-day Adventist Church do to arrest the deteriorating sexual situation? It is not enough to climb Mount Sinai and proclaim the Ten Commandments. We need to do more, particularly in the areas of proclamation, counseling, and support.

Proclamation begins with the church living out God's plan for human sexuality within the bonds of marriage. The immutable standards that govern sexual relationships must be affirmed. Pastors and youth leaders need to find ways of effectively pointing out that sexual relationships are not a question of "free choice" and "safe sex," but part of a great divine moral order. Human behavior cannot be guided by what is available through technology. A technical advance that provides a way of preventing pregnancy or a medical insight that cures disease cannot be consulted as a basis for moral direction. The higher moral standard of who we are, whose we are, and who we are ever called by God to be, is clearly more definitive and compelling. Focusing on God's intention for human sexuality clearly shows that sex is a beautiful experience, a gift from the Creator to be enjoyed within the realm of marriage. Such focus would challenge adolescents to look at sex in a more wholistic way.

Counseling is the second area of opportunity for the church to work with those infected with the HIV virus and AIDS. They and their families are in serious need.

One 24-year-old AIDS patient said, "I wish I could have seen God's plan as clearly before as I do now after I have been infected. Why was my vision so dim and my spiritual perception so dull? Why couldn't I have seen the beauty and reasonableness of God's plan for a happy and healthy family?"

No other disease can subdue the heart and soften the soul to the pleading of the Spirit as does AIDS! It provides an excellent opportunity for the minister to give hope and courage to patients who have lost hope. One young AIDS patient, who had not been a Christian, accepted Jesus as her Saviour in her last few days of life and was baptized into the Seventh-day Adventist Church. She said, "I know that one day soon I will be raised in immortality and will see my Lord face-to-face. I am not afraid of dying. My only concern is for my mother and family members who are not Christians." She asked the minister to tell her mother about Jesus and requested that he preach on the second coming of Christ at her funeral service when all

her relatives would be present. Today her mother and a large number of her relatives have joined the church.

The pastor who cared for this person said, "In all of my 20 some years in the ministry, I have never found more fertile ground for the pleadings of the Holy Spirit than among HIV/AIDS patients and their relatives and friends."

Seminars on how to counsel AIDS patients have become a regular feature in Zimbabwe. Hundreds of Seventh-day Adventist pastors and ministers from other denominations have received such training. In counseling the AIDS patient, the attitude of the AIDS counselor can make a significant difference. If counselors have to give real help to AIDS sufferers, they must have a disposition to love, heal, and save. They cannot afford a judgmental attitude.

Counselors are called to listen as patients share what is in their hearts—their fear, agony, anger, anxiety, and remorse. More than anything else, the AIDS patient needs compassion along with spiritual and emotional reassurance. If counselors are open, patients will be able to unburden their guilt and pain and find peace. HIV/AIDS sufferers experience a huge flood of fears when they hear for the first time that they are the victims of the disease. Only the Saviour can calm the raging storm that comes up when such a diagnosis is made.

Support services is the third area in which the church can serve those affected by HIV/AIDS. Because hospital services worldwide are costly, more and more patients are cared for at home. In Africa, home-based care is quite common. It allows for family involvement and provides opportunity to educate the extended family and the immediate neighborhood on the destructiveness of the disease, and what can be done about it.

Zimbabwe has formed an interdenominational AIDS network to enable churches to identify areas of need and mobilize community resources in order to provide HIV/AIDS patients with necessary support and care in their homes. This network gives home-based caregivers training in prevention and counseling.

Such teams are usually composed of a church worker, a nurse's aide, and a driver, all under the supervision of qualified medical personnel. This team along with a pastor is responsible for services such as:

- Emotional and spiritual support to the patient and the family
- Nursing services in the home
- Financial support when possible
- Health education for family members, schools, parent-teacher associations, and the community
- Training of care counselors

Orphan care

As an extension of the home-based care services, churches in Zimbabwe have adopted a program to identify and care for orphans left destitute by parents who have died of AIDS-related causes. Such children are placed in Christian homes rather than being left on the street or being placed in an institution. The program is a formidable challenge to the church as the number of orphans mushrooms each year and the resources of the church do not. Yet these initiatives cost little and are culturally appropriate in Zimbabwe. The churches have the added responsibility of educating the orphaned children and training them in occupations that can give them a sense of dignity and personal fulfillment. This outreach of the church is worthy of support from people everywhere.

AIDS is heinous and tragic. It kills the patient and leaves the family in bewildering tragedy. Motivated by love the church must seek to minister and bring the power of Christ to the sufferers and their survivors. The responsibility of the church does not end in proclaiming moral standards alone, but in a caring ministry. If Christ were to walk the streets of our cities today, He would be deeply involved in ministry to those who have AIDS, providing physical, emotional, and spiritual support and care. He is present today through His church. This kind of work is the highest work of the church. ■

[1] World Health Organization Global Program on AIDS, December 1995.

[2] A. P. Waterson, in *British Medical Journal*, March 5, 1983.

[3] *Ibid.*

[4] S. A. Farag, "Report on the United National Conference on Population and Development" (Cairo: September 1994).

AIDS: wrestling with fear and grief

Millie White

The personal, emotional, and familial trauma of AIDS

I thought it'd never happen to me.
I was safe, that's what mattered.
Then they told me I was "HIV,"
And my whole world was shattered.

I hovered, crying there for hours.
My heart was torn and tattered.
I questioned why from higher powers,
And yet my life was shattered.

I cried, I wept, I begged, and screamed
Emotions wild and scattered.
The worst news I had ever dreamed
Was the pain that left me shattered.

I know the facts, I know the deal,
And my soul lies bruised and battered.
Yet few could know just how I feel,
Afraid . . . alone . . . and shattered.

—MWE, 1995

Tornadoes, floods, blizzards, earthquakes, bombings, fires—cataclysmic disasters alter people's lives swiftly and permanently. But what about the events that attack the body and sear the soul? The disaster that shatters an increasing number of lives is HIV (human immunodeficiency virus) and AIDS (acquired immune deficiency syndrome). In the mid-1990s AIDS became the leading killer of all Americans aged 25-44. Among those aged 15-24, AIDS is the seventh-leading cause of death in the United States. In the same nation, every 30 seconds, a woman is infected with HIV; every two minutes, a woman dies of AIDS. According to the Centers for Disease Control and Prevention in Atlanta, one in every 250 Americans is infected with HIV. Behind the alarming statistics and dismal headlines are real human beings fighting against seemingly insurmountable challenges as they live and thrive with HIV/AIDS. It is a disease that knows no bounds.

The basics of life

A person's life is irrevocably altered once he or she has become infected with HIV. Of course, many people do not even know that they are infected, because they feel perfectly healthy. In fact, it takes an average of 8 to 11 years for a person to progress from being HIV positive to having AIDS. As the body begins to weaken from the onslaught of HIV, individuals must face changes that will alter their lifestyle in simple and radical ways. Many PWAs (persons with AIDS) have to reduce their working hours and eventually quit altogether. Intermittent illness and doctor's appointments can make it difficult to maintain a rigorous work schedule. It is especially difficult to work around one's illness if one does not feel comfortable revealing it to an employer. Eventually most victims in the United States apply for Supplemental Security Income/Social Security Disability. The process is complicated and delivers barely enough for a person to survive. It can be both humbling and humiliating for hardworking people in their prime to obtain federal assistance.

The loss of employment brings other changes. People may have to find cheaper housing. That may mean applying for government housing or moving in with aging parents or other relatives. Others may have no place to go and end up living on the street. Sadly,

Millie White is a case manager at Chattanooga Cares in Chattanooga, Tennessee.

some may not even be able to get into a nursing home when they become too ill to care for themselves. Decisions also have to be made regarding health insurance and medical treatment. If a person was receiving health benefits through work, they may have to apply for Medicaid (U.S. government assistance program) once they leave work. Most private insurance companies will not cover people with HIV/AIDS. This makes it more difficult to get good medical care. Many doctors do not want to deal with Medicaid red tape or with the complexities of the HIV disease. Doctors who are uncomfortable dealing with the disease do not aggressively help AIDS patients fight the disease and cope with the ravages of its fallout. By the time a person develops full-blown AIDS, they are on a treatment regimen consisting of a massive number of pills. They are forced to cope with drug interactions and side effects that can affect their moods, appetite, and freedom to perform daily activities. Finally, many people have to learn to live on limited budgets that barely allow for the essentials such as food and clothing. Food stamps and assistance from local food banks can be very helpful. Unfortunately, PWAs are often unable to eat nutritionally, which is very important for people with compromised immune systems. People in the United States and many other countries can obtain clothing from local service agencies. Any unexpected expenses can put PWAs in a crisis situation with few options.

It's all in your head

Many of the changes in a PWA's life are psychological in nature. Perhaps one of the biggest heartaches brought on by HIV is whether or not to reveal one's illness. A person must decide to whom they are going to tell and how they are going to tell them. They also have to be willing to risk rejection, fear, and disapproval. People often blame themselves for becoming infected, and feel a desire to hide the behavior that was associated with the infection, such as drug use or sexual activity. It takes great courage to face one's situation honestly and to move beyond denial to coping with the crisis. They also have to know enough about HIV/AIDS and its effects before informing others who may well have all sorts of questions and reactions to their announcement. They must also be ready to accept the fact that some loved ones will rally behind them while others will walk away and never look back.

It takes great courage to face one's situation honestly and to move beyond denial to coping with the crisis.

PWAs also face the task of reinforcing current relationships as well as building new ones. Relationships are typically complicated and fragile; dealing with a catastrophic illness stretches relational bonds to the limit. It takes honesty to overcome the fear and stigma surrounding HIV/AIDS. Familial problems that existed before the person became infected with HIV tend to become magnified. Loved ones have to go through their own process of accepting and coping with the disease. They have to figure out how they will relate to the family member with HIV/AIDS. It can be hard to accept the person's lifestyle (for example, their drug use and/or gay friends). Family members also must face decisions on how they can best support the PWA while maintaining their own lives. Is the PWA going to move in with them? Are they going to help out financially? Who will care for the PWA if they become ill? If the family is going to survive intact, members must also deal healthfully with the stresses of being caregivers as the person becomes ill. Unlike other terminal diseases that cause a steady decline in one's health, HIV/AIDS is unpredictable. PWAs often ride a roller coaster of good health mixed with bouts of life-threatening illness. Caregivers must tread a fine line between treating the person with HIV/AIDS as being alive and active, and coping with chronic illness.

Once a person knows their HIV status, it can be very difficult to initiate new friendships. They tend to feel like social outcasts. They may also hesitate to trust others if they feel nobody wants them anymore. Many are afraid to reveal their status and are afraid that they might expose others to HIV. But having HIV does not take away a person's need for human relationships or their ability to change, grow, express emotion, and make commitments. Outlets for socialization tend to shrink when a person becomes HIV positive. Work opportunities may be eliminated. Churches can become unfriendly. Accessibility to restaurants, theaters, and other places of social gathering can become difficult as one's health falters.

Some have found comfort and friendship with local AIDS service organizations that provide support groups and activities. Others have chosen to let people know up front that they have HIV/AIDS. If after such a disclosure the friendship continues to grow, it is probably genuine.

Since the majority of people with HIV/AIDS are young, they must face the difficult task of continuing to care for their children in the face of a sometimes debilitating illness. This can be especially difficult for single mothers. Putting the needs of their children before their own becomes increasingly difficult.

Many have to decide whether or not to have children. This is a hotly debated issue, and there are no easy answers. While some PWAs do not want to risk dying before their children or passing

on the virus to a baby, others feel that the risk is minimal (about 8 percent transmission of HIV from mother to baby if the mother is on AZT during pregnancy). Some would like to enjoy the pleasures of having a family as well as leaving a part of themselves behind. The number of children orphaned by AIDS grows every day, so it is crucial that everything possible is done to make the best arrangements for them.

Facing the attitudes of people

People with HIV/AIDS must face a daily barrage of attitudes born of ignorance, fear, and judgment. It often becomes their task to educate those around them. This can be grueling at best, especially when everyone seems to want to know the most intimate details about their lives (i.e., how they got infected, how they cope with it, how people treat them, etc.). Yet many PWAs have embraced the challenge and have become outspoken advocates in their communities for those with the disease.

Many people infected and affected with HIV have also fought political battles in the war against the disease. In a climate of apathy toward anyone using the American "system," many social programs are being cut. Even major legislative measures are in jeopardy, such as the Ryan White Care Act and the Housing Opportunities for People With AIDS Act, which fund support services for thousands. Although much headway has been made in the medical treatment of HIV/AIDS, funding for additional research may be eliminated. Politicians tend to blame people for the circumstances in which they find themselves. Concerned individuals must continue to fight to ensure that all people have access to the assistance that they need.

Believing in somedays

Living with HIV/AIDS is a harrowing experience, but there are gifts amid the suffering. People faced with their impending demise often learn to enjoy the "precious present." So often, young people are constantly looking toward the future without savoring the here and now. Many PWAs have reevaluated their priorities and have made lifestyle changes to accommodate what is really important to them. In fact, some see their HIV positive state as a second chance to make things right and to live truly. Being chronically ill removes the illusions that one has control over one's life and that options are unlimited. Individuals often seek to repair damaged relationships and to reinforce healthy ones.

Wrestling with grief

People living with HIV/AIDS must wrestle with seemingly endless grief. There is personal grief over the many losses they have experienced, such as lost employment, lost time and opportunities, and severed relationships. It is also common to grieve their own impending death. Some who have lived with the virus for several years tend to experience "survivor guilt" because so many others with the disease have succumbed to it. Along with their own fears and struggles with HIV/AIDS, many PWAs face the loss of friends and/or relatives to AIDS. It can be very isolating emotionally to grapple with such major, ongoing losses. Others find it a real struggle to live with the disease and yet to be referred to as "the one dying of AIDS."

Laughter plays a crucial role in facing HIV/AIDS. It takes great strength and creativity to find something funny in the midst of night sweats, chronic diarrhea, and an often impersonal health-care system. Humor also leads the way toward healing. When fear is confronted and dealt with, it is easier to take on the problem. PWAs typically develop a zest for life that ordinary people do not share. Life is too short for them—they plan to enjoy it to the fullest despite their limitations.

In the United States and some other countries there is a dizzying array of treatment combinations and preventative therapy options for HIV/AIDS patients. There is research being done every day that may lead to improved medicines and possibly even a cure. A lot of PWAs cope with an uncertain future by educating themselves on the newest procedures and treatments. Many have taken to heart a slogan that was coined at the beginning of the epidemic: "Be here for the cure." Some are participants in clinical trials and are willing to try anything that may boost their health and prolong their lives.

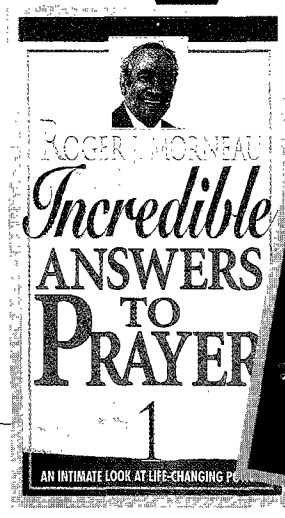
Living with HIV/AIDS demands great courage and patience. Living in a "crisis mode" helps to develop these traits. The disease shatters thousands of lives each year, but many put the pieces back together again with the help of those who love them. Even though HIV may not be what they bargained for, it has not robbed them of their ability to share and to love.

AIDS is robbing our society of the amazing potential of so many—and we are all poorer without them. We must unite as men and women from ordinary, healthy family situations to fight the epidemic with courage, common sense, and love.

In general the church community has failed people infected and affected with HIV/AIDS. It is time for the church to take responsiblity for the compassionate care of those who have been neglected and ostracized by society. As Christ did, Christians must accept people right where they are without demanding that they change before assistance is given. In an era when social services may not or may no longer exist, the church has a precious opportunity to redeem itself and to make a great, positive impact on others. ■

VIDEOS

FOR THE WHOLE FAMILY



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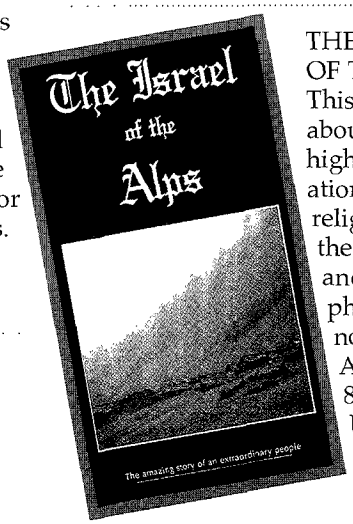

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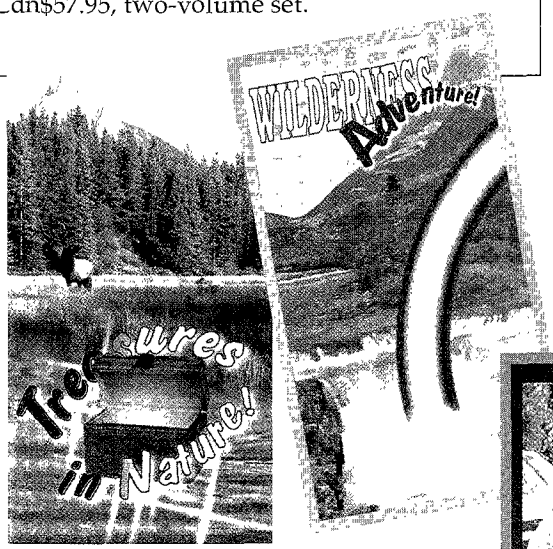

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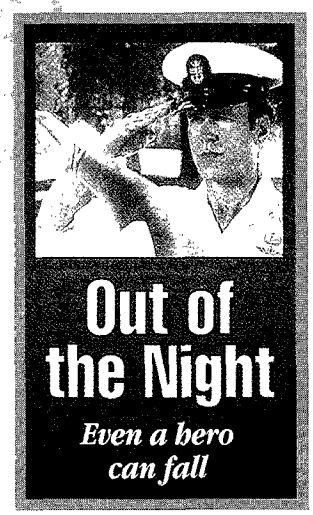

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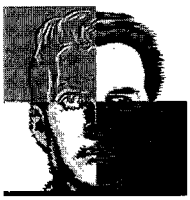

Counseling *people in* crisis

The crisis of suicide

Vern R. Andress

That cry for help may come anytime. The pastor needs to be ready.

The phone call interrupted my dinner. The voice on the other end was desperate. "I'm at my wit's end, and you are the only one I can turn to. If you can't give me one good reason to live, I've made up my mind to end it all."

The words were slow, deliberate, and almost imperceptible; the voice unforgettable and bone-chilling. Such calls come hundreds of times each year. A minister's chance of getting such a call is greater than that of almost any other professional, including physicians and psychologists. Each year between 25,000 and 30,000 people kill themselves. It is estimated that 10 times that many attempt suicide.

Suicide is a major problem today. Pastors need to have a proper understanding of the issues involved. They need a clear insight into the mind of the suicidal individual in order to be better prepared to face that desperate cry for help.

The mind of the suicidal person

In the late 1950s psychologists Edwin Shneidman and Norman Farberow coined the phrase "the cry for help" to describe the generally ambivalent feelings of the suicidal person. The suicide threatener is not simply a manipulative person capriciously trying to get attention, but rather is someone who is in so much pain that they have concluded there is no other solution to their problem except a permanent end to pain—death.[1] The interesting point is this: Such persons are ambivalent about life and are looking for a reason to live. In their desperation they are willing to gamble with life. If they find some hope that the future will be better, they will opt for life. If they sense no future hope, they will opt for death.

The suicidal person: a profile

Shneidman and Farberow suggested that suicidal people generally fall into one of three categories: the threatener, the attempter, and the committer.

The threateners tend to be young women between the ages of 15 and 25. They make their threats known to parents, teachers, pastors, and significant others either vocally or by leaving notes where they can be found. Their level of ambivalence is the greatest, leaning in the direction of wanting to live rather than wanting to die. They want to get the attention of significant others and the concomitant commitment to help them end their painful existence in a life-supporting way.

The suicide attempter is often a single woman, who is usually somewhere between

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19 and 30. Three out of four people who attempt suicide are female. Again, the level of ambivalence is high, leaning in the direction of wanting to live. This is shown by the fact that the suicidal gestures of attempters usually involve a method with a relatively safe margin that allows for rescue before death actually takes place. Taking medication (sometimes prescribed, but often over-the-counter) is the preferred method. The slow action of medication helps to reveal the attitude "If I am rescued, it was meant to be; if I'm not rescued, then my time has come." Attempters frequently commit their act in the presence of others, or in locations where they expect others to be so they can be rescued. It is not unusual for them to take the medication and then telephone a friend, a pastor, or a suicide hot line, explaining what they have done and asking for help. Their notes are often left in conspicuous places and frequently explain the reason behind their attempt and the seriousness of their intent. It is not uncommon for a person to make several attempts, leading significant others to feel that they are being manipulated and therefore to become calloused and indifferent. Unfortunately, their attempts can become unintentionally fatal.

Three out of four suicide committers are male. Typically, the male is older and shows his lethality by selecting a method with little room for rescue or change of heart. Guns, especially handguns, are the most common means of suicidal death, with hanging and jumping close seconds. Unlike the act of taking a medication, with its fairly long margin of safety, the methods typically chosen by the suicide committer are precipitously fast-acting. Once the trigger is pulled, there is no opportunity to reverse the action.

Typically, suicide committers may be single, separated, divorced, or widowed. Marriage seems to act as a buffer against suicidal death, perhaps because it represents a readily available support system. Separated or widowed males are considered to be highly lethal to themselves, while single or divorced females pose a similar high risk.

Alcohol also plays an important, if somewhat vague, role in the lethality of the committer. About one third of those who commit suicide have a detectable amount of alcohol in their blood at the time of their autopsy. Alcohol's exact role in suicidal behavior is not clear. Does it reduce the person's inhibitions toward self-destruction, does it enhance their hopeless feelings, or does it merely cloud their mind and make it hard for them to perceive any other alternatives that may be available to them?

Why suicide?

The most common question asked following a suicide threat, attempt, or an actual death is "why?" In the case of threateners and attempters, the individual can be asked that question directly. The answers are often vague and inconclusive. In the case of committers, we can only speculate. Suicide notes are rarely a good source of information. First of all, only about one third of suicide committers leave a note.[2] Most of the note writers are female,[3] and the notes rarely give any indication as to motive. Such notes often contain directions as to how to close out a person's estate or how to dispose of their body. Frequently they are requests for forgiveness either from significant others or from God. When they do give an indication about motive, they reveal unbearable and unending mental or physical anguish and pain. The major themes of these notes are hopelessness, helplessness, and loneliness.

Researchers usually turn to those closest to the deceased to find out why the person may have resorted to the extreme step. Unfortunately, the inner thoughts and feelings of people are highly guarded secrets of life, and more often than not, the survivor-victims of suicide are caught off guard and left perplexed as to motive. In looking back over the life of their loved one or friend, especially the last few days, they suddenly become aware of "clues" that the deceased dropped here and there encoding their hopelessness and their tendency toward self-destruction. But these indicators were either missed, or they were taken to be less than serious.

Suicidologists believe that the leading motives for suicide are a sense of helplessness and hopelessness over some event in the person's life over which they feel they have no control.

Suicidologists believe that the leading motives for suicide are a sense of helplessness and hopelessness over some event in the person's life over which they feel they have no control, such as irreversible physical illness and pain, or an anguishing disruption in personal relationships with no perceivable positive outcome.

Suicide is not an impulsive act with little forethought or planning. In fact, it is well designed and thought out. Research suggests that most suicides evolve over at least a 90-day period preceding the attempt, the planning process being quite orderly and methodical, with three distinct stages.

Stages in suicide planning

The first stage is called the resolution phase. This is usually the longest phase and is accompanied by a great deal of agitation and restlessness. During this time the individual is struggling with the moral and ethical issues of suicide. They are asking themselves whether or not suicide is a sin or what effect it will have on loved ones and friends. The deep significance of these questions accounts for the high degree of edginess and agitation felt by the individual. Their significant others experience this as a time of extreme moodiness and impatience.

The second stage, the initiation phase, involves less time than the first and produces a milder form of agitation. In this phase the individual formulates actual plans for the

act. The person wrestles with what means should be used: shooting, hanging, jumping, drug overdose, etc. The person also plans on where to do it: at home or off in some remote region. If at home, which place: the garage, the living room, a bedroom? The person also thinks about who might find their body: family members, friends, police, or a maid in a motel. Once they have resolved these issues, they begin to gather the means for carrying out their suicidal act, usually collecting an overabundance of the items they plan to use.

When the first two phases of the plan are in place, the individual often becomes very calm as he or she enters the third stage or postponement. Knowing that they are capable of solving their problem, they relax and bide their time until they fulfill their plan. This serenity often catches the family and friends off guard, so that when their loved one finally commits the suicidal act, they are surprised. People close to the victim often say such things as "I can't believe he actually killed himself. If he had done it a few months ago I would not have been shocked . . . he was so anxious and agitated back then. But recently it seemed as if things were going so much better. He seemed so relaxed."

Clues to suicide

Identifying clues to suicidal tendencies is important, particularly for family members and significant others so that they can be of help to the person concerned. Such clues include the following:

1. Unusual periods of sleeplessness. Because individuals are so burdened in the first stage of the suicide plan, they find it difficult to sleep. They wrestle with thoughts that may affect them for eternity, and these thoughts aren't easily turned on and off. Such insomnia is frequently accompanied by periods of general sadness.

2. Sudden changes in appetite, weight, or sexual drive. These could include either an increase or a loss in appetite, an intensification or loss of interest in sex, or an unusual preoccupation with and consumption of drugs and alcohol.

3. Loss of interest in family, friends, and familiar pursuits. Suicidal individuals often become so preoccupied with their own thoughts that they begin to neglect their friends and family. They do not participate in family functions or discussions. To a noticeable extent they lose interest in such things as sports, hobbies, and work.

4. Frequent discussions of death, the wish to die, or feelings of worthlessness. Such comments as "You'd be better off without me," or "I can't take much more of this," or "I wonder where people go when they die, and if they feel any pain after they are dead" should be taken as possible indicators of a contemplated suicide. This is especially true if these comments are made along with other types of clue behavior.

5. Sudden, unusual interest in death and death rituals. When individuals uncharacteristically begin to discuss making or changing a will or insurance policy, or when they show excessive concern about making funeral arrangements, it may indicate some suicidal intention.

6. Unexplainable or illogical giving away of prized possessions. When an individual begins to give away things they have spent a lifetime accumulating, especially to casual acquaintances, such behavior should alert family members to the possibility of suicide.

7. Collecting information and means for suicide. This could include a sudden interest in guns, the collecting and hoarding of medications, or a surprising interest in news accounts of other people's suicidal deaths.

When that call comes

When you get that urgent call in the middle of your dinner or in the middle of the night, what should you as a pastor do? Here are a few basic points.

1. Remain calm and don't act surprised, frightened, or overwhelmed by what the person is telling you.

2. Take seriously anyone's talk of suicide. Don't get caught in the "boy who cried wolf" syndrome. Remember, everyone who talks about suicide is a potential danger to themselves.

3. Be genuine and honest in expressing your interest, concern, and support for the person with whom you are talking. Often they will say something like "Why should you care about me? You hardly know me; even the people who are closest to me don't care." Give an honest answer, something like "It's true, I don't know you very well, but I want to hear about your pain; I care about your well-being, and how you deal with that pain."

4. Don't be judgmental or moralistic. Telling them that they are committing a horrible sin or reminding them of how selfish suicide is will only add to the guilt that has led them to contemplate suicide.

5. Don't argue. Don't tell them they can't commit suicide. They really can, and nobody can stop them if they are intent on such an act. They may go ahead just to prove they are in control.

6. Listen carefully, especially to the hidden meanings behind the words. Often the one thing the person most lacks in life is another person who is genuinely willing to listen. Never rush in with platitudes or suggestions. Let them have their say. Many times they won't come right out and say they are going to kill themselves. Instead they will make such statements as "I'm thinking about checking out . . ." or "My time has come . . ." Get them to clarify these vague statements by asking a direct

question, such as "Are you telling me that you are thinking about killing yourself?" Such a question tells them that you are listening and that you are actually hearing their message. By listening carefully, you may hear something that will significantly help you in giving them aid.

7. Get them to seek professional help from someone trained in dealing with suicidal behavior. To do this, you should maintain a current list of professional counselors in the area. A good source of information is the local suicide-prevention hot line, if there is one in your area.

8. Act quickly. After you have established a strong rapport with them by your genuine concern, gently insist that they immediately see someone for counseling. If necessary, encourage them to get into a hospital setting.

9. Don't assume guilt for things over which you have no control. If you deal with suicidal people long enough, the chances are high that you will eventually be involved with one who refuses your intervention and commits suicide. At times like this it is easy to torture oneself with feelings of guilt. Remember that no one is ever responsible for someone else's actions. If you feel burdened by your feelings, don't be too proud to seek professional help yourself.

Be ready for that cry for help

Suicide is a unique kind of death. Almost without exception it leaves people behind who will have a complicated process of grieving because of the unanswered questions surrounding the death and the assumption of guilt for the person's actions. As a pastor-counselor, it is important to understand these burdens felt by the survivor-victims of suicide. Pastors should know the process of referral and the process of grief recovery. They should also be alert to minister to the bereaved ones, especially at times such as the loved one's birthdays, special holidays, wedding anniversaries, and the bereavement anniversary when memory has a way of bringing back the tortured past. As a pastor-friend you may want to send survivor-victims a little note of concern and encouragement at these special times to let them know you care. Survivors generally receive a great deal of concern and caring right after the death of their loved one, but soon after, their special needs and pains are forgotten as people rush on with their busy lives.

As a minister, you should always be ready for the cry for help and for the cry of the grieving. ■

[1] Edwin S. Shneidman and Norman L. Farberow, eds., *The Cry for Help* (New York: McGraw-Hill, 1958).

[2] Vern R. Andress and David M. Corey, *The Demographic Distribution of Suicide in Riverside Country Between 1965 and 1969* (Loma Linda, Calif.: Loma Linda University, 1976).

[3] L. B. Borque, B. Cosand, and J. Kraus, "Comparison of Male and Female Suicide in a Defined Community," *Journal of Community Health* 9 (1983): 7-17.

CONTINUING EDUCATION EXERCISE

The crisis of suicide

1. You receive a phone call from one of your parishioners who is intending to commit suicide. The caller says, "I'm thinking about cashing in my chips." List the steps you would take in dealing with this situation.

2. Write down some of the clues that a suicide intender leaves. How would you alert the family and loved ones to watch for these clues?

3. Suicidal people fall into three categories. Can you identify them? Think back in your ministry and see if there were parishioners who might have fallen into these categories. How could you help anyone you may detect in the future as being in one of these categories?

4. Make a list of professional counseling and referral personnel specializing in suicide in your community, and place the list in a specific, easily accessible location.

Suggested reading

Farberow, Norman L., ed. *The Many Faces of Suicide.* New York: McGraw-Hill Book Company, 1980. Discusses the characteristics of suicidal behavior.

Lester, David. *Why People Kill Themselves.* 3rd ed. Springfield, Ill.: Charles C. Thomas, 1992. A leading suicide researcher provides an encyclopedic review of current literature on suicide.

McIntosh, John L., Dunce, Edward J., Dunce-Maxim, Karen. *Suicide and Its Aftermath.* New York: W. W. Norton, 1987. Discusses the effect of suicide on the significant others who are left behind. Gives suggestions on how to care for survivor-victims.

Shneidman, Edwin S. and Norman L. Farberow. *Clues to Suicide.* New York: McGraw-Hill Book Company, 1957. The seminal work on suicide demographics and the characteristics of suicidal behavior.

AIDS and Adventist youth

Gary L. Hopkins, Joyce W. Hopp, Helen P. Hopp, Christine Neish, and Gayle Rhoads

An AIDS risk appraisal of students attending SDA high schools in the United States and Canada

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The acquired immunodeficiency syndrome (AIDS) has become a major global threat. Worldwide, millions of persons have been diagnosed with and died of this dreaded disease. In the United States as of October 1995, a little over one half million persons with AIDS were reported to the Centers for Disease Control and Prevention (CDC).

Clinically, overt AIDS represents only the end-stage manifestation of a prolonged infection with the human immunodeficiency virus (HIV). The CDC[1] reported that 20 percent of the diagnosed cases of AIDS were in the age group of 20-29 years. Since the period from the time of HIV infection to the development of AIDS is generally between eight and 10 years,[2] there is a high likelihood that adolescents are becoming *infected* with the HIV and are *diagnosed* with AIDS when they are no longer adolescents.[3]

Currently there is no known cure for AIDS, nor is there a vaccination to prevent HIV infection,[4] although considerable research money has been directed toward this effort. Methods of preventing HIV transmission include abstinence from HIV risk behaviors such as IV drug use and avoidance of HIV-infected body fluids (semen, breast milk, blood, and vaginal fluid).

Seventh-day Adventist leaders recommend the maintenance of a monogamous sexual relationship between non-HIV-infected individuals in a marriage relationship as the most effective method for preventing HIV transmission. Until a cure is available, health education targeted at reducing AIDS risk behaviors will be a main method of preventing HIV transmission.

Christian schools typically advocate health standards that include (1) abstinence from dangerous substances, including tobacco, alcohol, and drugs, and (2) abstinence from sexual intercourse until marriage, along with other biblically based principles.

The Seventh-day Adventist Church sponsors 93 four-year high schools (academies) in North America. Four surveys of students in these high schools revealed that some adolescents practice sexual and drug behaviors that place them at risk for contracting or transmitting the HIV.[5] Because of the practice of such HIV risk behaviors, research is needed in the SDA high school population in order to determine the possible points of educational and behavioral intervention to address the potential problem of HIV/AIDS.

Current research

In 1995 the authors conducted research to describe the HIV/AIDS risk factors of a sample of students attending SDA high schools throughout the U.S. and Canada. This research was to assess students' AIDS-related attitudes, normative beliefs (perceptions of social pressure), and their perceived control regarding AIDS risk behaviors.

Questionnaire development

We constructed a questionnaire based on an extensive review of the professional health literature on AIDS and AIDS risk behaviors specific to the adolescent period of development. The purpose of this questionnaire was to measure accurately and identify determinants of behaviors that could place adolescents at risk for transmitting or contracting the HIV. The questionnaire was divided into four sections: (1) demographic characteristics of the respondents, (2) HIV/AIDS-related knowledge, (3) HIV/AIDS-

related behaviors, and (4) intentions, attitudes, social pressures, and perceptions of control related to the HIV/AIDS risk behaviors of sexual intercourse and substance use.

Sample selection

Permission for the research was granted by Dr. Gil Plubell, director of the North American Division, Office of Education. The office of education also provided partial funding.

Application was then made to the Institutional Review Board (IRB) of Loma Linda University (LLU), under whose authority this research was conducted, for a review and acceptance of the research protocol. The functions of the IRB, as required by federal law, are to protect the subjects of research from emotional and/or physical harm and to assure that ethical research guidelines are followed. The IRB accepted the protocol proposal, but required that before students could answer the questionnaire it was necessary to obtain written consent from their parent(s).

Each of the 93 schools was mailed a box containing parental consent letters equal to its student enrollment. The schools applied mailing labels with the names and addresses of the parents of their high school students. The schools then mailed the letters, a total of 13,368. Parents who chose to allow their children to participate in this research signed and mailed a consent postcard to LLU. A total of 2,834 students were thus enrolled in the study. The students represented 85 of the 93 four-year high schools in the NAD.

Questionnaires were mailed to each of the participating schools with a list of the names of the students whose parents had granted consent. Each questionnaire was placed in a manila envelope with a letter to the student advising them as to the sensitive content of the questionnaire and guaranteeing that there would be no attempt to identify students by name.

Results

Response rate. A total of 1,765 completed questionnaires were returned, yielding a response rate of 62.46 percent of the 2,826 parental consents. Sixteen of the 85 schools did not administer a total of 1,061 questionnaires.

Demographics. The majority of the respondents attended boarding schools as compared to day schools (53.7 percent versus 46.3 percent). The median age of the respondents was 17, with an age distribution of between 12 and 19; 56.4 percent of the respondents were female; and 93.3 percent were SDA. The distribution of respondents by year in high school was fairly equal (24.1 percent freshmen, 24.0 percent sophomores, 27.9 percent juniors, and 24.0 percent seniors) with the modal year of enrollment reported as eleventh grade. A comparison of the ethnicity of the respondents with the total student population attending four-year high schools throughout the NAD revealed that in the study sample White students were overrepresented (79.3 percent versus 58.0 percent) and all minorities were underrepresented.

Knowledge. Accurate knowledge regarding modes of HIV transmission was high. The average score was 90.92 percent.

Substance use. Regarding the use of substances, Figure 1 demonstrates that non-SDA students who attended SDA high schools were more experienced with the use of all substances. The differences in the rates of use of all of the substances were statistically significant.

Parents' use of substances. In order to determine whether or not an association existed between the students' reports of parental substance use and the students' rates of substance use, three questions were designed to measure this relationship. The students were asked if either of their parents or guardians smoked cigarettes, drank alcohol, or used marijuana. Figure 2 shows that when at least one of the parents used either tobacco, alcohol, or marijuana, the rates of the students' use of all of the substances increased.

Sexual intercourse. Of the total

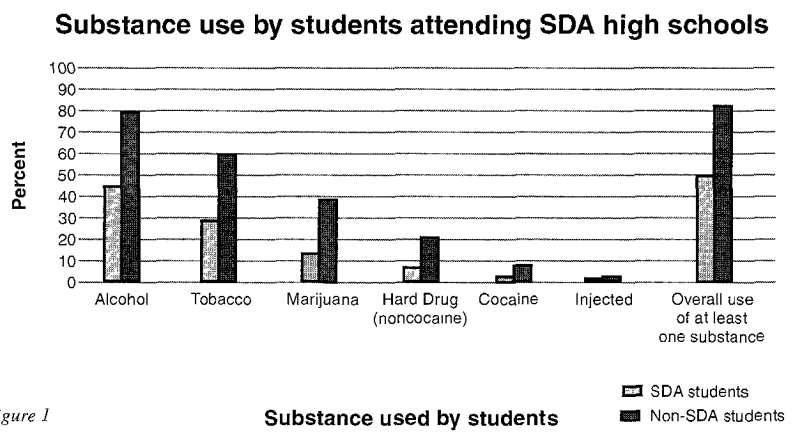

Figure 1

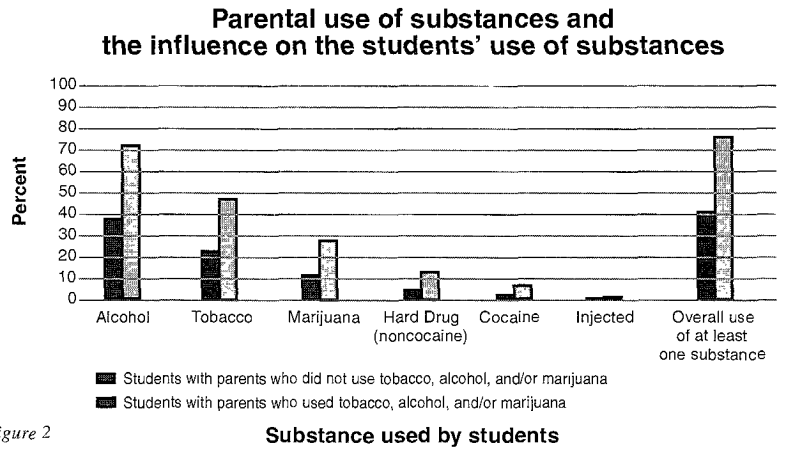

Figure 2

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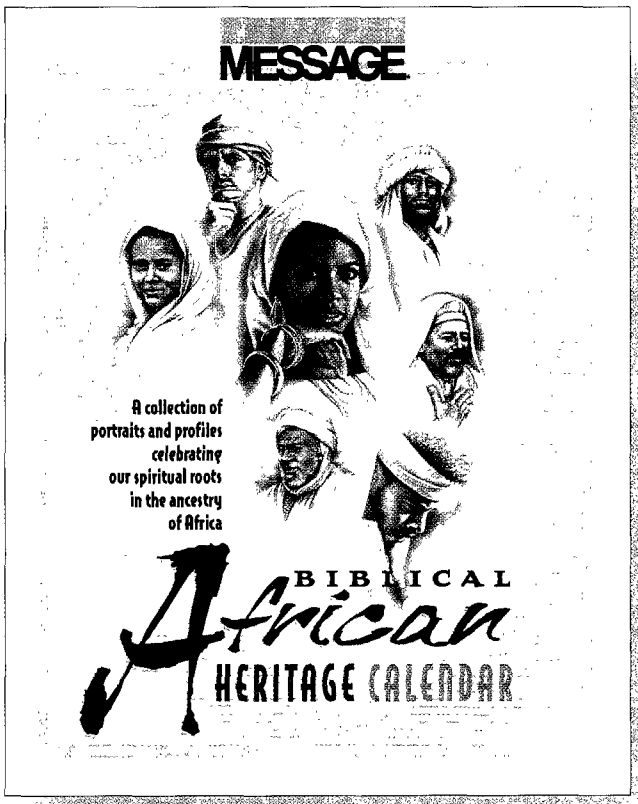

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sample, 16.3 percent reported having had sexual intercourse. Female students reported a lower rate of sexual intercourse (14.6 percent, N=144) when compared to males (16.2 percent, N-284). The median age at first sexual intercourse was 15 for both sexes. The mean age at first intercourse was 14.5 for males and 15 for females.

Parental and students' substance use behaviors and students' sexual experience. Substance use by parents and by students appeared to have a relationship with the students' past sexual experience. Students who used substances were shown to be the most sexually experienced (Table 1). When students reported that they had a parent who also used a substance, the rate of sexual intercourse increased. The lowest rates of sexual experience were among students who had not previously used substances and whose parents, as reported by the students, also did not use substances.

Homosexual experience. Seventy-nine (4.6 percent, N=79) students reported sexual experience with someone of the same sex. The proportion of students with a history of a homosexual experience was higher in males than in females (5.0 percent, N-41 versus 4.2 percent, N-38).

Intentions to have sexual intercourse before marriage. The respondents were asked, "How likely is it that you will have sexual intercourse before marriage?" This question was followed by a seven-point *unlikely/likely* scale. The students who demonstrated a greater intention to have sexual intercourse before marriage were those who (1) were already sexually experienced, (2) were experienced with substances (i.e., drugs), (3) had a parent who used either tobacco, alcohol, or marijuana, and (4) were non-SDA.

Attitudes, social pressure, and perception of control toward sexual intercourse before marriage. Three separate questions were designed to measure the students' attitudes, perceptions of social pressure, and control regarding sexual intercourse before marriage. Each question was followed by a seven-point scale. The students who (1) were already sexually experienced, (2) were experienced with substances, (3) had a parent who used either tobacco, alcohol, or marijuana, or (4) were non-SDA demonstrated attitudes and perceptions of social pressure more favorable toward engaging in sexual intercourse before marriage. These same four groups demonstrated a lower perception of control over sex before marriage.

Determinants of the behavior to have sexual intercourse before marriage. Using appropriate statistical tests, measurements were made to determine whether the students' attitudes, perception of social pressures, or perception of control best predicted their intentions to have sex before marriage. It was found that perceived control was the strongest predictor. Students who (1) were sexually experienced, (2) were experienced with substances, (3) had a parent who used either tobacco, alcohol, or marijuana, or (4) were non-SDA

Association of sexual intercourse in relation to students' and parents' use of substances

Substance use		Sexually experienced students	
Parent	Student	Percentage*	Number
No	No	3.5	25
Yes	No	5.9	7
No	Yes	26.3	135
Yes	Yes	30.3	117

Table 1 **Percentage of total sample*

demonstrated a lower perception of control over sexual intercourse before marriage than those were otherwise.

Determinants of perceived control. The items that best predicted the students' perception of control over sexual intercourse before marriage were *encouragement from teachers* and *spiritual strength.*

Discussion

Substance use. Many students attending SDA four-year high schools across the North American Division practice substance-use behaviors that place them at risk for serious health problems, including transmitting or contracting the HIV. Although rates of substance use in SDA schools are typically lower than those in public schools (Figure 3), students who do use substances (including alcohol, tobacco, cocaine, and other drugs) are more likely to practice AIDS risk behaviors.[6]

Because of the association of substance use with AIDS risk behaviors, it is imperative that schools consider the future role of substance abuse counseling for adolescents.[7]

Parents have the most important role in influencing the lives of their children, and hence there is a need to counsel parents regarding their own use of substances. The present research demonstrated that parental use of tobacco, alcohol, or marijuana was significantly associated with their children's (1) use of drugs and (2) rate of sexual intercourse. This research demonstrates that parental use of substances may be a factor in the AIDS risk behaviors of their children. When students reported that their parents did not use tobacco, alcohol, or marijuana, and when the students themselves did not use any substances, the rate of sexual intercourse was only 3.5 percent. One must remember, however, that the parental substance use was reported by the students and not by the parents themselves.

Sexual intercourse

Sexual intercourse, the key AIDS risk behavior, as reported in this research, was found to be moderately prevalent. The rate of intercourse for this sample was 16.4 percent for all students. SDA students were less likely to have been sexually active than non-SDA students (14.6 percent versus 37.1 percent). Though the prevalence of sexual intercourse in this sample of students attending SDA schools is lower than the rate of 53 percent in public schools, the students who begin their sexual experience as adolescents are more likely to have multiple sexual contacts, thereby increasing their likelihood of eventual contact with an individual who is HIV-infected.

SDA educational system

The SDA Church places a strong emphasis on Christian education. The North American Division has 1,050 schools, ranging from kindergarten through high school. Enrollment in the schools totaled 50,988 in the fall of the 1994-1995 school year. SDA schools are typically staffed by teachers who are members of the SDA Church.

The SDA Church holds a strong belief in the value of abstinence from premarital sex and from harmful substances including tobacco, alcohol, and addictive drugs. This research demonstrates that the strongest predictors of perceived control relating to sexual intercourse before marriage for those students who responded was *spiritual strength* and *encouragement from teachers.*

These findings reaffirm the belief that those who are chosen to teach in the SDA system should be committed to demonstrating Christian values not only in the classroom but also in all interactions with students. Those who work in the SDA school system need to have a sense of accountability regarding the seriousness of their roles in the schools. Administrators and school board members who are responsible for selecting teachers should carefully search for teachers who will make themselves available both in the classroom and outside the classroom to students for encouragement and counseling regarding issues such as substance use and premarital sexual intercourse.

Non-SDA students attending SDA schools

Until the last few years, North American Division policy has limited the number of non-SDA students admitted to the denomination's elementary and secondary schools. Schools serving grades K-6 were allowed 15 percent non-SDA students. Grades 7-12 were restricted to no more than 10 percent non-SDA. Those schools that admitted greater proportions of non-SDA students were designated "mission schools." In recent years local school boards have become increasingly ready to accept more non-SDA students. The driving force behind this philosophical shift seems to be that of financial necessity, although some explain the practice as part of the evangelical mission of the church.

Teachers and administrators quite universally report experiences with outstanding non-SDA students who contribute in a positive way to the Christian environment on campuses. There are undoubtedly outstanding non-SDA Christian young people enrolled in SDA schools. The current research, however, suggests that the church might be well served to review its policies regarding this issue.

Limitations in external validity

It is important to keep in mind some

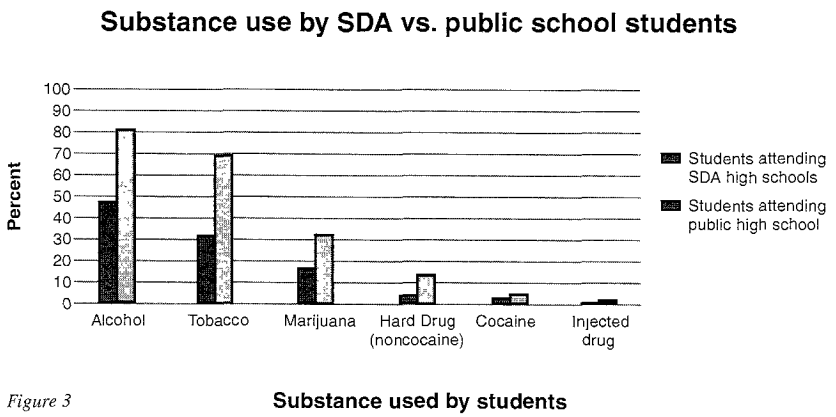


Figure 3

limitations of this data set. Although serious attempts were made to secure a representative sample of all students attending four-year SDA high schools throughout the U.S. and Canada, the responses collected represent (1) an overrepresentation of White students, (2) only the responses of students whose parents or guardians consented to their students' participation, (3) a lack of representation of high school-age students who attended junior high schools, and (4) an underrepresentation of students attending inner-city schools.

The need for continued research

During the process of contacting the 93 four-year high schools in the NAD and arranging the logistics of this research, it was clear that many parents and individuals in school administrative positions were skeptical of how such research could be of value to them. Commonly expressed fears were that reporting simple descriptive statistics regarding rates of sexual intercourse and substance use might place the SDA educational system in a bad light and serve as an embarrassment, while yielding little benefit to the schools and the students.

Useful conclusions drawn from this research were *not* that a certain proportion of SDA youth engaged in sexual behaviors or substance use, but were rather that SDA youth are not immune or exempt from engaging in behaviors that place them at risk for unintended pregnancy, sexually transmitted diseases including AIDS, and the legal and health consequences of substance use. Educators can now act by creatively designing strategies that, when implemented, may serve to reduce the consequences of the behaviors studied. ■

[1] *HIV/AIDS Surveillance Report,* Part 7, No. 1 (Atlanta: Centers for Disease Control and Prevention, 1995).

[2] V. L. Tucker and C. T. Cho, "AIDS and Adolescents: How Can You Help Them Reduce Their Risk?" *Postgraduate Medicine* 89, No. 3 (1991): 49-53.

[3] G. C. Zimet, D. L. Bunch, T. M. Anglin, R. Lazebnik, P. Williams, and D. P. Krowchuk, "Relationship of AIDS-related Attitudes to Sexual Behavior Changes in Adolescents," *Journal of Adolescent Health* 13, No. 6 (1992): 493-498.

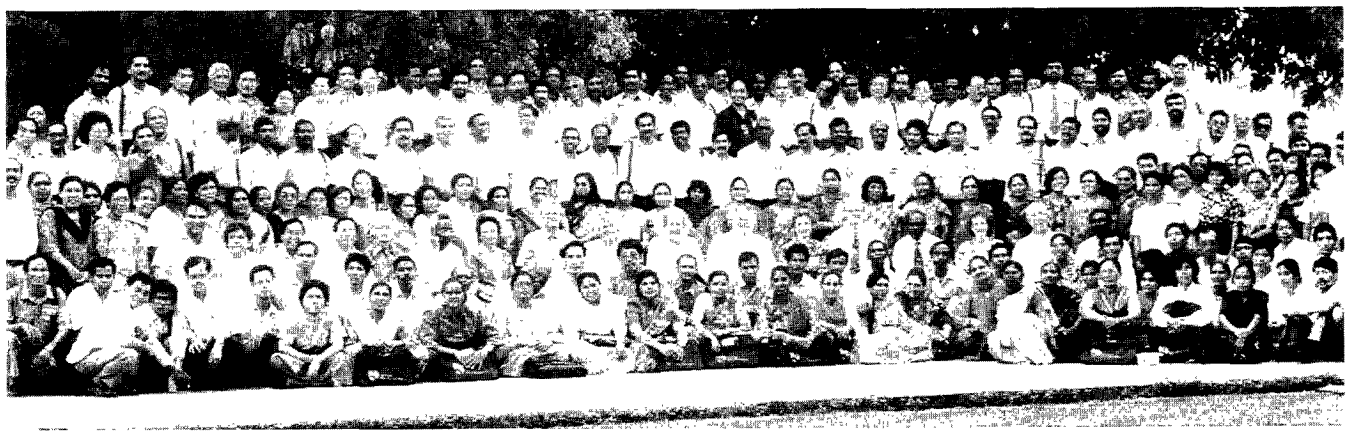
[4] H. Palacio, "Safer Sex," in P. T. Cohen, M. A. Sande, P. A. Volberding, eds., *The AIDS Knowledge Base* (Boston: Little, Brown, and Company, 1994).

[5] See G. Ludescher, "AIDS-related Knowledge, Attitudes, and Behaviors in Adolescents Attending Seventh-day Adventist Schools in California" (doctoral dissertation, Loma Linda University, 1992); P. L. Benson and M. J. Donahue, *Valuegenesis: Report I: A Study of the Influence of Family, Church, and School on the Faith, Values, and Commitment of Adventist Youth* (Minneapolis: Search Institute, 1990); G. L. Hopkins, "AIDS-related Knowledge, Attitudes, and Behaviors of Twelfth-Grade Students at Loma Linda Academy" (unpublished manuscript, 1994); and D. Gray, "Human Immunodeficiency Virus and Acquired Immune Deficiency: Beliefs, Knowledge, and Behaviors of High School Students Attending Seventh-day Adventist Academies" (doctoral dissertation, Andrews University, 1994).

[6] K. R. Miner, "Educating About HIV/AIDS," in P. Cortese and K. Middleton, eds., *The Comprehensive School Health Challenge: Promoting Health Through Education* (Santa Cruz, Calif.: ETR Associates, 1994), vol. 1, pp. 413-441.

[7] M. Hochhauser, "AIDS and Chemical Dependency: Prevention Needs of Adolescents," *Journal of Psychoactive Drugs* 21, No. 4 (1989): 381-385.

World Ministers Council—Southern Asia Division



More than 1,500 pastors and spouses attended the Southern Asia Division session of the World Ministers' Council. They met at three locations: Salisbury Park, Pune, for the Central India Union; Lowry Memorial Junior College, Bangalore, for the South India Union; and at Roorkee high school for the Northern and Northeastern India unions. Pictured are the attendees at Roorkee.

The Ministerial Association agreed to three locations rather than one combined venue in order to make it possible for pastoral spouses to participate. Southern Asia ministerial secretary John Willmott and Shepherdess coordinator Frances Campbell hosted each session.

General Conference Ministerial Association staff members Jim and Sharon Cress, Rex Edwards, and Rae Lee Cooper were joined by several guest presenters, including Gregory and Carol Allen (Ellen G. White Estate), Adly Campos (Family Life evangelist), Lowell Cooper (Secretariat), John M. Fowler (Education Department), Tom Neslund (Health and Temperance Department), Stanton Parker (Adventist Risk Management), William Shea (Biblical Research Institute), Ron and Dorothy Watts (British Columbia Conference), and Lloyd Wyman (Pacific Union Conference). ■

Seminary evangelism—new directions

Benjamin Schoun

Evangelism in the M.Div. program is stronger than ever. Since NADEI (North American Division Evangelism Institute) has been operating from the seminary campus, we have seen greater integration of evangelism with other seminary studies. We have been able to offer more variety to meet the needs of various ethnic and cultural groups. And most importantly, according to Russell Burrill, NADEI's director, is the creation of a mind-set that embraces outreach. While some students would prefer to do only academic studies or only field work, this program provides a balance between study and ministry that will be needed in their work for the rest of their lives.

Recently Russell Burrill conducted a field school in the nearby towns of St. Joseph and Stevensville. About 30 were baptized, boosting morale and enthusiasm for soul-winning in the church. Four groups of students are conducting their own prophecy seminars in towns around the area.

The Center for Youth Evangelism conducted a contemporary outreach to the local high school students in Berrien Springs. It was called Cafe Vertigo. Building on the image of the world of the students spinning dizzily out of control, Cafe Vertigo was a place to stop, focus, and find clarity. The music, drama, and speaker, José Rojas, attracted 300 students, about half of whom were from the public high school. Follow-up continues through "The Group," a voluntary Bible study group made up of public high school students. Plans are to develop a community youth center that will permanently offer to the youth of Berrien Springs a variety of service programs, mission trips, and social activities.

The seminary faculty have been regularly involved in evangelism. At least eight teachers from a variety of departments have held meetings recently in Michigan, Belarus, Puerto Rico, Poland, Bosnia, and other places. Others conduct regular Bible studies. Recently the Old Testament Department created a new course entitled "Archaeology in Evangelism." In other courses teachers are helping students to understand how course materials are usable in gospel work.

The D.Min. program has a special concentration in evangelism and church growth. There are major conferences such as SEEDS '96, the one on church planting that was held at the seminary in June. A certificate and master's program for lay witnessing is being developed as well. Besides teaching traditional and proven methods of evangelism, an important new course is "Innovative Evangelism." Creative teachers and students will seek to develop and test new ideas for reaching population segments that have not been reached.

This increased emphasis on evangelism has led the seminary faculty to establish an umbrella organization to coordinate and strengthen its offerings in this area. While the official name has yet to be chosen, this entity will be somewhat like a school of evangelism. It is not separate from the rest of the seminary. In fact, all the departments of the seminary are represented on its administrative committee and the seminary as a whole still approves programs and grants degrees. It will bring focus to their work, strengthen common resources, reduce overlap, and more effectively serve the church. ■

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Conserving the catch

James A. Cress

"Again, the kingdom of heaven is like a dragnet that was cast into the sea and gathered some of every kind, which, when it was full, they drew to shore; and they sat down and gathered the good into vessels, but threw the bad away. So it will be at the end of the age. The angels will come forth, [and] separate the wicked from among the just" (Matt. 13:47-49, NKJV).

Adventists are doing the work of angels! Many times that is expressed in charitable, self-denying, and benevolent actions. But with regard to new believers, too often we do that which Jesus says must be reserved for the day of judgment and for angels who will serve as God's agents. We want to sort the catch. We want to discard the bad. We want to stop fishing and start evaluating the catch. In short, we want to judge.

Jesus took the illustration from everyday life—a large net, pulled by boats, gathering all in its path. If it were possible for the dragnet to select only that which is edible, clean, and palatable, then the eventual process of sorting, preserving, and discarding would be unnecessary. However, this is not the function of the dragnet. It gathers all that it sweeps across, and all remain together until the time the fisherman, not the fish, do the evaluation (judgment).

This parable is not a depiction of one-to-one, personal evangelism; it is far more inclusive. It is all-embracing in its scope. As Chaney and Lewis say: "Most modern evangelicals who, if they fish at all, fish for sport, have misunderstood the figure Jesus used. They think of a fisherman as a man who uses a rod, line, and lure. Fishing is a one-on-one proposition. In this way, this text has been used to encourage modern Christians to become personal evangelists. The early disciples fished with nets. Fish were in schools, hopefully, and were certainly not caught one at a time. Growing churches have captured that vision. They have learned how to fish with nets."[1]

This parable teaches two clear lessons. First, God expects great numbers to be gathered in. Second, He expects the church to cope with the reality that both good and bad will be caught.

The good and the bad

Like the parable of the wheat and tares (Matt. 13:24-30), the parable of the dragnet demonstrates that both good and bad will remain together until the end of the world. Thesc two parables also avoid a separatism that prevents the people of God from associating with the people of the world. We are to be in the world, but not of the world.

Unlike other theological models for developing disciples or nurturing newborns, this parable does not deal with any transition or process from bad to good or from good to bad, but simply asserts the fact that both exist together in the same environment. That environment is the church.

Jesus clearly teaches that it is the role of the church to nurture new believers more than to evaluate them. Peter Wagner says, "In the early stages of growth it is sometimes difficult to tell true disciples from counterfeits. But that judgment is not usually the responsibility of the evangelist who is concerned more with discipling than perfecting."[2] The church's role is to take that new believer into full discipleship where their character can enter the discipline of being perfected.

Jesus does not envision the church as a "holier than thou" club that stands over against the rest of the world. Just as He ate with publicans and sinners, so His disciples will move and live among people who do not believe, as well as among those who do, and yet who behave badly. The dragnet allows for variety, and the possibility of undesirable fish being part of the catch. "Men are all alike sinners, but not sinners alike."[3]

Some of those sinners, and a good deal of their misbehavior, will be exhibited within the milieu of the congregation. Of course, much of this misbehavior will occur in the lives of new believers (recently pulled in by the dragnet).

If we understand the implications of nurturing newborns, this energetic misbehavior is to be expected. If we understand the imperative of discipling, then we know that the same misbehavior is to be carefully corrected and developed into appropriate behavior and fruitful discipleship. Both of these objectives are mandated.

But either way, discarding the bad in the catch is the work of angels! ■

[1] Charles L. Chaney and Ron S. Lewis, *Design for Church Growth* (Nashville: Broadman Press, 1977).

[2] C. Peter Wagner, *Church Growth and the Whole Gospel* (San Francisco: Harper and Row, 1981), p. 140.

[3] Myron S. Augsburger, *The Communicator's Commentary: Matthew* (Waco, Texas: Word Books, 1982), p. 179.

Shop Talk

Treat for children

Just a little thing has caught on big with the children at our church and bonded me to them as their pastor. Each week following the worship service, after saying goodbye to exiting parishioners, I immediately go to my study, where 25 or 30 children are waiting. They have come to expect a small piece of candy, for which they thank me and leave.

This little thing has developed into a real ritual. Parents have told me, "The children will never forget you. To them you will always be a favorite." I don't have a big ministry to our children, but this at least gives me one personal contact each week.—Thomas Schultz, Winnipeg, Manitoba, Canada

Treat for the elderly

Several senior saints live in a nursing home adjacent to our church. Occasionally my husband and I have lunch with them. The nursing home activities director counts this as a contact with the patients, which they need for their continued accreditation. More than that, the residents really enjoy seeing us put on our bibs and share a meal with them.—Betty L. McCallister, New Martinsville, West Virginia

Physical fitness club

We have organized a physical fitness club. A number of elders, deacons, and other members get together three times a week for jogging or brisk walking. While our physical health has improved significantly, most of all we have enjoyed building relationships.—Danielo D. Palomares, Davao del Sur, Philippines

SongView software

SongView is computer database software that enables your worship leader to compile an unlimited number of song lyrics, access them instantly during a service, and display them on a projection TV, screen, or other video device. The result is a smooth transition between song lyrics without empty screens, out-of-sequence songs, or other visual distractions. The virtually seamless flow of song lyrics promotes participation and facilitates spontaneous worship.

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For more information call 508-252-5339 or fax 508-252-5613. Or you can write: SongView, P.O. Box 460, Rehoboth, MA 02769

Creative baby dedications

You can make baby dedications special for parents by purchasing name plaques containing the new baby's name with its Christian meaning. Expound on the meaning of the name during the dedication prayer. Presenting these name plaques has become a tradition to which new parents look forward.

Another way of bringing creativity into baby dedications is to present the parents with a live green plant, rose, or fresh floral arrangement and liken it to the growth and care of the new child.—Becky Anderson, Bemidjii, Minnesota

Stress without distress

Take a "minute vacation" to remember a happy time. Quit tugging; take one thing at a time. When things pile up, take one thing at a time. Share your love with someone. Have a good laugh. Build in time today for play. Smile. Sort out the possible from the impossible. Share a dream with a friend. Give yourself a pat on the back. Give someone else a pat on the back.—Dan Tohline, Jonesboro, Louisiana

People ought to obey God.

People ought to be chaste.

People really need to keep the Sabbath.

People ought to think more like I do.

People ought to look more like I do.

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