

## Introduction

In an 1845 circular to parents, Amherst College faculty warned of the numerous “dangers [that] attend College life.” The circular described frequent cases of drunkenness, solicitation of prostitutes, gambling, smoking, and other habits “unfavorable to study and morality” among Amherst students. These accounts will probably be familiar to modern faculty, students, administrators, and parents. Stories about the health risks faced by modern college students regularly make headlines both in journals of higher education and in the popular press. College health professionals face continual pressure to do something about major health crises such as sexually transmitted diseases, depression, binge drinking, and epidemics of meningitis and other contagious diseases as well as to deal with more mundane yet more common issues such as managing chronic illness, preventing obesity, and encouraging regular exercise and healthy eating habits. These ongoing student health problems have led parents increasingly to demand that institutions of higher education take responsibility for the well-being of the student body. Baby boomer parents who once protested against parental rules on campus now suggest that colleges and universities return to a variation on their traditional role in *loco parentis*. College health professionals write of the frustrations of combating high-risk behaviors while respecting students’ adult status and the need to promote independence and self-sufficiency.

When I reflect on my undergraduate experience at the University of Vermont in the early 1980s, I share some of this ambivalence about the best ways to protect student bodies while promoting personal autonomy

and freedom of thought. I saw many of my classmates suffer alcohol problems exacerbated by the institution's reputation as a top "party school" in a state with a legal drinking age of eighteen. Like my classmates, though, I enjoyed the freedom and independence of college life. As a resident assistant, I was faced with the frustration of trying to control excessive drinking and obnoxious behavior without violating students' rights as adults. That same year, I took a seminar on the works of Michel Foucault, a scholar in residence during part of the fall 1983 semester. I was struck by some of the similarities between Foucault's ideas about the social construction of disciplinary institutions such as prisons, clinics, and asylums and the rules and regulations my supervisors in Residential Life expected me to enforce. I eventually wrote a seminar paper on the history of dormitories as institutions of social control. Ironically, Foucault's death from AIDS made tragically clear the limits of social constructivist interpretations of medical history. My experience as a client of the University Health and Counseling Services also demonstrated the shortcomings of Foucault's work, since it did not fully consider the perspectives of patients and their families.

Still, Foucault's ideas remained with me as I went on to graduate study at Cornell University. My graduate work in the social history of medicine and women's studies gave me a more nuanced view of the social construction of knowledge than that provided by Foucault. My courses illustrated the ways in which medical theory and practice both reflected and reinforced gender norms, racial stereotypes, and social hierarchies. Yet I also learned that clients were not passive victims of medical opinion and social control. Instead, patients and their families played an active role in the clinic and at the bedside, arguing with doctors, shopping around for care that suited their needs and pocketbooks, accepting and ignoring expert advice as they saw fit. My dissertation, later published as *"A Doctor of Their Own": The History of Adolescent Medicine*, examined the social, cultural, and scientific factors that shaped the emergence of this new subspecialty. I focused on how parents—and, more importantly, teenagers themselves—shaped the field of adolescent medicine.

*Student Bodies* extends this story into the young adult years, illustrating how college and university health programs evolved in conjunction with shifting standards of medical care and public health practices in the United States. College health is not a specialty in the classic sense, since there is no medical board specifically for that field. Nevertheless, there is a professional organization, the American College Health Association, which publishes the *Journal of American College Health*. Experts in this field make special knowledge claims for a particular class of patient based on their age

and circumstances, a process that in some ways emulates the emergence of adolescent medicine as a subspecialty. Indeed, a number of college physicians today receive fellowships in adolescent medicine and/or attend meetings of the Society for Adolescent Medicine (SAM). The *Journal of Adolescent Health* frequently publishes articles on college student health issues. In 1995, SAM adopted a position statement declaring that adolescent medicine covered the ages between ten and twenty-five. The theme for SAM's 2005 annual meeting was the young adult/older adolescent. SAM advises parents about how to ensure that their children make healthy adjustments to college. Therefore, considerable overlap exists between the two fields, and college health can to some extent be seen as an extension of adolescent medicine into the college years. Some members of SAM have argued that the age of adolescence should be extended to cover the late twenties and early thirties to reflect the fact that the period of semidependency usually associated with adolescence has been extended because of longer periods of education, preparation for careers, and/or economic dependence on parents.

This book also examines the relationship between the development of college health as a field and the social construction of young adulthood as a life stage. I argue that college health programs did not emerge *sui generis* but rather were intertwined with the dramatic expansion of higher education in the late nineteenth and early twentieth centuries. Those who had formerly been excluded from elite antebellum colleges—women, blacks, recent immigrants—flocked to the new women's colleges and coeducational public and private universities created in the years following the Civil War. By the 1920s, growing numbers of parents and young people—especially those from racial and ethnic minorities—saw higher education as a means of upward social and economic mobility. Although elite colleges tended to reinforce the status quo by using entrance physical examinations to deny admission to those with “undesirable” physical and mental characteristics, public institutions and more progressive private ones used college hygiene programs to salvage and even rehabilitate unhealthy student bodies. Thus, expanding preventive health measures and clinical services became a way for institutions to deal with the new issues created by an increasingly diverse student population.

Most importantly, this book shows the central role students and their parents played in legitimizing the professional aspirations of college health experts. It explores the ways in which students shaped or even thwarted experts' attempts to regulate the student body. Gender role expectations strongly influenced the success or failure of students' strategies of resis-

tance. The sexual double standard, combined with administrators' eagerness to retain men as clients, ensured that male students were less likely to face restrictions on their behavior than were female students.

To understand how health policies were implemented on the local level, this book draws on archival collections at Amherst College, Cornell University, Dartmouth College, Harvard University, Howard University, Radcliffe College, Smith College, Stanford University, the University of California at Berkeley, the University of Michigan, the University of Minnesota, the University of North Carolina at Chapel Hill, the University of Pennsylvania, and Yale University. I selected these institutions to provide regional and racial diversity as well as a mixture of public and private four-year institutions. More importantly, these institutions have the richest archival records on student health. To extend the story to a broader range of institutions, I have also relied on national surveys, published articles and books, data from funding agencies such as the Commonwealth Fund and the Rockefeller Foundation, and the records of the American College Health Association, which are split between Stanford University and the association's headquarters in Linthicum, Maryland.

Chapter 1 illustrates how gender norms and anxieties about female health shaped the higher education experience for women at both single-sex and coeducational institutions. It shows how the earliest college health programs emerged in response to ambivalent attitudes toward women's higher education in the late nineteenth century. Notions of women's traditional roles as mothers and the need to create an inexpensive and abundant teaching force to staff the nation's public schools promoted expanding educational opportunities for women. Yet this desire to "educate the race" via women conflicted with anxieties about "race suicide" of the white, native-born middle classes as it became apparent that female college graduates were less likely to marry and that those who did had fewer children than women who did not attend college. Members of the emerging black middle class shared these concerns that using educated women as a means of racial uplift would contribute to lower rates of marriage and childbirth among the black elite. They were also concerned that racial segregation and white prejudice made young black women more vulnerable to health problems. In some ways, those who supported collegiate-level study for women were quite progressive for their day in that they believed that women deserved the same education as could be had at elite men's colleges. However, they were also influenced by the work of physicians who warned of the dangers of higher education to women's health and took special pains to protect female student bodies by mandating regular habits

regarding sleep, diet, and above all physical exercise. The dearth of reliable medical therapies at this time led many physicians to advocate a shift from curative medicine to hygienic improvements and state-sponsored preventive medicine measures, including mandatory physical education for schools and colleges. Teaching physical education and hygiene at women's colleges became a common career path for female physicians in the nineteenth and early twentieth centuries, a time when there were few other professional options for women with medical degrees.

Chapter 2 shows how concerns about race suicide shaped the development of health programs for men just as they did for women. Educators and medical experts claimed that excessive study caused nervous ailments and that white college men appeared to be smaller and less physically fit than men from racial and ethnic minorities. African American leaders also became concerned about the health of the elite young men who would go on to lead and strengthen the race as a whole. Men's colleges and coeducational universities in the period after the Civil War created physical education programs and athletic departments for male students as a way of ensuring that college men's bodies were as well developed as their minds. College officials also recognized that physical activity could be used as a way to divert male students away from "unwholesome" pursuits such as smoking, drinking, and illicit sexual activity. This desire to make college men manly yet moral was especially critical to administrators and health professionals at historically black institutions, who sought to overcome stereotypes about black male sexuality. College health officials had to modify their policies to suit student interests. Nowhere was this struggle between institutional control and student autonomy more apparent than in college athletics, which originated as informal contests organized by students and alumni. College physicians initially attempted to ban these activities, since the brutality of early contests resulted in high rates of injury and death. Yet student protests were so great that college health officials eventually had to recognize the limits of their efforts to combat the elitism of college athletics and promote exercise for all.

Chapter 3 examines the impact of sanitary science and bacteriology on college hygiene programs as well as conflicts between town and gown over attempts to protect student bodies from epidemic disease. It focuses on two case studies—the University of Pennsylvania and Cornell University—to illustrate the differences between urban and rural solutions to public health issues. Once again, notions of gender as well as race and ethnicity shaped how particular campuses responded to threats of epidemics and contagious disease. Warnings about the allegedly harmful affects of higher education

on the health of young women led women's colleges and coeducational institutions alike to impose parietal rules that required women to live on campus, where their moral and physical well-being could be closely monitored. During most of the nineteenth century, officials were reluctant to assume the same responsibility for male students, largely because they believed that doing so was superfluous. After the Civil War, the average age of male students had increased to eighteen, and many administrators believed that men did not need the close supervision that had been imposed on the young boys who had previously attended college. By the early twentieth century, many parents found this situation increasingly intolerable, believing that their sons needed as much supervision as did their daughters. These efforts were constrained by fears that too many controls over male campus life would "feminize" men as well by as strong resistance from male undergraduates. These concerns about preserving gender role norms would create a separate and unequal college experience for women.

Chapter 4 explores how college hygiene departments gradually evolved from emphasizing physical education and sanitation into comprehensive health centers offering clinical care. Although preventive measures such as physical examinations and medical inspection of campus facilities became standard practice by the early 1900s, colleges and universities hesitated to establish clinics for students because they feared opposition from local physicians' groups, who were already disturbed by the spread of contract practice in factories, mining camps, and other industries. To address these concerns, college health professionals during the 1910s began a self-conscious effort to upgrade their field and establish special claims to knowledge that other physicians lacked. In 1920, physicians working in colleges and universities came together to form the American Student Health Association to share ideas and to establish networks for those engaged in college health work. At the same time, professionals in college health were influenced by the "new public health" of the early twentieth century, which focused on individual risk factors rather than broader environmental and social dangers. College health programs emphasized individual health care and hygiene education while downplaying the broader programs of sanitary reform that had characterized earlier public health efforts. This chapter argues that the professional legitimacy of college health as a field hinged partially on changing notions of about college students as a class of patients and the college environment as a locus for medical practice. During the early twentieth century, college health experts extended the adolescent status of semidependency into the young adult years, applying the

concept to men as well as women. College physicians drew on the work of noted child psychologist G. Stanley Hall, who suggested that the college experience prolonged the adolescent stage of life. Emulating Hall, college physicians attempted to alleviate gender discrepancies in the regulation of campus life. Doctors argued that male students remained adolescents and therefore deserved the same protections in loco parentis as did their female counterparts.

Students played a central role in the growth of clinical services, as many found the free market of medical care in college communities beyond their means. Student demand for affordable medical care became especially strident at public universities. Those with limited resources found themselves forgoing medical care and/or dropping out of school entirely because of untreated health problems. In response, student organizations sought ways to finance health services for less fortunate students. Modeling themselves after insurance programs offered by fraternal organizations such as the Odd Fellows and Freemasons, some college organizations began in the early twentieth century to create health care funds for students who could not otherwise afford medical care. College physicians responded to these student-led initiatives by demonstrating the link between poor health and wastage of human potential. Drawing on examples from industrial medicine and the conservation movement, physicians argued that clinical services would help prepare student bodies to fit into the emerging industrial capitalist social order. They also claimed that college health services took the place of the family doctor and health supervision offered in students' own homes. This metaphor of the college infirmary as a surrogate home proved a successful strategy for parents. Students, however, did not usually share physicians' views about their ability to make mature health care decisions. Nevertheless, students compromised to obtain affordable and accessible health care.

The mainstream medical profession remained opposed to student health services as well as other forms of contract practice. Chapter 5 looks at how professionals in college health used links between student health and the health of the nation to further legitimize medical services for college students. This relationship between the fitness of the student body and the well-being of the body politic became especially prevalent in the 1930s and 1940s, as concerns about the strength of the United States as a world power intensified interest in preserving the health of the nation's student population. Although college students made up a small percentage of the young adult population throughout the twentieth century, college physicians argued that by virtue of their roles as future leaders and voters,

protecting student bodies—in particular, male student bodies—was essential to the nation’s viability. Disclosures about the poor health of college-aged military recruits during World Wars I and II as well as high rates of sexually transmitted diseases and tuberculosis among the college-aged population in 1920s and 1930s exacerbated existing fears about racial degeneration and provided yet another incentive for improving health services for college students. Physicians at both white institutions and historically black colleges and universities called for greater attention to black student health as part of a larger program of racial uplift. Physicians argued that college students, both black and white, could help sell hygiene to the American public, thereby elevating the status and cultural authority of the mainstream medical profession. These simultaneous efforts to “sell” college health programs by linking them to the nation’s health culminated in the 1947 report of President Harry S. Truman’s Commission on Higher Education, *Higher Education for American Democracy*, which stated that one of the major goals of higher education was to help improve the health of the individual student and thereby raise the standards of individual and community health throughout the nation. Although the mainstream medical profession remained opposed to Truman’s attempts to establish national health insurance, the medical establishment became convinced that college health services, like other forms of prepaid group practice such as Kaiser Permanente, constituted a reasonable middle ground between traditional fee-for-service care and state-funded medical care.

Protection of the student body was not limited to physical health. Chapter 6 examines the emergence and development of mental hygiene programs for college and university students. Many professionals involved in student health services and student personnel work were inspired by the mental hygiene movement that began in the 1920s. Like their counterparts in elementary and secondary schools, college mental hygienists became interested in finding ways to prevent and treat mental disturbances in college students before they led to academic difficulties and failure. Student health services frequently worked in conjunction with departments of clinical psychology to study the incidence of emotional difficulty among the student body, as well as to design tests that would help predict which students would be most likely to experience maladjustments while in college. In the process, college health centers created psychological services that helped students manage the stresses of late adolescence and the academic and social pressures of college life. College mental hygiene experts also emphasized the importance of mental hygiene programs in fostering mature minds and healthy personalities among the nation’s youth. Experts



argued that giving students a greater role in college health programs formed a central part of promoting maturity and independence in college students.

This new commitment to a truly student-centered health service would have unintended consequences in the ensuing decade, as students rebelled against the paternalistic structure of American colleges and universities. Chapter 7 examines how student unrest in the 1960s and 1970s created new challenges for college health services. Throughout the 1960s, physicians and other health care professionals on college campuses became accustomed to treating students injured during protests as well as to fielding increasing requests for advice on birth control, sexuality, and the use of illegal drugs. Student leaders emulated the broader consumer rights movement by demanding a greater role in the services offered and in how their health fees were spent. Allied with other social movements of the 1960s and 1970s, such as the civil rights movement, women's liberation, gay rights, and disability rights, the student health activism during this period also led to more inclusive policies regarding race, physical appearance, and physical ability. During the 1970s, the American College Health Association recognized students' role in shaping health care by establishing the Student Advisory Committee to help shape the future of college health services. The student protests of the 1960s culminated in the abolition of parietal rules on most campuses. Unfortunately, student activism also prompted a backlash that reduced state allocations and institutional commitment to campus health programs that served "unruly" and "ungrateful" students. Faculty too criticized the medicalization of higher education by college health experts, especially those associated with psychiatry and student counseling.

The final chapter uses two recent health crises during the past two decades—the AIDS epidemic and the increase in mental health problems among students—to illustrate continuities and changes in college health over the past quarter century. The appearance of these and other dangers to student health has reopened discussions about the extent to which institutions of higher education are responsible for the health of their students. Members of the American College Health Association have used the new health risks faced by modern students to justify the ongoing need for college health programs emphasizing prevention and early intervention, especially given the escalating costs of medical care and the expanding ranks of uninsured and underinsured young adults. Notions about the relationship between the health of the student body and the health of the nation continue to play a major role in twenty-first-century health care debates. At

the same time, the student movements of the 1960s and 1970s make a return to a paternalistic model of health promotion inappropriate, especially given that the fastest growing section of the student population falls beyond the traditional college age of eighteen to twenty-two and often has parental responsibilities of its own. Finding a balance between overly protective supervision and utter neglect continues to vex professionals concerned with the health of student bodies in the twenty-first century.