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Health and Friendships of LGBTQIA+ College Students

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Health and Friendships of LGBTQIA+ College Students

by

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ABSTRACT

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Others (LGBTQIA+) college students continue to face discrimination in seeking healthcare, having to navigate lack of access, heteronormative practices and protocols, and biased attitudes, even when accessing university health services. Moreover, LGBTQIA+ college students are unlikely to be able to rely on traditional sources of support such as family, and have a need to create a sense of home, by making friends. In this thesis, I explore friendships as an avenue through which these students seek health information and knowledge. I argue that health and friendship intersect in the lives of LGBTQIA+ college students in two ways. First, I find that LGBTQIA+ college students build emotional intimacy with friends to create networks of care, with different friends providing them various kinds of support around health. I argue that this care fills a gap left by institutions and other social relationships, which are not able to provide LGBTQIA+ college students with emotional support around their health. Moreover, it is because friendships are such voluntary and intimate relationships that they are able to fulfill LGBTQIA+ students unique needs for support regarding their health. This care also enables these students to maintain their health and well-being in an environment of limited access to adequate healthcare services.

Second, I argue that health discussions between friends are a site of production and sharing of experiential and embodied knowledge, and that the sharing of this knowledge is itself a form of care. Experiential and embodied knowledge is shared within and through LGBTQIA+ college students' networks of care. There is healthcare, and then there is care around health. It is the former which is provided by friends through health conversation. Hence, health conversations with friends are an extension of these students' health. The sharing of such knowledge allows LGBTQIA+ students to cope with their circumstances, as well as to increase emotional intimacy with their friends. These health-related discussions thus play a significant role in these students' understandings of health, as well as the maintenance of their well-being.

CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and others (LGBTQIA+) individuals continue to face discrimination when accessing high quality healthcare in the United States.[1] Transgender individuals, for instance, face significantly more disadvantages in accessing healthcare than cisgender individuals, and have more health-related issues due to discrimination (Bradford et al. 2013). In relation to sexual orientation, LGBT individuals generally face more difficulties in accessing healthcare than heterosexual and cisgender individuals (Albuquerque et al. 2016). For instance, women in same-sex relationships are less likely to have health insurance and have more unmet medical needs than heterosexual women (Buchmueller and Carpenter 2009).

More specifically, LGBTQIA+ students on college campuses accessing university healthcare services face discrimination and receive inadequate care (Hood et al 2019, 809). For instance, they experience microaggressions such as misgendering by healthcare providers[2].

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[1] High quality healthcare is defined by Mosadeghrad (2012) as multi-dimensional, including characteristics such as "availability, accessibility, acceptability, appropriateness, affordability, technical competence, timeliness, privacy, confidentiality, empathy, attentiveness, caring, responsiveness, accountability, accuracy, reliability, comprehensiveness, continuity, equity, environment, amenities and facilities" (258). Here, I use this definition qualitatively, as a way to contextualize the experiences of my participants who share stories of dissatisfactory and/or discriminatory care.

[2] Healthcare provider as used here includes licensed professionals such as doctors, nurses, psychologists, therapists, counsellors and other mental health professionals, and hospital staff who provide medical care to individuals.

LGBTQIA+ college students also feel that there is insufficient outreach towards them by university health services. LGBTQIA+ college students are thus navigating this climate of discrimination by and within the healthcare system.

Furthermore, scholars have also demonstrated that LGBTQIA+ college students are less likely to rely on traditional sources of support such as family, particularly as many LGBTQIA+ students do not receive acceptance from their families and/or are not able to reveal their identities to them (McGarry and Haggerty 2007). Weston (1991) argues that LGBTQIA+ individuals may rely on “chosen families” which are not organized through blood relationships or marriage and child-rearing (206). She asserts that these chosen families also “embrace friends” as a part of them (Weston 1991, 3), creating kinship and familial feelings between friends in ways which are different from heteronormative ideals. As such, friendships are a key avenue for LGBTQIA+ individuals to seek support and create a sense of community.

Moreover, many college students move away from home, which is also likely to shift their reliance on families, more towards others in their own individual social circles. Kusenbach and Paulsen (2013) argue that “a sense of home is socially and interactionally constructed” (195), asserting that people actively seek to create a sense of belonging and community wherever they are. Making friends is one such way of creating a sense of home (Borchard 2013, 88). Hence, LGBTQIA+ college students are likely to form and rely on friendships for a sense of community and support.

Additionally, existing literature indicates that both LGBTQIA+ individuals and college students do not necessarily trust family members and others in their social circles as reliable sources of health information (Solebello and Elliot 2011). Meanwhile, they are also likely to face discrimination when seeking healthcare, which means they cannot rely on healthcare providers for adequate care either. Within this context, they are likely to rely on their own chosen, voluntary, and intimate relationships for support regarding their health. One such significant type of relationship is friendships. It is because friendships play such a significant role in the lives of this particular group, that I wanted to explore what role these relationships play in the maintenance of our health and our navigation of healthcare.

Friendships in particular are sources of emotional support and affirmation for LGBTQIA+ individuals (Hughes 2019; Rumens 2010). Friendships with and between LGBTQIA+ individuals have been reported to improve their well-being (Hughes 2019), especially when other sources of social support such as families are not available due to homophobic and transphobic attitudes (McGarry and Haggerty 2007). Other marginalized groups such as migrant communities also face dissatisfaction in accessing healthcare, and rely on their interpersonal relationships for support and care (Bradby et al. 2020). Moreover, gender also plays in a role in provision of support around healthcare, particularly when there is limited access. For instance, women tend to shoulder the burden not just of care work, but also to find ways to navigate discrimination and inadequacy of healthcare services (Bradby et al. 2019).

For college students in particular, friendships are significant relationships which provide an educational role in the lives of individuals as they are generally within the age bracket of emerging adulthood and are exploring their identities and sexualities (Martínez Alemán 2010; McDavitt and Mutchler 2014). While health-related communication between college students has been suggested as a significant area of exploration, the extant literature on health-related communication between college students does not focus specifically on LGBTQIA+ students. The literature is also largely focused on sexual and reproductive health related communication between friends (Byron 2017; Pariera and Abraham 2020; Rutledge et al 2011; Rittenour and

Booth-Butterfield 2006). Health communication outside of sexual and reproductive health, particularly through the lens of friendship is largely unexplored.

Studies explore the topics college students discuss with their friends in relation to sexual health, such as their sexual encounters, and use of condoms and birth control (Byron 2017; Rittenour and Booth-Butterfield 2006). College students have varying preferences for which individuals they prefer to discuss different sexual matters with as well (Rutledge 2011). Most significantly, various types of sexual health communication between friends involves sharing of personal experiences (Porter et al 2019).

The sharing of information and personal experiences between individuals is a form of knowledge production and meaning-making (Rich 1986; Ellingson 2008). This form of knowledge is embodied and subjective, and is particularly important for marginalized groups (Rich 1986; Ellingson 2008). For LGBTQIA+ college students who likely will have to navigate discrimination in trying to access healthcare, the sharing and production of embodied knowledge through communication between friends is particularly significant for their well-being (McGarry and Haggerty 2007).

The sharing of information and experiences has been reported to influence people's health behaviors and related decision-making (Quinn et al 2020; Busse et al 2010; Holman and Sillars 2012; Miller-Ott and Durham 2011). Friendship communication may not be limited to discussions between LGBTQIA+ individuals. Rather, it may include various members of their social networks and friendship groups. College students may have to depend on friendship networks for health-related information and support in part because many of them attend college away from home and family. This effect is likely amplified for LGBTQIA+ students who are likely to have to navigate stigma and discrimination when seeking healthcare.

This is particularly significant in the context of the COVID-19 pandemic, during which health services have been negatively impacted, limiting healthcare access (Bojdani 2020; Garcia et al 2020; Litchman and Rigel 2020). At the same time, health needs of college students have changed, particularly with the worsening of mental health (Lee et al. 2021). Moreover, the pandemic is also widening pre-existing inequities in access to healthcare along racial, ethnic, gender and sexuality lines, with minority groups facing disproportionate impacts of the pandemic, both in relation to disease burden as well as limited access to healthcare for a variety of health issues (Krouse 2020; Wilder 2021; Phillips II 2020; Moore et al 2021; Kamal et al 2021).

As such, it is important to explore the ways in which LGBTQIA+ college students communicate with their friends about any and all health-related matters, including mental health, physical health, experiences with healthcare providers, and health behaviors. In this study, I address the following research questions: How do health and friendship intersect in the lives of LGBTQIA+ college students? How do LGBTQIA+ college students discuss health matters and share health-related experiences with their friends? How do they create emotional intimacy with their friends and how does it relate to the sharing of health information?

Literature Review

To understand the health-information sharing behaviors between LGBTQIA+ college students and their friends, it is important to explore scholarly work on friendships, health communication among LGBTQIA+ individuals, and health communication between college students. Moreover, there is a need to understand how embodied knowledge is produced and shared by this particular population, as individuals rely on their friends for information and support around healthcare (McGarry and Haggerty 2007; Byron 2017; Rittenour and Booth-Butterfield 2006).

Friendships

Since friendships are a particular avenue for the production and sharing of embodied knowledge (often through the sharing of personal experiences between friends), it is important to first explore the concept of friendships. This includes understanding how friendship is defined and conceptualized, as well as the significance of these relationships, especially for marginalized groups such as LGBTQIA+ college students. The significance of friendships for this group revolves around knowledge production and sharing, operating as sites of resistance, and identity affirmation.

Friendships are defined by Bowlby (2011) as intimate and voluntary relationships which "involve some degree of emotional involvement" (608). Bowlby (2011) argues that friendships are relationships characterized by care, even if it only means that friends distantly "care about one another" (608). Hence, she asserts that friendships are a type of "informal caring relationship" (Bowlby 2011, 608). Since, friendships involve emotion, it is important to understand the role it plays in these relationships. Bunnell et. al. (2012) explain that friendships involve "emotional labor" through the act of caring about and for one another (499).

Moreover, friendships involve connections which are not necessarily limited by physical presence. Cronin (2015) argues that friendships are often characterized by "felt connection", which is "maintained primarily through practices of the imagination (alongside occasional co-presence)" (668). Cronin (2015) also argues that individuals have different "spatial sensibilities of friendship" which operate both on geographical and emotional planes (677). In terms of emotions, this means that people experience different meanings of friendship and have varying levels of emotional intimacy with their friends.

This is especially relevant in the context of the COVID-19 pandemic, as college students, especially those who joined universities during the first year of the pandemic with social distancing rules in place, have been affected by social isolation (Lippke 2021). Lippke et al (2021) argue that students have used different coping mechanisms to mitigate loneliness, such as maintaining relationships virtually using digital devices, especially as they feel the need for deeper emotional connections during a global crisis. During these times, the significance of Cronin's (2015) "felt connection" becomes clearer as individuals negotiate physical distance to create and maintain emotional intimacy (668).

Furthermore, friendships can be a means of collective knowledge production and meaning-making, particularly in the context of limited access to healthcare due to discrimination and the adverse effects of the COVID-19 pandemic. Chowdhury and Philipose (2016) argue that "friendship is to know someone, and to know them in particular. We can have friendly feelings and desires, but friendship itself is intimate, personal, caring, in particular, attached, and connected" (2). Through these intimate relationships, we share individual and collective experiences, which can be based on different aspects of our identities Hence, Chowdhury and Philipose (2016) conceptualize friendship as "our resistance to the divisive and fragmenting lies of structural power; the seeds of global compassion, generosity, empathy and love" (3).

When experienced by marginalized groups, friendships as sites of such collective meaning-making can shape individual negotiations with powerful social structures. Women's friendships, for instance, can be sites of resistance, because there are various "societal forces which wrench women's emotional and erotic energies away from themselves and other women"

(Rich 1980, 637). Women’s friendships are complicated by structural processes such that they are engaged in “double-think” – even as they cherish woman-to-woman friendships, “indoctrination in male credibility and status can still create synapses in thought, denials of feeling, wishful thinking, a profound sexual and intellectual confusion” (Rich 1980, 646).

Along with operating as sites of knowledge production and sharing about our bodies and health, friendships are also a source of identity affirmation and support, particularly for minority groups such as college students of color and LGBTQIA+ individuals. For instance, Haynes (2019) argues that African American women who are college students in predominantly white educational institutions seek friendships with each other as a way to insulate themselves from discrimination and prejudice within on-campus housing.

Similarly, Hughes (2019) explores friendships between queer women of color who are enrolled in a women’s college. She argues that friendships between queer women of color are a source of emotional support and provide motivation to individuals to participate in campus life which in turn strengthens those friendships (Hughes 2019). These friendships also affirm the individual, racial and sexual identities of individuals and improve their sense of self-worth (Hughes 2019). Rumens (2010) also argues that workplace friendships can be a source of support and affirmation for gay men.

Friendships are sites of support particularly for marginalized individuals who share identities, because “sharing the same experiences, particularly difficult times, can draw friends together and act to co-create identities interpersonally” (Cronin 2015, 669). Through the sharing of experiences, friendships function as networks or “communities of care” (Kathiravelu and Bunnell 2017, 501). Kathiravelu and Bunnell (2017) argue that friendships involve “constant affective ‘work’” which enables them to serve as relationships which offer care and support (500).

Moreover, Rebughini (2011) argues that friendships allow individuals to engage in “self-analysis” to understand and make legible their experiences (8). Similarly, Minai and Shroff (2019) argue that conversations are an important avenue through which women and LGBTQIA+ individuals and scholars share and learn. They posit friendships between women of color and between LGBTQIA+ individuals “as a conditional state of intimacies and affective attachments” that go beyond simplistic ideas of “feminist sisterhood” because these relationships are “neither unconditional nor devoid of contention and complexities” (Minai and Shroff 2019, 35). Other than providing emotional care and identity affirmation, and operating as sites of knowledge production and sharing, friendships can also play an educational role. For instance, Martínez Alemán (2010) argues that college women’s friendships are “learning relationships” in which these individuals can experience learning that is “purposeful, practical, and productive” (555). According to Martínez Alemán (2010), “these are relationships through which women’s identities consciously evolve” and that “women articulate the self and develop their identities through friendship with other women” (555), making friendships a site of knowledge production about self and identity.

These texts reveal that the friendships of and between members of marginalized groups and college students particularly of LGBTQIA+ individuals, are emotional connections which provide essential care and support to individuals. These relationships also allow individuals to learn more about themselves and to establish connections based on shared experiences. Friendships act as insulators from difficult experiences, operating as sites of resistance through a sense of shared experience and collective meaning-making of those experiences. To understand how knowledge production and sharing happens within friendships in the context of health, there is a need to explore health-related communication within LGBTQIA+ friendships.

Health Discussions in LGBTQIA+ Friendships

One particular point of intersection of health and friendship for LGBTQIA+ students which I explore is their discussions with friends about health. Friendships as sites of knowledge sharing allow for discussions about health matters, which has the effect of improving people's psychological well-being as they are able to express their emotions and experiences. Barrett et al (2015), for instance, argue that particularly in older gay and lesbian individuals, intimate relationships and friendships are significant as sources of support and identity affirmation within homophobic environments. Poteat et al (2020) also argue that gender and sexuality alliances in colleges improve students' well-being and increase opportunities for advocacy.

Similarly, Brandt and Carmichael (2020) argue that social support in online settings improves the well-being of individuals belonging to sexual minorities. These conversations about health matters are important because they can influence people's actions and behaviors. For instance, Hankel and Morris (2014) found that young LGBTQIA+ people find a sense of community through online groups and forums, where they can have discussions about various topics, including health and well-being. These discussions help in providing support and motivation for action. For instance, they report through discussions and support, students can mobilize and take action, such as demanding more inclusive sexual health curriculums (Hanckel and Morris 2014, 881-2).

Moreover, Holt-Lunstad (2017) argues that friendships are a key social relationship which have implications for individuals' health. She suggests that friendships can impact the physical health of individuals in three ways: "1) the extent of integration in social networks, (2) the quality of social interactions that are intended to be supportive (e.g., received social support), and (3) the beliefs and perceptions of support availability held by individuals (e.g., perceived social support)" (234). Moreover, she asserts that the relationship between health and friendships is "bi-directional" (Holt-Lunstad 2017, 234), whereby having friends allows us to be healthier and being health improves our abilities to create and maintain friendships.

One way in which friendships are implicated in our health maintenance is through health discussions which can influence people's decisions about adopting medication. For instance, Quinn et al (2020) report that uptake of the HIV prevention drug Pre-exposure prophylaxis (PrEP) increased among Black gay and bisexual men through peer and social network support. This is because discussions with peers filled in gaps left by healthcare providers, who failed to discuss or provide complete information to these individuals about PrEP. Quinn et al (2020) also argue that individuals trust information from their friends, which increased their trust in the medication, and reduced stigma associated with taking it.

Similar findings have emerged from the study of support groups. For instance, Huang et al (2019) in their study on healthcare virtual support communities argue that there are two aspects of interactions on health-related matters (417). The first is the sharing of medical information in order to address gaps in information provided by the healthcare system or by people's providers. The second is the provision of emotional support between participants in an interaction. Hence, these support groups and friendships between LGBTQIA+ college students have some similarities, since both are providing health information as well as emotional support to individuals. This indicates the intersection between health and friendship.

Furthermore, Byron (2017) argues that young people's friendships are significant in providing them support and in shaping their safe sex practices, beyond aspects such as the use of condoms. For instance, discussions between friends can help young people understand the nature and significance of consent (Byron 2017, 496). Exploring the ways in which young people discuss sexual matters with their friends, he suggests that “close attention to discursive relations between friendship and sex suggests that young people’s friendship cultures can ‘queer’ sexual norms, evade institutional agendas and forge new pleasures – sexual and otherwise” (Byron 2017, 497).

While health discussions can provide marginalized groups such as LGTBQIA+ individuals with an avenue for support and health information, there is also a risk to the sharing of such knowledge. This is because misinformation can spread through such conversations. This may occur in health discussions between LGBTQIA+ individuals and their social circles, due to the mistrust minorities are likely to have towards healthcare services.

Jaiswal and Halkitis (2019) argue that while in some cases, mistrust in the healthcare system, and more specifically in physicians or treatments, is a result of misinformation, in many other situations, “medical mistrust reflects the very real historical and ongoing injustices experienced by socially and economically marginalized groups” (79). This is especially the case for LGBTQIA+ individuals. They also argue that there are “myriad negative health consequences associated with medical mistrust, including lower utilization of health care and poorer management of health conditions” (79). This means that it is important to remain cognizant of the type of information which is being shared between friends.

This means that it is important for us to understand the discursive relationship between friendship and health as well, which includes but is not limited to sexual and reproductive health matters. By exploring health discussions of LGBTQIA+ college students, this intersection between health and friendship can be better understood. To understand the role of health discussions between LGBTQIA+ college students and their friends in the maintenance of their well-being through knowledge production and sharing, there is a need to explore health communication within college students' friendships.

Health Discussions in College Students' Friendships

Scholarly work on health information seeking behaviors in college students suggests that sexuality and sexual and reproductive health are significant discussion topics (Rutledge et al 2011). This communication is particularly significant within the context of inadequate sexual education provided to young students. Garcia and Fields (2017) argue that "feminist, queer and anti-racist sexuality education remain elusive and that LGBTQ students and teachers still navigate heteronormative ideas and institutions that compromise their safety and value as members of school communities" (473). This is also likely to be the case in navigating discrimination when accessing health services.

Moreover, gendered discourses around sexuality are reinforced on college campuses which influence young people's beliefs about sexual activity (Hamilton and Armstrong 2009). These beliefs are in relation to double standards whereby women are judged for their sexual activities whereas men are not, and men and women's expectations of sexual pleasure (Armstrong et al 2014). Within such a climate, LGBQTIA+ college students sexual and general health-related communication with their friends is particularly significant, since they do not always have access to comprehensive health information.

The extant literature on health communication among college students indicates that young people have different sources of medical knowledge. For instance, Baxter et al (2008) report that a significant number of college students rely on friends and family for health information. Furthermore, Lefkowitz et al (2004) report that female students are more likely to have sex-related conversations with their friends than males.

While most college students have multiple sources of information, they do not value all of them in the same way. For instance, not many students prefer their parents as the source of health information (Rutledge et al 2011). This is because parents can tend to push their children towards heteronormative ideas of identity (Solebello and Elliot 2011). Moreover, Rutledge et al (2011) find that individuals report their female friends as their primary source of sex-related information. Moreover, Pariera and Abraham (2020) also report that young women in college frequently discuss sex-related topics with each other.

Moreover, Rittenour and Booth-Butterfield (2006) argue that college students have frequent communication with their peers regarding sexual health, such as use of condoms and birth control. Such communication is also higher in female students as compared to males, and women are more comfortable discussing these topics with each other than men. Students also prefer to discuss information with peers they regard as belonging to the same gender (Rittenour and Booth-Butterfield 2006).

College students' comfort in talking to their peers and friends about sex-related topics varies. In a study on college student's health-information seeking behavior, Chang (2014) explored the ways in which Singaporean college students communicate with their closest friends about sexual health. The study shows that students are likely to talk to their friends about sexual activity and health if they believe that they will receive a positive or helpful reaction from them rather than a negative and judgmental one. Porter et al (2019) report that "peer sexual health discussions are often tied to life events, either of the participant or someone close" (143). Hence, sexual health communication between friends involves their personal, embodied experiences.

Moreover, the type of messages and information young people receive from their friends can impact their behaviors. For instance, Busse et al (2010) report that the types of sexual messages adolescents receive from their friends can impact their decision to become sexually active. Similarly, Holman and Sillars (2012) report that sexual communication about 'hooking up' between college friends impacts their decisions to engage in certain types of sexual behavior. Miller-Ott and Durham (2011) report that women rely on friends and family for information and support in relation to genital HPV, and it can influence their attitudes towards preventive measures. Since health discussions involve the sharing of experiences and information, I argue that these are a site of production and sharing of embodied knowledge.

Embodied Knowledge

This study explores how health and friendship intersect in the lives of LGBTQIA+ college students. Friendships are a significant avenue for care and support; hence, it is important to explore the role health-related communication within these relationships. In this study, I argue that this health-related communication produces embodied knowledge. Hence, to understand how experiences and knowledge are shared among friends, there is a need to understand the concept of embodied knowledge.

Kline (2010) argues that certain bodies and their experiences have historically been considered "bad science" because anything feminine, nurturing, and related to subjective experience was disregarded by scientists for lack of objectivity (2). She explains that certain feminist groups since the 1980s have been trying to "challenge the division between subject and object in medicine and to introduce a different form of knowing based on subjective experience (2). These feminists have argued that it is within the commonalities of our experiences and feelings that we find solidarity and support, emphasizing the significance of lived experience

(Kline 2010; Fonow and Cook, 1991). Instead of thinking “around” and “about” their bodies, we need to think “through” our bodies (Kline 2010, 3).

The idea of thinking ‘through’ the body is particularly applicable for individuals who identify as LGBTQIA+. This is especially relevant to LGBTQIA+ individuals’ interactions with healthcare providers, which are shaped through powerful structures that claim objectivity of knowledge. These structures have been produced and reproduced throughout the history of medicine and science, and they limit LGBTQIA+ people’s agency, as well as their knowledge and control over their own bodies (Haraway 1991; Rich 1986; Libbon 2007).

Libbon (2007) argues that Western medicine pathologizes certain bodies by essentializing them within a fixed category of sex and gender, and then regulating the behavior and actions of these bodies, marking as anomalous whatever falls out of these fixed categories. Hence, women and LGBTQIA+ individuals own knowledge of their bodies has been historically discredited and demeaned. This is especially true for young people’s knowledge of their own bodies, which is often marginalized in favor of institutionalized medical knowledge (Byron 2017).

Challenging the presumed universal legitimacy of this knowledge, Haraway (1991) proposes resistance to institutionalized knowledge and argues for the “union of the political and the physiological” (9). By doing so, we can pose a challenge to the presumed objectivity of scientific discourse. She emphasizes that all disciplines within science, including biology, form a “field of academically institutionalized knowledge production” (197). In order to challenge the notion of “scientific objectivity”, Haraway (1991) posits the concept of “situated knowledges” – knowledge cannot be disembodied because it is always being produced by someone (197). She insists on a “feminist objectivity” through which we can have “many heterogeneous accounts of the world" instead of one specific knowledge bank which claims to be disembodied and therefore objective (198).

Haraway (1991) reinforces the ideas of feminist standpoint theory, one significant goal of which is to begin research from "the daily lives of oppressed groups" (Harding 2009, 195). By thinking through and within a marginalized groups standpoint, we can challenge institutionalized forms of knowledge production and validation (194). This is in line with Rich (1986) who contends that there is a need to study the actual lived experiences of women as the first step in understanding how much power they have over their own "sexuality" (23) and "procreative capacities" (23).

This does not mean that we view the "personal for its own sake" and focusing on an "individualistic telling" of personal experiences (Rich 1986, 10). Instead, Rich argues that we must use the personal for the political, aiming for a collective understanding of women's experiences of varying forms of oppression. This will result in a "collective movement to empower women" (Rich 1986, 10). Rich's argument also applies to LGBTQIA+ individuals, because their lived experiences need to be studied in order to account for their knowledge of their own bodies and health.

It is particularly important to acknowledge and understand the lived experiences of LGBTQIA+ individuals AND consider these as part of knowledge creation (Collins 2004). Black feminist and queer thought also emphasize the significance of lived experience in analyzing how various systems of oppression shape individuals' lives and the ways in which these oppressive systems are resisted (Cohen 2005, 31). In doing so, researchers themselves produce embodied knowledges with radical political potential.

Ellingson (2008) defines embodied knowledge for researchers as that which “situates intellectual and theoretical insights within the realm of the material world” (2). She goes on to suggest that “knowledge grounded in bodily encompasses uncertainty, ambiguity, and messiness in everyday life” and “is inherently and unapologetically subjective” (2). This highlights the need for exploring how people, particularly LGBTQIA+ individuals, formulate and share their own embodied knowledge in relation to themselves and their health.

Moreover, queer feminist science studies scholars argue that “disciplinary scientific practices are inextricably conditioned by particular political economies and ideologies that regulate: a) what counts as legitimate scientific knowledge; and b) which kinds of people, bodies, and institutions can conduct scientific research in the first place” (Cipolla et al. 2017, 6). This means that certain types of knowledges are actively excluded from the realm of legitimacy. Understanding how knowledge is produced and shared by LGBTQIA+ college students is thus a way to excavate these excluded embodied knowledges. Doing so requires that we focus on the “contextualized and situated materiality” of our bodies (Roy and Subramaniam 2016, 36). This means exploring the experiences of LGBTQIA+ college students within the climate of discrimination they are likely to navigate when seeking healthcare.

Through the above-mentioned texts, we understand that the discourse which enables the pathologizing of certain groups, such as women and LGBTQIA+ bodies, also attempts to appear ‘neutral’ and ‘objective’. We need to recognize and understand alternative accounts, such as those which emphasize experiential knowledge. We need to find value in embodied knowledge rather than the institutionalized knowledge imposed on our own bodies and physiological and emotional experiences. Hence, it is important to understand how LGBTQIA+ individuals know their bodies (Kline 2010), and where this knowledge comes from, and how they share this knowledge within their friendships. This can be achieved by first exploring the health communication between LGBTQIA+ individuals and their friends.

My study conceptualizes health-related communication between LGBTQIA+ individuals and their friends as the production and sharing of embodied knowledge. Various marginalized groups share embodied knowledge and form networks as a way to navigate oppressive structures, such as discrimination by the healthcare system. This is also the case for LGBTQIA+ individuals sharing health related experiences and knowledge with each other.

Friendships are relationships in which embodied knowledge is shared, sought, and accepted. The idea of experience as embodied knowledge is particularly relevant to the discussion of friendships, because these relationships are sites of agentic expression and various forms of support. As such, people share their embodied knowledge, for instance, their experiences, with their friends. This is also part of the process of collective knowledge-making, and is thus important to explore. More specifically, there is a need to explore how LGBTQIA+ individuals share health-related embodied knowledge with their friends.

While sexual health related communication between college students and their friends has been documented, the experiences of LGBTQIA+ college students with such communication remain largely unexplored. Moreover, there is also a need to explore how LGBTQIA+ students discuss health-related matters with their friends in general, other than sexual and reproductive health, such as mental or physical health as well as experiences with healthcare services and in accessing healthcare.

To address these gaps in scholarship, this study explores the ways in which LGBTQIA+ students communicate with their friends about their experiences around health and seeking healthcare. It also explores the ways in which LGBTQIA+ college students build and understand emotional intimacy with their friends to establish networks of care and support which allow for the production and sharing of embodied knowledge around health Finally, this study explores the ways in which health and friendship intersect in the lives of LGBTQIA+ college students.

CHAPTER TWO

METHODS

In this study, I analyze the experiences of LGBTQIA+ college students around health and friendship, particularly their communication with their friends about health-related topics. This study is exploratory and descriptive in nature, and it takes a social constructionist approach, wherein I study people's meaning-making and ways of knowledge and experience sharing (Loseke 2017, 29). Rather than assuming that humans are acted on and shaped entirely by their physical and social environments, a constructionist approach suggests that meaning-making occurs because people are agentic individuals who actively create meanings and interact with their environments and each other (Loseke 2017).

Since my approach is exploratory and descriptive, I employed inductive logic in order to develop concepts and classifications as they emerged from the data collected (Loseke 2017). Since this study explores complex meaning-making through interactions between individuals, a qualitative approach was more suitable since it would allow people to express themselves and their ideas in detail (Loseke 2017).

I also employ feminist methodology, because it explores the ways in which embodied knowledge is produced and shared. Landman (2006) argues that "feminist methodology is informed by feminist epistemology; in particular, who can be agents of knowledge, what can be known and how knowledge is validated, and the relationship between knowing and being (ontology)" (430). This study employs a feminist epistemology by mapping the knowledge production and sharing of young LGBTQIA+ individuals. This is because I consider them agents of knowledge and the sharing of experience as a form of knowledge production and validation. This is particularly significant given the history of embodied knowledge being rejected within the field of medicine in favor of "traditional male constructions of knowledge" (Landman 2006, 430).

Moreover, Rich (1986) argues that we need to let theory emerge from the experiences of individuals, a bottom-up approach, instead of a top-down one whereby we fit experiences into theory. With such an approach, it is important to document lived experiences. We need "personal testimony mingled with research and theory which [derives] from both" (Rich 1986, 10). By exploring people's personal experiences of knowledge sharing within friendships, this study has employed a feminist methodological approach.

Data Collection

The qualitative method I used for collecting data for this study is semi-structured, in-depth interviews. Interviews were a useful data collection tool for this study because they yield "thick, rich data" for qualitative investigation (Turner III 2010, 7). Moreover, interviews are "about how and why, helping researchers to understand their interviewees' views of processes, norms, decision making, belief systems, mental models, interpretations, motivations, expectations, hopes, and fears" (Guest 2013, 163). Hence, I conducted 16 interviews with LGBTQIA+ graduate and undergraduate students at the University of South Florida. These interviews were conducted between July to October 2021.

These interviews were conducted using the “general interview guide approach”. This method allows for both structure and flexibility (Turner III 2010, 8). Hence, the same set of questions was used for each interview, but the discussion was also shaped by the information interviewees provide during the conversation. Follow-up questions were posed to participants as and when appropriate. The questions were designed to explore people’s health-related communication with their friends, to understand the intersections of health and friendship to see if and how embodied knowledge is produced and shared through health discussions. The questions explored various aspects of health-related discussions with friends.

The interview guide included five main lines of inquiry, in addition to participants’ demographic information. The initial questions explored the background of participants’ friendships – the different friends they have and how they know them. The second line of inquiry was focused on health discussions interviewees have with their friends, such as which topics and experiences they discuss and how the discussions happen. This was followed by exploring what the experience is of sharing health-related information with friends, and how these discussions work to provide support to participants and their friends. Next, I explored participants’ prior experiences of seeking healthcare, to understand the context in which their health discussions take place. Finally, the last line of inquiry focused on how health discussions with their friends impact people’s decision-making and behaviors, as well their relationships with friends.

The interviews were between 60 to 90 minutes each, and were recorded as audio files with the participants’ permission. All 16 interviews took place on video chatting platforms which participants are familiar and comfortable with, namely Microsoft Teams, Zoom, and Skype. This was due to the COVID-19 safety and prevention guidelines issued by the Center for Disease Control (CDC), as well as the preference of participants themselves in order to ensure their well-being. Video-chatting platforms are a useful way to conduct interviews during the pandemic, since they can allow participants to be just as responsive and expressive as they would be in person (Torrentira Jr. 2020, 83).

However, while most interviewees were able to turn on both audio and video for the entire duration of the interview, three participants preferred to turn it off after the initial introduction to ensure a better connection on limited internet bandwidth. I relied on tone of voice and facial expressions where possible, along with follow-up questions for interpreting what participants were saying. Interviews were recorded using the recording feature on the application being used – Microsoft Teams, Zoom, and Skype all allow for such recording. These were then transcribed.

Sample

The selection of interviewees for the purposes of this research was from graduate and undergraduate students enrolled at the University of South Florida (USF) who self-identify as part of the LGBTQIA+ community and are between the ages of 18 and 30 years, because many graduate and undergraduate students fall within this age range. This includes individuals who identify as lesbian, gay, bisexual, transgender (transitioned, transitioning or not transitioned), non-binary, queer, intersex, asexual, or any other identity they have which they believe associates them with the LGBTQIA+ community.

I did not use a specific term or label to recruit participants because gender and sexual identities are understood here as “identity work” (Crawley and Green, forthcoming). This means that people engage in “relational and emergent” meaning-making practices. Crawley and Green’s (forthcoming) analysis of the queer lexicon reveals that people have used a variety of terms at different points in time as they engage in formulating their identities, which themselves are evolving.

Employing this understanding of identity work, I did not want to impose specific identity terms on my participants, instead I wanted to allow them to use their own words to describe themselves. For the purposes of clarity, my recruitment flyer and email included the acronym LGBTQIA+, and mentioned that individuals were eligible for the study if they self-identified as part of the LGBTQIA+ community. Moreover, for the sake of convenience and clarity in writing, the term queer was used interchangeably with the acronym LGBTQIA+. For the purpose of interviewing and data analysis, I accepted the identity terms participants used as informative for the study, while acknowledging that these terms can and do evolve for individuals across time and space.

Furthermore, I employed a qualitative approach, using interviews to collect my data. The sample size was determined based on the requirements of a thesis project and limitations of time and resources. Since the study is focused on a particular population, LGBTQIA+ college students and their experiences, it required a non-probability sample. Non-probability samples are used when the focus of the research is on a particular group of individuals rather than the whole population– in this case, LGBTQIA+ college students (Bernard et al 2017, 39).

The sampling technique used for recruiting participants was purposive sampling, which entails that “you decide the purpose you want informants to serve, and you go out to find some” (Bernard et al 2017, 50). Bernard et al. (2017) argue that purposive sampling is particularly useful for “intensive case studies” in which the objective of the research is to explore a particular phenomenon (50). For this study, purposive sampling was used in order to find participants who would be able to provide insights on the experiences of LGBTQIA+ college students health and friendships. As such, these participants are a kind of "cultural expert" (Bernard et al 2017, 39) allowing the researcher to explore how friendships and health intersect in the lives of queer individuals.

In order to recruit participants, I relied my own social network, as well as campus organizations such as the USF PRIDE Alliance. I had attended meetings of the USF PRIDE Alliance and was able to send my recruitment flyer to some of its members. I also relied on the USF Office of Multicultural Affairs (OMA) to help me connect with potential participants. The OMA offers specific programs for LGBTQIA+ students, such as support groups and educational talks (University of South Florida 2022). Hence, they are in direct contact with many LGBQTIA+ faculty and students. Moreover, the recruitment flyer was sent to professors in different departments at USF, so that they could electronically circulate it amongst their students. I also relied on professors and graduate instructors to electronically distribute the flyer amongst their students. I then began receiving responses to my flyers from various USF students, and was able to set up interviews with them.

I endeavored to make the sample as racially and ethnically diverse as possible within the constraints of purposive sampling where one has to "take what you can get" (Bernard 2017, 50). This was possible by recruiting participants through the USF's Office of Multicultural Affairs. However, the sample has limited racial/ethnic and gender diversity. Table 1 below provides a description of the participants. U refers to undergraduate students, and G refers to graduate students. Out of 16 participants, four were graduate students, one was a graduate medical student, and 11 were undergraduate students at USF. 10 out 16 participants self-identified as white. All racial and ethnic terms are participants self-identifications. The participants belong to different majors and departments at USF.

The table also provides the pseudonyms, which I assigned, for each participant, as well as the gender and sexual identity related terms participants preferred to use for themselves. While all participants seemed forthcoming in discussing their gender and sexuality, some of them did not wish to rely on one particular term, or mentioned that they only used specific terms for the purposes of clarity, not wishing for their experience to be reduced to one or more terms. Once again, due to the constraints of purposive sampling, gender diversity was limited, with 10 participants identifying as cis women, two as trans men, one as trans woman, two as non-binary, and one participant who explained that they were questioning their gender identity. While this is partly explained due to self-selection, with individuals choosing to participate, it may also be due to the tendency of cisgender and white women to be over-represented in health-related research (Whitaker et al. 2017).

Table 1. Demographic Information of Participants.

Pseudonym	**Age**	**Level of Study**	**Race/ Ethnicity**	**Gender**	**Sexual Identity**	**Friendships**
Matt	25	G	White	Trans man, he/him	Queer	Friends at USF in department, from undergrad, from high school
Emma	22	U	White	Woman, She/her	Bisexual	Friends at USF in department, friends outside dept, roommates who are USF students, friends in Florida
Sophie	26	G	White	Trans woman, She/her	Bisexual	Online video game players, some friends at USF in department, friends in kink community, friends from hometown outside Florida
Mia	25	G (Inter-national Student)	South Asian ancestry	Non-binary, They/ them	Queer	Friends at USF in dept., friends from high school outside USA
Anna	19	U	Black (Carribean American)	Cis woman, She/her	Pansexual/doesn’t like terms	Friends from high school, friends from different workplaces, online friends

Table 1 (Continued)

Sarah	18	U	White	Woman, questioning, she/her	Lesbian	Roommates who are USF students, friends from high school, friends from USF extracurricular activities
Julia	27	G	White	Cis Woman, She/her	Lesbian leaning Bisexual	Friends at USF in dept., friends from hometown outside Florida, friends from undergrad, roommates who are USF students
Leah	19	U	Hispanic	Cis Woman, She/her	Ace, bi romantic	Online video game friends, friends from high school, friends at USF in dept.
Carol	27	U	White	Cis Woman, She/her	Bisexual	Friends from church, friends from workplace, friends from undergrad, friends from hometown outside Florida
James	19	U	Puerto Rican family	Trans Man, He/him	Pansexual	Friends from high school
Mary	27	G	White	Non-binary, They/them (only with friends, otherwise she/her)	Lesbian, asexual	Friends at USF outside and within dept., friends from undergrad, friends from USF PRIDE Alliance
Maeve	24	U	White	Cis Woman. She/her	Gay	Friends from high school, friends from workplace
Karen	25	U	White	Cis Woman, She/her	Bisexual	Friendships with family members, friends from hometown outside Florida, friends in Florida
Grace	18	U	White and Asian	Cis Woman, She/her	Queer	Friends from hometown, some friends at USF, friends from high school
Brooke	28	U	White	Cis Woman, She/her	Bisexual	Friends from undergrad, friends from workplaces, friends among wife's coworkers
Rebecca	24	U	Black/ African American	Cis Woman, She/her	Bisexual	Friends from high schools, friends of family, friends from neighborhood

Ethics

The proposal was submitted to the IRB, along with the recruitment materials and a verbal informed consent form based on IRB's approved format. The IRB approved the study and it was exempt from a full review. Informed consent was obtained from participants before interviews after explaining the purpose of the study to them. The IRB approved verbal consent script was used for each interview. Participants were also informed of their right to end the interview if they feel uncomfortable at any point.

I confirmed with my participants that they had privacy at the time of the interview, particularly as they were revealing personal information about themselves and those in their social circles. Participants were also assured of confidentiality, which was maintained throughout the interview and writing process. The interview transcripts were anonymized by the use of pseudonyms, which have also been used throughout the writing of this thesis in order to protect the identities of the participants. The audio recordings of interviews were deleted at the end of the writing process, while the de-identified transcripts will remain on the password protected device of the researcher for future use, for example for the purpose of academic publications. Participants were informed of this during the verbal consent process, and are aware that their de-identified data will remain with the researcher.

Data Analysis

During and after the data collection, audio recordings of interviews were transcribed using the automated transcription website, Trint (2021). The website provides a secure way to upload audio files. The files transcribed via Trint were then proofread and edited, as there were errors and inaccuracies within them. Once the interview transcriptions were complete, I began the process of coding them.

I first did initial readings of the transcripts in order to identify major themes emerging from the data and develop codes which would help me organize the data. The interview transcripts were coded thematically. A theme here is defined as “an extended phrase or sentence that identifies what a unit of data is about and/or what it means” (Saldaña 2013, 175). Hence, I used recurring words, phrases and ideas as themes in the data. The themes were determined by reading and rereading interview transcripts and listening to interview recordings to see what emerged from the interviews. Major themes that emerged were: participants’ experiences with and understanding of creating and maintaining friendships and emotional intimacy, forming connections across shared experiences and identities, their experiences with healthcare providers and issues with accessing quality healthcare, different health-related topics they discuss with their friends, as well as how these are discussed, and the impact of health discussions on their decision-making.

For the purpose of coding the data and organizing it based on the emerging themes, I used QSR International’s qualitative analysis software, NVivo (2020). The interviews were coded, with main codes and subcodes to identify evidence for each theme. I engaged in two cycles of coding and subcoding, as recoding can allow further categorization and narrowing down of themes, creating more clarity in the analysis (Saldaña 2013).

Recoding also allowed me to identify patterns as well as differences within the data, for instance, if a theme recurs in some interviews but not in others (Saldaña 2013, 59). For instance, recoding allowed me to separate out, using subcodes, participants’ negative experiences with mental health providers in general from those which are from USF’s Counselling Center. Hence, codes such as “experiences with USF Student Health Services”, or “building connection” were used.

Positionality

Levy (2013) provides recommendations to researchers in relation to positionality, since it is a significant factor in why we choose a particular research topic and method as well as how we analyze data. Reflecting on my own positionality in relation to my participants, I believe I am both an insider and an outsider since I shared commonalities with my participants such as my position as a graduate student at the University of South Florida (Levy 2013).

However, I am an international graduate student, which means that my experience of friendship and healthcare was somewhat different than most of my participants, only one of whom was an international student. Despite these differences, participants did not seem hesitant or reticent during interviews, and seemed interested in talking about their experiences around health and friendship. Moreover, since I was not speaking in a South Asian accent, they may not have been able to perceive that I was an international student, and this information did not come up during the interviews. Furthermore, by asking open-ended questions, and allowing participants to express themselves, I was able to ensure their comfort and safety during interviews.

CHAPTER THREE

LGBTQIA+ COLLEGE STUDENTS' FRIENDSHIPS

To explore the intersections of health and friendship in the lives of LGBTQIA+ college students, I first begin by analyzing the ways these students understand friendships and the meanings they attach to these relationships. I also explore the ways in which these students build connections with those with LGBTQIA+ identities, as well as those who do not belong to the LGBTQIA+ community. Next, I explore how friends provide care and support which helps students maintain their well-being. Finally, I consider the ways in which these relationships provide intimate spaces for health discussions.

Defining Friendship

Friendships here are defined based on the work of Bowlby (2011), who suggests that these are voluntarily relationships which people can enter or leave, and are "a source of care and support in many people's everyday lives" (606). Bowlby (2011) goes on to argue that "friendships can range from relationships that are close and emotionally intense to those that might be described as fleeting and emotionally limited, as in someone we describe as an acquaintance" (607). Moreover, both Bowlby (2011) as well as Bell and Coleman (1999) point out that this particular understanding of friendship is limited to North American and some European social contexts.

Despite varying intensities, Bowlby (2011) argues that friendships necessarily involve some level of "emotional involvement" (608), which can then lead to provision of informal care in the relationship. In order to understand the idea of emotional involvement, it is necessary to have a functional definition of emotions and affect. Bunnell et al. (2012) provide such a definition in the context of friendships. They suggest that "emotions can be understood as ways of knowing, being and doing, as bodily experiences that can be expressed personally and interpersonally" (498).

Meanwhile, they define affect as "what forms the messy, precognitive and inexpressible 'substratum' that circulates between and connects bodies" (Bunnell et al. 2012, 498). This means that affect is what we as bodies can do and our abilities to form connections. Bunnell et al. (2012) explain that friendship is a particular type of relationship which indicate that being affected and affecting others is "emotional labor" which requires "the production and reproduction, for example, of mutual trust, reciprocal care and fondness" (499). They go on to argue that "affect is the 'bedrock' of the emotional work of friendships" (499).

Building Connections and Emotional Intimacy

The development of emotional involvement within friendships is dependent on different variables. Based on interviews with 16 graduate and undergraduate students at USF, there are four main ways in which participants create intimacy when making a friend or strengthening a friendship. Participants revealed that in some instances, connection is instant, while in other cases, time plays a significant role as emotional vulnerability is slowly explored. Yet another factor in creating emotional intimacy is through a step-by-step process of slowly providing important information about one's experiences and gauging the response of the other person, using it as an encouragement for further vulnerability. Finally, closeness is built through shared experience, whereby participants are able to connect through what they have in common.

Instant Connection

Participants shared that connection is oftentimes sparked from initial meetings and conversations. One participant, Matt, who is 25, white, a trans man, queer, and a graduate student, maintains several friendships with friends who live in close proximity as well as those who live far, in his home or college town. He suggested that emotional connections in friendship can develop intensely and instantly, forging long-lasting relationships that continue even without physical proximity, and with limited communication.

> “So much of it depends on when and how you met a person, so like... Some of the people that in some ways I would understand as close friends and that, like, if they reached out to me and were like, Matt, I need this from you, or like if they were like Matt, I'm in Tampa, do you want to grab a beer? That I would drop everything and be so excited are like people that I only like really live near and could see them physically all the time for a very short period of time. But like that, those experiences were so formative that like it impacts the relationship long into the future, even if you aren't constantly communicating with them, even if you aren't like, always there for them, the same way that maybe someone that lives closer and has more proximity in other ways, is.”

This falls in line with Cronin’s (2015) assertion regarding “felt connection”, a type of emotional bond which is “maintained primarily through practices of the imagination (alongside occasional co-presence)” (668). Matt’s experience suggests that in many cases, connection simply depends on early, formative stages of a relationship. These connections can allow individuals to change their established emotional boundaries and overcome their limitations in being emotionally vulnerable. For instance, Mia, who is 25, South Asian, non-binary, queer, and an international graduate student says:

> "There are certain people, I think, that you meet them and there is that instant connection that causes you to rethink some of the steps that you're going to take to get to an intimate place so. There is a friend who I met here. She's not in my cohort, but I met her in undergrad and we just had an instant connection. And it was almost like the rationality in my mind was kind of like turned off. And I was like, you know what? This is a person you can trust. And so we do have a close, intimate relationship. And she's not my best friend, but. She is closer to me than maybe someone I did know in high school because we did have that instant connection and it allowed me to open up much quicker than I normally would with people."

Cronin (2015) argues that we need to understand the "spatial sensibilities of friendship", which means exploring the ways in which people experience geographical as well as emotional spaces in their friendships and the meanings they attach to these (677). In her own analysis, Cronin (2015) finds that these spatial sensibilities are "composed not only of feelings which can be strong and sustained, but of social norms and people's interpretation of those norms in their own relationships" (677).

Based on interviews with my participants, I found that individuals attach different meanings to friendship and emotional intimacy, which in turn impacts their affective abilities in friendships and the kind of emotional involvement and labor they expect and reciprocate. Moreover, the different spatial sensibilities of friendships – geographic and affective – people have are particularly relevant during the COVID-19 pandemic, as physical distancing requirements meant that people had to maintain their relationships using virtual platforms (Lippke et al. 2021). During the pandemic, participants were able to maintain "felt connection" despite geographical and/or physical distance that limited in-person interactions and activities (Cronin 2015, 668). This is in part because participants reported already having friendships which were largely virtually maintained even before the COVID-19 pandemic, due to different geographical locations. For instance, Julia, who is 27, white, a cis woman, and lesbian leaning bisexual, explained that she maintains close friendships with those in the state where she lived during her undergraduate studies,

> “Even though we don't really talk that much like we don't talk every day or anything like that…social media helps a lot. I think one of my friends and I like we like Snapchat together so like we have a Snapchat streak going on for like a year. So that was helpful. Like group FaceTimes and things like that. We play like Jack Box or, like online games together. I think part of it is just that, like we have so much in common and also just like, you know, as you get older, it becomes harder to make friends in other areas. So, like, they might have, like work friends and stuff, but they're not necessarily as close as like as I am with them and stuff, and so even if we don't like talk so much when we do talk, it's like nothing has changed.”

However, while some participants were able to maintain their instant and intimate emotional connections with different friends and friend groups with both those who are at USF and outside of it, those who joined USF during the pandemic (graduate or undergraduate) had a somewhat different experience. Some of these individuals were not able to form strong, intimate connections with their peers at USF if all of their engagement was virtual. One such participant, Leah, who is 19, Hispanic, a cis woman, asexual and bi-romantic and an undergraduate student explained her experience of forming short-lived connection which were not sustained,

> “Well, I have met people online in college because I have been taking mostly online classes. That's the thing. So I just basically met people online. And the one of the few classes I got to go to the campus for, I made a few friends there, but we haven't really reconnected after that class finished, if that makes sense.”

Hence, while in some instances different spatial sensibilities allow for the maintenance of meaningful, intimate and lasting connections, this is not the case for everyone, as the COVID-19 pandemic affected individuals differently.

The Passage of Time

While spatial understandings of friendships play a role in the maintenance of intimate connections, in other cases, my interviewees revealed that the passage of time plays a significant role in allowing people to establish enough trust to become emotional vulnerable and hence create a sense of intimate connection. This trust revolves around emotional vulnerability being received well, respected, and the expectation that what is shared in conversations would be kept private from others outside the friendship. One participant, Maeve, who is 24, white, a cis woman, gay, and an undergraduate student provided an example of building emotional connection with a friend in this way:

> "It took me probably almost a year of being friends and talking to them to be able to try and trust them. And it was just like her pushing, her asking questions or trying to help me in a way when I would say I was feeling down or having...whatever. And her pushing me and her talking about like similar situations. And it just helped me feel like there was a safety net there so that if I would say something, she wasn't going to like, make fun of me or talk down to me or go and just talk about me behind the back or something like that."

"Baby Steps"

One specific and strategic way in which the passage of time allows for closeness is when people slowly start broaching certain subjects with a friend, gauging their responses to assess whether or not they can continue to discuss those aspects of their life and experiences. Sarah, who is 18, white, a woman (questioning her gender identity), lesbian, and an undergraduate student, provides a glimpse into her process of using this conversation style as a way of developing trust over time:

> "If I'm talking to a brand-new friend, I just met somebody for the first time. At first, it's kind of just like reading the room. There's like that initial interaction where it's like, oh, like introducing yourself and everything. And I guess like the next time was like ...throughout the next interactions, it's like literally just like feeling the vibe, like seeing like you're comfortable talking about this,

> well, maybe I can be comfortable talking about this and then that can lead to this. And it's like when like it's more about reading the room of when to get into deeper topics, like what your views on certain things are, and like trying to just like read someone's personality and see if it's like, is this OK to talk about and stuff like that."

Other participants also described their experience of the 'baby steps' of emotional vulnerability, which allows them to establish trust in their friends and allows them to be able to seek emotional support and simultaneously build connections. Rebughini (2011) argues that friendship is "an elastic and negotiable interpersonal space in which it is easier to expose yourself, express your own doubts and fragility, and ask for help with the self-analysis of your own life experiences" (Rebughini 2011, 8). To negotiate this interpersonal space and build space for talking about one's experiences, individuals can use various approaches. For instance, one way in which participants assess the reactions of those they converse with is by exploring what common ground lies between them, especially which experiences are shared by both people in the conversation.

Shared Experience and Queer Friendship

Shared Experience

Discovering the experiences that they have in common allows people to be more forthcoming about their own personal information as well as develop in interest in the experiences of their friends. This helps create a sense of connection and speeds up the process of building emotional intimacy with others. One participant, Grace, who is 18, white and Asian, a cis woman, queer, and an undergraduate student, describes this process for one of her friend groups:

> "I think for us as a group, all of us being queer has kind of... I think I'm not going to say like they go hand in hand, but the fact that we're all queer and we've all kind of had some mental health issues

> has made us a lot more easily able to communicate than if it was only some of us or only like only me and stuff like that, because we... Like I said, we have been technically friends for less than a year. So we got very close very quickly and I think that shared experience is what helped us become so close so quickly."

This is in line with Cronin's (2015) assertion that "sharing the same experiences, particularly difficult times, can draw friends together and act to co-create identities interpersonally" (669). Forging connections through conversations regarding shared experience is also a way of developing trust and is a marker of closeness, that is, how people understand the emotional depth of a friendship.

Queerness as Shared Identity

Similar to Grace, other participants also felt that their relationships with those they share LGBTQIA+ identities with can allow for specific kinds of conversations, emotional vulnerability and resulting connection. One participant, Mary, who is 27, white, non-binary, lesbian, asexual, disabled, and a graduate student, discussed her experience of having conversations with other queer friends as compared to cisgender and heterosexual friends,

> "Honestly, I feel like it makes us over share more. Even within the disabled community, the people I talk to the most are the other queer disabled people like me. They're just more relatable. It's like you have a lot more in common with them. I feel like potentially we share more. I think because we're already used to kind of that structure of like talking about your experiences and like, you know, normalizing it and identifying with being part of a marginalized group, like we already have that structure and part of our lives. It's really easy to kind of apply that same mindset to, like, talking about health and talking about chronic illness or like the identity of being disabled. It's like, you know, in the LGBT community, like we have in-depth conversations about like personal experience and like how we identify like one of my friends just recently switched between identifying as bisexual and identifying as a lesbian. And, you know, we talked a lot about what goes into that. And like, does it matter if you are potentially theoretically attracted to men or does it matter what you are kind of choosing to do? *We have those discussions all the time, and I think*

> *it kind of translates into being more comfortable sharing these kind of intimate details, because those are super personal questions, but they're super common within the community* [emphasis added]."

Mary's narrative reveals that certain aspects of her experience, particularly her experience as a queer individual is deeply personal and is easier to discuss and share with others who also identify as being on the queer spectrum. Moreover, despite the uncertainty around identity terms or their evolving nature, her narrative suggests that she finds affirmation and acceptance from the very ability to share those uncertainties.

In her study on queer college women's friendships, Hughes (2019) found that friends "conveyed appreciation for their ability to be their authentic selves within the friendship connection" (17). In fact, beyond just affirmation and acceptance of the work individuals themselves undertake in order to understand and make legible their queer experience, participants experience "a depth of self-awareness, as a result of the emotional value of the friendship, as well as an increased awareness of the other" (Hughes 2019, 17). This is similar to the experience of Mary. It indicates that friendships between queer individuals not only serve to emotionally affirm, they also help participants arrive at better understandings of themselves which would then be reflected in other aspects of their lives.

Cronin (2015) argues that a connection that has been formed between friends over time "acts to create not only a biography of that particular friendship but also an individual's own sense of self as a biographical unit" (667). For my participants, this is especially the case with friendships between individuals who are queer. Alternatively, those who do not have the friendly queer space available to have certain discussions describe that they curate their conversations with friends to avoid revealing certain personal information about themselves. For instance, Emma, is 22, white, a cis woman, bisexual, and an undergraduate student, and her closest friends identify as straight while she is bisexual. She had not mentioned to her friends that she was in an open relationship with her partner, who is a bisexual man, because she was afraid that they would have a negative reaction to this information and would not understand or relate to her experience in a meaningful way,

> “I think things like that that are kind of taboo even for my progressive straight friends. They’re like, see, I told you bisexual people can't be monogamous and they just want to sleep with everyone, you know .... So just because its partially true for some people and all that kind of stuff, it's a little complicated to get into. And I also don't really share that kind of stuff with them because being straight, it's not that they don't ever have to think about it. Like you could be straight and have an open relationship, any of that kind of stuff. But they both don't, like, find that attractive to them or just that's not what they do… I just think that's one of the taboos that still transcends everything. It’s like, ‘OK, you're bi that's cool. You’ve had some bad experiences with doctors as a bisexual person and a woman. Cool.’ And then the next one [open relationships] is like….’OK but why are you doing that?’ Like, I feel like that's kind of a boundary that they're not ready for yet.”

Not only do friendships amongst queer individuals shape individuals’ experience of self and identity, they also provide a space to discuss aspects of social life such as homophobia and discrimination, within the context of healthcare and beyond. For instance, Grace, who is 18, white and Asian, a cis woman, queer, and an undergraduate student, describes her experience with queer friends,

> “I've been a lot more comfortable either expressing things about my health or even just saying like, oh, I find this woman attractive. Whereas previously I had a friend group that was all people from my church. … And I think I wasn't able to be as intimate with them. I would say just kind of struggles when it comes to being worried about homophobia and stuff like that have helped us in being supportive. Like I have a friend who…his roommate has expressed that, like he's not uncomfortable with him being bisexual…And so he's been kind of like stressed about that. And so we're kind of encouraging him to be more open because that's his space to work with, like getting a pride flag and stuff like that. How that's his space, too. And you should be able to freely express

> himself. Shared experience is something that we're able to communicate with about as well as just, you know, having stress about coming out to parents or family members and stuff like that…And so just kind of us being encouraging each other with struggle specific to being queer identifying... We've been able to support each other with that."

Hughes (2019) argues that friendships between queer women can help individuals in "navigating discrimination" (69). In the context of my participants, this extrapolates beyond queer women to queer individuals in general. Participants revealed that they were able to discuss situations of homophobia and/or discrimination in order to seek advice, affirmation, or emotional support. In this case, "friendship is an important impulse that counters fear and speaks truth to power in a unique way, by embodying and experiencing human and heart-centered connections" (Chowdhury and Philipose 2016, 2-3).

Beyond Shared Identity

While shared experience can be linked to shared identity, such as being queer, it can also be a result of other forms of life experiences or of shared health conditions and concerns, such as mental health in the case of Grace's friends. Similarly, Emma might have felt comfortable discussing her open relationship with her straight friends in spite of how they identify, if they were interested in open relationships or had experiences with them. I argue that shared experience expands well beyond shared identities because 1. There is no monolithic queer experience especially since queer individuals have varied intersecting identities, and 2. There are several different interests that bring people together to form strong emotional attachments. Matt, who is 25, white, a trans man, queer, and a graduate student, points out that differences in people's experiences around queerness can shape conversations,

> "How I come into the conversation, of course, like whenever I'm talking about trans health with a non-trans person is going to be different, especially early on if I don't know the person well.

> Because I guess I don't know what that reaction is going to be like, and whenever it is someone I know pretty well I still think that. The dynamic is a little different when you're talking to other trans folks that are also on HRT and that have also like dealt with doctors' BS. I also think that equally important is like talking with, like really realizing how much my own privilege has shaped my understanding of health and my ability to access health. If I'm talking to my friend, that is a trans person that doesn't have good insurance then from the beginning, like I have to think through what I'm saying and like be careful to understand that, like they might not have the same opportunity as I do, because it's like the class position related to insurance status…And that definitely informs kind of how I come to conversations."

Matt's experience in discussing trans health with friends indicates that individuals are not bound to have shared experiences based on the same or similar identities. Moreover, participants explained that they formed connections over other shared experiences, such as those related to specific health experiences. Several participants identified the ability to relate to someone as a strong determinant of forming and maintaining a friendship. For instance, Mary, who is 27, white, non-binary, lesbian, asexual, disabled, and a graduate student, recounts her experience,

> "So it's like not just, oh, this is my experience and like this is how it affects my life, which we still have, we still have those conversations about like the broad impact of like dealing with being a person with some kind of disability or illness and how frustrating it can be. And like how upset we can get about it, but like we talk about the specific symptoms and the specific experiences as well. I have another friend who we specifically bonded because we were both like, hey, we're both graduate students at USF with chronic illnesses who are like queer and nonbinary. You're just like, oh, we're the same person. Where we talk a lot about, like, systemic aspects of being an ill person, which is not to say I don't talk about that with other people, but we have more in-depth conversations about like I guess academia and how it affects dealing with health, how like insurance is shipped to people with chronic conditions, preexisting conditions that they don't like to cover, they're like you don't actually need treatment for that."

Mary’s narrative reveals that her ability to relate to the experiences of a friend as a not just a queer person, or a chronically ill person, but also as a graduate student at the same university is what enabled her to form an emotional attachment and friendship with another person. In a study on transgender individuals’ friendships with other trans and non-trans persons, Galupo et al. (2014) argue that while shared experience is generally understood as an aspect of all friendships, for trans individuals, “transgender specific experience was central to their definitions of support, acceptance, and experiences. For example, instead of having someone to talk to, a benefit expressed by transgender participants was can talk about transgender issues” (200).

In the case of my participants, it is important for them to connect not just over their shared experience as queer individuals, but also other aspects of their lives, such as their student status and their health concerns. Another participant, Sophie, who is 26, white, a trans woman, bisexual, and a graduate medical student, identified another aspect of her life that she is only able to discuss with those who have that shared experience,

> “Okay, so I'm in the kink community. It's like, you know, BDSM [Bondage and Discipline, Dominance and Submission, Sadochism and Masochism]...dungeons and play parties and toys, stuff like that. And so it's like a very... It's like an actual community. People are much more like open and sex positive and health positive. And like it has like a very bad reputation of being like. You know, maybe like rapey [violation of consent] like, you know, oh, you're going to get, you know, roofied. that's like the perception I think a lot of people have of that community. But it's actually people look out for each other. The bonds are kind of deeper because you're like trusting someone with this like thing, your sexuality that's like. Often regarded as very like...and rightfully so, worth protecting and being careful of and so. You know, I can talk about that stuff with them and they can talk about it with me and. You know, so there's a... It's a sex positive culture. People get tested for STDs very regularly. People watch out for each other, especially in like public, like it's not truly public spaces like this is not happening like at a park, but like if there's like a dungeon, like a business or if

> it's at someone's house, people watch out for each other. People bring food for potlucks. You know, and it's not always about sex, it can be just about like playing, you know, like. Floggers or ropes or whatever. So, yeah."

The narratives of participants such as Sophie, Mary, and Matt indicate that in many instances, it is important for individuals to experience a sense of community, whether it is a community of trans individuals who have undergone Hormone Replacement Therapy (HRT), or that of queer and disabled individuals, or the kink community.

Networks of Care and Support-Seeking

A sense of community is important for participants for two main reasons: 1. It generates feelings of belonging and inclusion, and 2. It indicates that they have a network of care around them – a support system. Kathiravelu and Bunnell (2017) argue for "urban friendship networks as communities of care" (501). Similarly, my participants described creating networks of care, which means that individuals have different people in their social circles who fulfill unique needs around health, particularly the non-medical aspects of health and well-being maintenance. One participant, Mia, who is 25, South Asian, non-binary, queer, and an international graduate student, describes her experience,

> "To have conversations that are not in this clinical pathological setting of a hospital, just talking to a friend like my back has been killing me for weeks and I am in my 20s. And it shouldn't feel this way without someone saying here's a prescription for something…Sometimes just talking about something psychologically helps, even if, like physically you do still need to see a doctor, you know what I mean? *And so I do think it's not just like talking about health. It is health* [emphasis added]…like when you go to a doctor and you share a problem, whether it's a health problem or a mental health problem, there are very few sort of avenues... Like they're going to tell you go to physical therapy or take this pill versus like a friend or someone close to you is going to... I guess look at it from a different perspective, and I think that is sometimes really helpful when you don't want a solution, you just want someone to listen."

Mia’s narrative indicates that people need support and care regarding various aspects of their health, physical or mental, which is different from medical care provided by the healthcare system. This support and care are essential for the emotional and subsequently physical well-being of the person, and friendship is one avenue where it can be accessed. This type of care and support is also an example of the “constant affective ‘work’ that goes into the maintenance of a friendship” (Kathiravelu and Bunnell 2017, 500). Kathiravelu and Bunnell (2017) argue that friendship networks as communities of care involve labor which “often unremarkable, but that sustains everyday socialities” (500). Based on participant narratives, it is clear that a gap in care left by institutions is fulfilled at an interpersonal level, and it involves the type of affective labor Kathiravelu and Bunnell (2017) describe.

Moreover, different friends and people can fulfill varied needs for emotional support. For instance, one participant, Carol, who is 27, white, a cis woman, bisexual, and an undergraduate student, explained that she discusses various aspects of sexual and mental health with her closest friend, however, there are some conversations for which she needs other friends,

> “I suppose like I don't talk about, like women that I find attractive …with my friend Jessica, because she's cis and heterosexual and when I'm feeling it out it doesn't feel like she's quite like as open, I think. She should be accepting, like she should be willing to listen, but she might not have anything to contribute to that conversation…A lot of my work friends, like, …I feel like we talk about those things a little bit, it's extremely nonjudgmental and open there because a lot of them are on that spectrum of sexuality and stuff. So, yeah, it's easy to talk about it at work.”

Hence, Carol’s various emotional needs are fulfilled by different friends and friend groups, based on what they have in common and the kind of engagement they are able to provide in conversations on particular topics.

What Type of Support?

Participants not only identified different needs that different friends in their social circles fulfill, they also pointed out various types of support they seek, particularly emotional support, for the maintenance of their health and well-being. The four main types of support participants explained they seek in conversations with friends are: 1. the ability to listen when one person is talking about their experiences and feelings, or ‘being there’, 2. Advice and information around a topic/problem, 3. Actionable support, and 4. Engaging in a conversation by providing one’s own experience to relate to someone.

The ability to listen and ‘be there’ is a form of providing care which extends beyond any specific conversations. One participant, Anna, is 19, Black, Caribbean-American, a cis woman who does not prefer an identity term for her sexual orientation, and an undergraduate student. She describes what type of care and support she seeks from her friends,

> “I like to see that somebody is genuinely listening like they genuinely care, because you can always just open your mouth and talk and it'll just go one ear out the other. But I like people to have the knowledge and the information and maybe even think about it, because I think sometimes my friends will be like, oh, hey, you know, you mentioned you were feeling this way the other day. How are you doing now? Or like, hey, yo, don't eat that. You know how it makes your stomach, like, don't upset your stomach, like little things like that to just show me little things like that, show me that they care, that they actually listen, because it's like you can care about yourself to an extent, but you also need somebody else to kind of weigh in and it makes you feel like you're being taken care of on all sides. The parts of that you forget or ignore- somebody else is filling in that gap. And it's like. Nothing is going unseen or untouched.”

Anna’s narrative suggests that her friends and those in her network of care are doing essential work in helping to maintain her health and well-being by helping her maintain a sense of self and belonging by remembering aspects of her life that she herself pays limited attention to. This aligns with Sias and Bartoo’s (2007) assertion that friendships are “are well-placed to provide unsolicited social support, so that the target individual does not need to ask for it" (461). In Anna's case, she does not need to solicit care on an everyday basis – it is carried forward from conversations in which she shared information about herself.

In other instances, participants described that they were looking for specific information and advice about a topic rather than just a listening ear. Mia, who is 25, South Asian, non-binary, queer, and an international graduate student describes one particular situation in which she sought support in this manner,

> "So outside of my cohort, my friend groups don't have much experience with psychiatric medication. So they've had experience with therapy and other forms of mental health services, but not really medication. So I myself am not on medication, but one of my family members was recently put on it. So obviously we were trying to find out as much information before that happened. And that's when I turned to my cohort members because I knew that they had experience with that. So they were the ones that I really asked, in addition to my own research that I was doing as well."

Asking for advice in a friendship is a marker of trust and some level of emotional attachment, as Mia goes on to explain,

> "I think everyone has unique experiences and. when you ask for advice, you don't have to take it at the end of the day and just listen to someone and say, OK, and then never follow through with it, like if you don't believe it. But I think when you're asking for help. You are inherently saying, I trust your opinion on something, even if you're not an expert, because I'm talking to a friend, I know you're not a doctor. I know we don't have medical training. I'm asking you for your experience, not for your expertise. And for me, that is important because I don't necessarily always want the name of the medication you are given when you have this. I want to know, you know, your experience because I think that it might be helpful to mine."

However, in many cases, friends have to rely on actionable support rather than giving advice in order to provide care and support. Rebecca, who is 24, Black, a cis woman, bisexual, and an undergraduate student, describes how she provides actionable support to a close friend,

> “So Trey has like high blood pressure and all that. And because like when we go out. A lot of the places we go to, we eat a lot. And in his family. High blood pressure, high cholesterol, all of those things he has. And he's not really comfortable telling people about those things. So I think and I think it was kind of embarrassing for him. So like entirely in being the friend that I am instead of kind of like putting him on the spot when we go to places like when he would ask me, like, Hey, what you wanna eat, I will kind of just like of throw out healthier options than what we would normally get. just looking out for him. And I would just like hype it up like, Oh, there's this no like Vietnamese restaurant and bar when you say it's really good. Even though I really don't want that, I just know for his I don't want him to die. So if I had to sacrifice eating like crabs and stuff to keep him healthy for a day then like, I'll do that. And then like I would just like we would have bets like who can cave with? A soda. Who is going to cave with a soda first? We would bet like big money. We bet like $100, $200, like first person to drink soda has to pay the other person. So just to get us healthier on our water regimen. So it was just like I would take his health into my own hands because I know he's irresponsible.”

Moreover, when a friend is able to engage with a conversation and relate their experience to the other person, it provides a sense of support. Sias and Bartoo (2007) argue that “social support interaction is characterized by self-disclosure, which is a key factor in friendship initiation and development” (461). Hence, the ability of friends to provide these different forms of support also builds trust and connection, as discussed in the first section of the chapter. This encourages people to become more comfortable discussing personal topics, specifically as their health. For instance, James, who is 19, of Puerto Rican origin, a trans man, pansexual, and an undergraduate student, describes how he became comfortable talking about his health with a close friend,

> “It's sort of when you talk to somebody and they confide in you that they've been through that stuff, then, you know, they're significantly less likely to judge than someone who hasn't been through that stuff. And I have a hyperactive attention deficit disorder (ADHD). And with people like me, when somebody gives their experience or something you try to show that you relate by giving your experience back. That's sort of how I was able to start

> talking to her about that, because she confided in me first. She showed me that vulnerability. So I wanted to show the same vulnerability back."

Thus, emotional intimacy also creates room for the sharing of health concerns among friends.

The above analysis was an exploration of how queer students build connection with their friends, as well as how friendships amongst queer individuals play a significant role in allowing space for certain conversations about queer experiences. However, we also see that shared experience, such as the queer experience, is beyond just one singular shared identity, as individuals connect and develop emotional attachments based on several different aspects of their lives. Many of these connections help them create a sense of community, which also establishes a network of care for queer students. This network of care fills a space between medical and non-medical needs that individuals have, and provides significant emotional support regarding health concerns. The various types of support that queer students seek and receive also aid in making them more comfortable in sharing information and experiences around their health with their friends. The following chapter explores the ways in which LGBTQIA+ students share their health concerns and experiences with their friends.

CHAPTER FOUR

HEALTH CONVERSATIONS

This chapter explores the conversations LGBTQIA+ college students have with their friends regarding their health. Participants shared that they discuss different experiences around health and a broad range of health-related topics. These conversations serve as a way to cope with difficult experiences, as well as to establish greater emotional intimacy between friends. Health-related conversations are also a way for queer students to seek information and advice about their health, and they inform individuals' decision-making about their health. The following analysis expands on these assertions, and shows that health-related conversations are a way of producing and sharing embodied knowledges. At the same time, there is a risk to sharing information among friends, as it may discourage them from certain beneficial health behaviors.

How Do We Talk about Health?

Based on interviews, health was a significant topic of conversation between queer students and their friends. Within the conversations that queer students have with their friends regarding health experiences, there are several different areas which are discussed, which can be categorized into the following five topics: experiences with providers, with illness, with treatment, with accessing healthcare, and with USF Student Health Services and the USF Counselling Center. Each of these areas of discussion includes physical health, mental health, sexual health, and trans health – classifications outlined by participants themselves, who categorize their health in these distinct ways, as applicable to each of them based on their identities and health concerns.

Conversations with Friends about Healthcare Provider Experiences

Participants discussed with friends their experiences with healthcare providers by narrating events and analyzing them, particularly when the experience with a provider is negative, highly positive, or surprising. The discussions most often take place around negative experiences with providers, which participants share in order to seek emotional support from friends, to make them aware of their everyday activities, and to ensure that friends are wary of certain providers if they seek care themselves in the future. Hood et al (2019) argue that queer college students face microaggressions in their interactions with their providers, and some participants in this research reported similar experiences. One participant, Matt, who is 25, white, a trans man, queer, and a graduate student, describes a conversation he had with friends regarding an unpleasant and discriminatory experience he had with a mental healthcare provider via the USF Counselling Center,

> "Yeah, so I remember this was last year. Like, I was just like having some trouble with anxiety and I thought that going to counseling might be a useful thing. So I signed up for an appointment and they matched me with this counselor and she was just like really bad, like just like bad at counseling, but also transphobic on top of it. But like, I think that she thought she was like the world's best ally. Yeah, it was pretty bad. Like she was talking about how, like there is like "real" intersex people that like have like full two sets of everything. And I was like, fuck, like this is bad on so many levels. But yeah, it's pretty bad. So basically what I did in that case was I got through the session and later she asked if I would want to schedule another appointment, and I said, nope, I'm doing great. And I talked to my partner about how awful it was. And I just like talked about the experience with two friends…And we just kind of talked about how, like, it's so sad that, like counseling can be such a great and productive experience,

> but whenever you have counselors that are transphobic or racist or et cetera, like, it ends up doing way more harm than good."

Matt's experience reveals that his conversation with his friends about his experience helped him to analyze it more broadly. Instead of the experience deterring him from seeking further counseling, his discussions helped him to recognize that it was this particular experience which is negative, and he reached the conclusion that such attitudes of mental health providers are harmful and queer individuals need protection from them. Moreover, this indicates that USF's Counselling Center could improve their services for LGBTQIA+ students.

Currently, USF's website indicates that they are aware of the specific health needs of this student population and that their counsellors strive to make their mental health services more inclusive (University of South Florida 2022). USF also offers group counselling services (as distinct from individual, one-on-one counselling) for LGBTQIA+ students during most semesters (University of South Florida 2022). However, despite these measures, participants reported that they were dissatisfied with the USF Counselling Center, revealing their own negative experiences as well as those of people in their social circles. Moreover, the COVID-19 pandemic may have worsened their experience of seeking services from the USF Counselling Center, as services were only provided virtually during this time.

Outside of USF's services, another participant, Brooke, who is 28, white, a cis woman, bisexual and an undergraduate student, described her experiences with gynecologists to her friends where she was treated in an unhelpful and discriminatory manner,

> "It would always come up with the questionnaire, you know, like they asked, like, have you had sex and like how many partners and things … they didn't ask, like, who that was with. So I think they just assumed it was with a man. And then and then they talk about like, oh, you're not on birth control, are you thinking about getting pregnant? And I'm like, oh, I can't get pregnant that way like I have a wife, we'd have to do IVF or something. And then they just

> like… it just gets very quiet and like there's no more eye contact. And it's just it's very uncomfortable. I think it's only happened with two providers and after each one, whenever I made a new appointment, I was like, I need to see someone different."

Brooke's experience was disturbing and unhelpful to her. Such experiences are in part a result of healthcare provider attitudes, as well as the assumed heteronormativity in medical protocols which fail to account for the different needs and concerns of LGBTQIA+ individuals (Hudak 2021). Such a situation requires emotional support for which friends are an important avenue. This is also because friends are aware of her identities and do not make assumptions regarding it, instead offering support knowing her specific concerns and needs.

Conversations with Friends about Experiences of Illness

Other than experiences with providers, participants also reported talking to their friends about their experiences of illnesses or health conditions that they experience. The discussions often revolve around the symptoms individuals are experiencing. One participant, Grace, who is 18, white and Asian, a cis woman, queer, and an undergraduate student, explained how she discussed her mental health concerns with her friends,

> "Yes, I actually told them [my friends] that I was getting tested because…I thought I have a lot of symptoms of ADHD. So I originally just talked to my therapist about getting tested for ADHD because I talked to my friends and I was like I had expressed to them like, oh, I've been seeing a lot of things saying that these things that I experience are symptoms of ADHD. And I had never thought of them as symptoms of ADHD. So and when they tested me for that, they also had screening for depression and anxiety. They did find that I do not have ADHD, but... they diagnosed me with the generalized anxiety disorder… And then I was like, hey, guess what, guys? Turns out I don't have ADHD. I'm just anxious. And so and then apparently one of my other friends went through the same thing. She got tested for ADHD and then was just diagnosed with anxiety and stuff like that."

Grace was able to discuss her mental health condition with her friends as she identified her own symptoms and underwent the process of diagnosis, and then found that her friend was able to relate to her since she had the same experience.

Other participants reported similar conversations with their friends in which they discussed their symptoms with friends as well as what it is like to have or live with a particular health condition. One participant, Anna, who is 19, Black, Caribbean-American, a cis woman, and an undergraduate student who lives with Ulcerative Colitis, a chronic illness, discusses her experience of living with her illness with her friends by telling them the everyday issues that impact her, such as the food she is able to consume. For instance, she explains that she discusses her illness with them and uses it to give them advice on how to maintain their digestive health,

> "I have UC [Ulcerative Colitis], I kind of have to watch out for what I eat. So they [my friends] don't know, like a lot of stuff that they eat messes with their digestive system. When they get coffee, coffee's going to really mess with you. Dairy is really going to mess with you. Acidic things and stuff like that is all going to mess with you."

For participants such as Anna, it is important to them to be able to share these aspects of their lives with their friends, particularly since they are so impactful on an everyday basis.

Conversations with Friends about Experiences with Treatment

For those with certain chronic illnesses, treatment also impacts their daily lives, whether it is in the context of taking regular medication or monitoring symptoms or maintaining a certain level of well-being. Participants with chronic illnesses as well as those who do not have them reported discussing treatment with their friends, such as experiences with medical procedures, medications, and therapeutic mental health services. For instance, Mia, who is 25, South Asian, non-binary, queer, and an international graduate student, explained that she discusses possible treatment options with her friends and others in her social circle before taking any action,

> “I talk to people who have had experience in it, and it's like my cohort members, I know we all have various mental health struggles. So when I was having issues with that or like in the family having issues with that, I contacted them when asking about like, do you have experience with this facility? Do you know this doctor? Have any of you been on this medication? And are there really bad side effects that I need to know about in advance? So they've talked to me about that.”

Mia’s narrative indicates that LGBTQIA+ students are particularly wary of experiences with medication, including psychiatric medication as well as for physical or reproductive purposes, which may be a result of their having to navigate discrimination within the healthcare system, leading to mistrust, as participants describe negative experiences with healthcare providers. However, beyond treatment for specific health concerns, queer students also discuss treatments for the maintenance of their health and well-being, such as contraceptive treatments. For instance, Emma, who is 22, white, a cis woman, bisexual, and an undergraduate student, explains that she talked to her two friends about her experience with an intrauterine device (IUD),

> “Both of them have been on some type of birth control. They both have sex with men like they're not asexual or anything. So we have kind of talked about that. They've asked me how an IUD was because they've heard that, like, it's kind of scary, but set it and forget it. That's fun for the type of people who like…if you can't take pills at the same time every day, if that’s annoying or unrealistic for you. So I've answered their questions about that from like, my personal experience.”

Emma’s narrative shows that describing her experience to her friends also allowed for their concerns about this particular contraceptive treatment to be addressed.

Conversations with Friends about Accessing Healthcare

Albuquerque et al. (2016) argue that LGBT individuals face more difficulties in accessing high quality healthcare than their non-queer counterparts. Unsurprisingly, interviews revealed that LGBTQIA+ college students face difficulties in accessing healthcare, due to health insurance, discrimination, or lack of information. For instance, James, who is 19, of Puerto Rican origin, a trans man, pansexual, and an undergraduate student, reported facing difficulty in finding an appropriate mental health provider who would provide care specific to his needs around transition,

> “Right now I am actively trying to seek out a specific professional. I want to take the gender affirming surgery. If you want it to be covered by insurance, you need a document stating from a therapist that it is a good choice that this client goes and gets the surgery. And one of the things that I'm looking for right now is to make sure that therapists I am looking for are certified in transgender identities because if they're not certified, they can't give me that paper. I found that out in the fall semester … where I had the therapist diagnosed me with… Body dysmorphia. But that was all she could do because she wasn't trained in how to deal with transgender identities so she couldn't help me at all on that front. So that's one of the things that I'm looking for in a therapist.”

James is able to discuss these barriers in accessing healthcare with his closest friend, who lives in another country and is not able to provide actionable support, but can provide him with emotional care throughout the process of finding an appropriate healthcare provider. While James has difficulty finding an appropriate provider and proceeding with his transition treatment due to health insurance requirements, Anna, who is 19, Black, Caribbean-American, a cis woman and an undergraduate student, described sharing with her the financial difficulties that made it hard to access healthcare,

> “My friends are also trying to help me. With applying for new insurance and stuff and trying to find...like even my friend was trying to get me signed up with her own doctor, because when I told her about the situation, she was like, that's unacceptable. They all know that I that I have Medicaid through my dad. Well, not anymore. Now, through my job I have [insurance] through my job now, but before I pretty much had Medicaid. So they knew about this whole financial situation I was going through an insurance situation ...so they would try to help me out, like they would sit

> there with me while I try to look through and try to see who accepted my insurance, things like that. But I'm still open to them with that kind of information as well."

While in some cases participants reported conversations around health insurance and finding appropriate providers, in other instances they turned to their friends for support in the face of discrimination and reproductive injustice. Karen, who is 25, white, a ciswoman, bisexual, married to a man, and an undergraduate student, described the difficulties she is having in undergoing a tubal ligation, since she could not use other forms of birth control and did not want to engage in abstinence,

> "I had to fight for 18 months with him [her doctor] until he finally scheduled my procedure because he told me, well, what if one of your children dies? Wouldn't you want to have an... am I supposed to replace one of my children? And that statement alone is like detrimental to your mental health."

She described how she sought support from her closest friend during the difficult time, during which she faced barriers to accessing a particular medical procedure,

> "I bitched, that's what I did. I didn't know what to do. I didn't know. I don't know. I was mad, I was mad, I was mad every time that my cycle was like a day late. I was so mad I would call Hannah and be like, I'm late. Will you go on a Facetime call with me while I run to Family Dollar and get a test because I'm freaking out, I'm having a panic attack, I think I might be pregnant. And I put my AirPods in and we get the car and we go to our general Family dollar or Walmart or whatever, and I'm like, all right, I've got the test. And she's like, Are you shaking? Yeah, I'm shaking. I don't want to be pregnant… I take the test that while she's still on the phone, she's very supportive."

Hence, Karen's friend was able to provide actionable and emotional support to her by being present during specific activities.

Conversations with Friends about Experiences with USF Services

Several participants also reported experiences around mental healthcare specifically through the USF Counselling Center. Students at USF revealed that many of their experiences through USF’s Counselling Center were unhelpful or discriminatory, particularly when counsellors are not able to provide care which is sensitive to the needs of LGBTQIA+ students, such as making transphobic comments or heteronormative assumptions about their clients. Participants explained that they have conversations with their friends about how they did not receive adequate care through the university. USF’s mental health care outside of the USF Counselling Center, via USF Student Health Services, was also reported as dissatisfactory by participants. Mary, who is 27, white, non-binary, lesbian, asexual, disabled, and a graduate student, explained that she spoke to her friends regarding her experience with a psychiatrist she saw through USF’s Student Health Services,

> “I was telling my friends about like what therapists to avoid because we talk about that when they're shitty, like if they're specifically homophobic, because that can be a really big issue with finding, like, mental health care or in my case, stuff for ADHD. I had a psychiatrist who did not believe I had a heart condition. Yeah. She asked me who treated it and she was like, was it a physician? And I was like, what other kind of person? [would be able to treat it]...I don't think that non doctors are allowed to diagnose people. But she thought I went to like some homeopath or something for some reason. She works at USF…So I just warn my friends, like, hey, if you go see a psychiatrist, don't go here because she is just such an asshole.”

While Mary’s experience was with a psychiatrist outside the Counseling Center, it was at the USF Counselling Center that participants and/or their friends had unhelpful experiences with, such as not being provided culturally sensitive care or care which is sensitive to LGBTQIA+ students’ needs. For instance, Mia, who is 25, South Asian, non-binary, queer, and an international graduate student, felt that the therapist could not understand her concerns as a queer person of color who comes from a different culture and requires different solutions to her concerns,

> “When I went to counseling at the USF Counselling Center, they were just like, oh, just like move out of your parents’ house. And I'm like, well, no, that's not my experience. I can't do that. Like, that's not something I'm in a place to do. So that's not a good suggestion for me. And I don't think like some counselors understand that, like. Our cultures are very different and a lot of them are not really willing to make that jump to saying, OK, we come from different places, but let me try and help you from your place rather than from what I think you should do… type of thing. So I do find… like for me, a lot of the time I can be like… No therapy or no mental health services is better than having those experiences because it almost makes it worse.”

Mia explained that she was able to discuss her concerns with another friend who is from the Middle East and is also queer, and can relate to her experience of being queer in a Muslim household. She went on to assert that she found more understanding and helpful responses regarding her mental health concerns from her friends rather than a mental healthcare provider.

Topics Discussed with Friends under Health Categories

While participants reported several different strands of conversation about their health experiences as described above, their examples of conversations also revealed that they understand health as constituted of different categories, namely physical health, mental health, sexual and/or reproductive health, and trans health. Within physical health, participants most often discuss chronic illness, diet and exercise, medication, eating disorders, weight, and injuries. Within mental health, they most often discuss attention deficit hyperactivity disorder (ADHD), autism, medication, eating disorders, anxiety and depression, loneliness, and general everyday concerns. Within sexual health, they talk most about menstrual health, birth control, safe sex practices, and sex and relationships. Within trans health, participants talk most often about gender dysphoria, gender-affirming surgery, hormonal treatments, and transphobia.

COVID-19 as a Discussion Topic among Friends

While the 16 participants talked about a wide range of health topics with their friends, it was interesting to note that COVID-19 was not a significant topic of discussion. Most participants felt that it was minor topic of discussion, which may be due to the pandemic conditions becoming “the new normal” by the time interviews were conducted (Corpuz 2021, 1), with people adapting to the changing environment. However, COVID-19 is clearly a constraining factor that shapes their everyday lives and also the services they get such as less availability of counseling and other services, and having to rely on tele-health services instead of in-person ones, particularly those when accessing services through USF.

While participants explained that it was not a heavily discussed topic among friends, they identified the following COVID-19 related discussion topics: 1. Learning about others’ experiences of COVID-19, such as the symptoms they were suffering from, 2. COVID-19 testing, such as which facilities to visit, 3. The COVID-19 vaccine, its availability, such as when it became available and at which facilities, and general discussions regarding anti-vaxxers and those who are against face coverings for COVID-19 prevention, 4. Exchanging opinions on measures the government is taking in response to the pandemic, 5. Mental health impacts of COVID-19, particularly the exacerbation of pre-existing mental health issues due to limited in-person interactions as well as increased stress, and 6. Shortage of medication such as Adderall – prescribed for ADHD (Attention-deficit hyperactivity disorder) during COVID-19.

Participant narratives indicated that while many discussions with their friends were not explicitly about COVID-19, they were about health concerns which were impacted by the pandemic, such as the ways in which it worsened the mental health of individuals. For instance, Grace, who is who is 18, white and Asian, a cis woman, queer, and an undergraduate student, explained that she talked about stress related to the pandemic, especially around the mode of instruction for her classes,

> “I've definitely expressed stress, especially moving from Virginia to Florida, because we have a lot less Covid cases up there compared to being down here. So, I have definitely expressed being a bit more stressed about Covid being a bit more of a problem here. I have talked with my roommates about going to Busch Gardens this fall for Howl-O-Scream and I've been actually debating it because of how bad the Covid numbers have been. It was... and also just talking about how stressed, stressful online school can be. That was a big thing because we all became friends during online school and there's always the risk of classes switching to online here. All of my classes are except for one that's temporarily online or in person. And so just kind of being nervous about stuff, returning to online instruction…And so it was just kind of stuff like that, or like one of my friends has been expressed that she's kind of avoiding parties at her school right now because those are kind of Covid hotspots.”

Health Conversations as Coping and Intimacy

While these conversations pertain directly to the participants’ or their friends’ health and well-being, I argue that they straddle a space between the medical and non-medical. This means that queer students and their friends are providing care to each other which in some instances cannot be provided by healthcare institutions and providers, particularly as this population is likely to have to navigate discrimination and is reported to have difficulty accessing quality healthcare as compared to their non-queer counterparts. In other instances, particularly in relation to mental health, this type of care can be provided by healthcare providers and institutions, but is not available or accessible to LGBTQIA+ students, leaving a gap in the maintenance of students’ well-being.

Conversations with friends about health experiences also act as a coping strategy for queer students. Samson and Gross (2010) demonstrate that humor can be a strategy for emotional regulation, and in this research, participants revealed that they also use humor regarding their individual and shared health experiences in order to make it easier to cope with health conditions as well as to maintain a level of positive engagement with their friends. Mary, who is 27, white, non-binary, lesbian, asexual, disabled, and a graduate student, provides an example of using humor as a coping and positive engagement strategy she and her friends employ. Here, her group of friends makes jokes about the size of a tumorous growth one of them was suffering from. The growth was supposed to be the size of a cantaloupe initially, and then became nearly as large as a soccer ball. This added a humorous effect to the words cantaloupe and soccer ball, creating a repertoire within the friend group from which they can draw humorous comments.

> “I just like making really cheesy jokes about life, which I think they do, too. They do the same thing with theirs. But like or like my friend who had the surgery, it was and it wasn't a cancerous tumor, but it was like a tumor in that it was a mass that was not supposed to be there and it was the size of a soccer ball, so we've been making jokes about this. Yeah, it's very spooky. It was not a fun time, but completely OK now. Great. I'm so glad that that didn't end up being like a cancerous thing because that would have been fucking terrifying. But like, we make jokes about the soccer ball and like whenever the words either soccer ball or cantaloupe, because it was initially supposed to be the size of a cantaloupe, whenever that comes up, we just stare at each other and try not to laugh.”

I find that humor can allow LGBTQIA+ students to communicate their everyday health experiences to their friends while also preventing the conversation from becoming too morose when they want to avoid that. Specifically, for those who struggle with chronic and mental illness, this strategy is particularly useful as participants felt that they could not constantly have conversations about it which were serious in nature.

The ability to use humor in conversations about personal health experiences is also indicative of a certain level of intimacy and familiarity in relationships. This humor is specific to friends, as people engage in it with those who share the same repertoire, based on similar experiences. This creates a significant level of comfort and trust to be able to discuss personal information about individuals' experiences. By creating an emotional space for coping with difficulties, including those which are a result of discrimination and exclusion, friendships here operate as a form of "resistance to the divisive and fragmenting lies of structural power" (Chowdhury and Philopose 2016, 3).

However, participants also revealed that they had different levels of comfort around specific health topics. Muraleetharan and Brault (2021) argue that students experience shame in discussing certain topics, even with friends and peers. Similarly, in this research, while some participants felt more comfortable sharing their physical and sexual health concerns with friends, others felt that these were more private and that mental health was easier to discuss. While in some cases, the lack of comfort was due to participants' own inhibitions, for others it was due to culturally learned behaviors. For instance, Maeve, who is 24, white, a cis woman, gay, and an undergraduate student, explained that she was able to talk openly and delve into details about her mental health conditions with her friends, was not able to have the same comfort level in discussing sexual health due to her religious upbringing,

> "Like sexual stuff has always been like this weird area that people don't like to talk about where we grew up. And in my family it's just not something you ever talked about. So it's just kind of a hidden away thing that we don't bring in…A lot of my friends know, it makes me uncomfortable to sit there and try and talk about it so they will steer clear of the conversation. Just growing up in a church setting, they're just like, Don't do this, don't do that, don't talk about it, don't do anything. So it's just kind of a weird topic for me to dive into."

However, participants revealed that when they did share their health-related experiences with their friends, it increased the level of intimacy between them. Emma, who is 22, white, a cis woman, bisexual, and an undergraduate student, describes the role conversations about her health experiences play in her friendships,

> “I think it makes it a lot more open, honest, and I feel like our friendship goes to like the next level of like... We're best, best friends kind of, I guess, because, like, if I mention, like taking my meds or whatever in a conversation and somebody were to like, either make a face or flat out say something like anti-meds [referring to medication for mental health conditions] or say something about like bipolar disorder means being crazy or any other negative thing like that if I mention it, then I wouldn't want to be friends with them anyway. And so I think with my friends, it definitely makes my relationships with them really deep and meaningful, because the more that we like holistically know about each other with the occasional boundary of something that's like, this is my personal thing that like I don't really tell anybody and I'm fine with that. For the most part, everything is really nice when it's open and when we find ways that we relate to each other, it kind of instills in my mind, like, OK, I'm not crazy. This happens to other people, too, so.”

Emma’s narrative reveals that these conversations help her build emotional intimacy with her friends, while also helping her cope with her health concerns and providing support. Meanwhile, as her friendships become more emotionally intimate, her ability to cope with health concerns also increases, as she realizes that others share similar experiences.

Information Seeking and Decision-making

Conversations with friends regarding health experiences are also an avenue for LGBTQIA+ students to seek information which can improve their health and well-being. Once, again, this information straddles the medical and non-medical, as it is often not technical in nature. For instance, they rely on friends’ experiences with accessing care, as well as experiences with symptoms, healthcare providers, and treatments. This aligns with literature on friends as informal sources of information about health resources, particularly for college students (Muraleetharan and Brault 2021; Kwan et al. 2010; Brener and Gowda 2001).

Kwan et al. (2010) demonstrate that college students have varying levels of trust in their health information sources, and while they might use one source more frequently than others, it does not indicate that they place greater trust in that source (Kwan et al. 2010). Hence, LGBTQIA+ college students rely on several sources of information about health-related topics, which they ‘triangulate’ based on their health needs in order to accumulate as much knowledge as possible about a health concern. From friends and others in their social circles, they receive experiential knowledge, while healthcare institutions provide them with technical medical information such as diagnoses and treatment options. This is combined with research participants engage in themselves using resources online, such as academic articles, informational websites, or relevant accounts on social media. For instance, Anna, who is 19, Black, Caribbean-American, a cis woman, and an undergraduate student and lives with Ulcerative Colitis described that she turns to her friends for certain types of health advice, which she then decides to take or not take based on her health needs,

> “Most of my friends don't have a... I don't think any of my friends have IBD, some of them do have digestive issues, but I wouldn't say severe enough for them to fully relate to me. But I do talk to them about it and just ask ways that they manage theirs, because sometimes the way that they manage is doing good for them. So I'll just try to see if maybe it'll work for me.”

On the other hand, Emma, who is 22, white, a cis woman, bisexual, and an undergraduate student, sought certain types of information using the internet as a resource,

> “YouTube is a big one because in general I know channels or even websites, but YouTube is my big one because some people are able to tell information in an entertaining way with infographics and fun visuals… there's a hashtag called doctors or dickheads. It's talking about experiences that people have had. And a lot of it is there are a lot of stories about women like they've endometriosis... Doctors not believing their pain, etcetera, but also doctors just sometimes flat out refusing to give them a birth control because it goes against any belief they have. And anyone who just talks down to any

> LGBTQ patient because of that anyway. So I think I also listen to a lot of their stories."

Relying on multiple sources of information for different issues and triangulating information from various sources informs queer students' decision-making about their health.

Scholars have argued that friends and peers are a significant influence in people's decision-making about their health. Quinn et al. (2020) demonstrate that friends and others in people's social networks can influence people's decisions around healthcare, such as the use of certain treatment options and medications like Pre-exposure prophylaxis (PrEP) for HIV prevention. Moreover, Carlos et. al (2010) argue that support from friends can increase the likelihood of condom use for gay and queer men.

Similarly, within my research, sharing personal health experiences with friends is a significant factor identified by queer students which influences their health-related decision-making, from seeking a diagnosis to choosing specific treatment options. For instance, Maeve, who is 24, white, a cis woman, gay, and an undergraduate student, explained that she convinced her friend to seek professional mental health care for her concerns,

> "The other day, I was talking to one of my friends and she was saying that she was feeling like suicidal. So just going to try to get her to start talking to someone on a professional level and try and push her to not self-harm and do anything like that and try and stay positive as best we could… She started looking into trying to get into a therapy session and trying to just work on keeping herself in a good mood rather than only thinking about the negatives."

Such conversations have significant influence on queer students' and their friends' decision-making about their health, as the care and support provided amongst friends allows for the development of an embodied knowledge base. On the other hand, in some instances, sharing of experiences can act as a warning for friends to avoid certain providers or treatments. For instance, Sarah explains,

> “I never really wanted to try the counseling center. I had a few friends try it and they said that not a lot of people were helpful and they kind of felt like the counselors there didn't want didn't really want to be there, they felt like they like. It's hard to explain they were just like saying that something was not right, like they didn't fully listen to me like it just didn't help. So I was just like, oh, well, I don't really want to go through that either, so.”

Sarah’s narrative suggests that her decision not to use the USF Counselling Center and to rely on other mental healthcare professionals was influenced by her friends’ experiences, which made her feel that she was unlikely to have a positive experience utilizing this particular campus service. However, it is important to note that other students may not have the resources to pay for mental health services, forcing them to rely on the USF Counselling Center as it is a free service.

Conversations as Production and Sharing of Embodied Knowledge

The evidence provided above indicates that conversations between queer college students and their friends about health experiences involve care work that friends do for each other by offering various kinds of support. These conversations also create a body of knowledge which is embodied and experiential, and significantly informs the decision-making of these individuals. Embodied knowledge here is defined as that which is produced through our bodies, rather than simply being about them.

More specifically, I rely on Ellingson’s (2008) definition, who asserts that this is the type of knowledge is “grounded in bodily experience” and is “inherently and unapologetically subjective” (2). Moreover, embodied knowledge is focused on lived experience in a way which allows for a sense of collectivity to emerge, particularly for marginalized groups (Rich 1986). Through their health discussions with friends, participants share their lived experience and create networks of care, exchanging information and experience as knowledge. These conversations also produce a sense of collective, shared experience based on different identities.

If knowledge can be embodied and subjective – produced by us as subjects through and about our bodies, it means that we can challenge the assumption that all knowledge must be objective. This aligns with the understanding of science put forth by queer feminist science studies scholars, who suggest that “science is not a static or unchanging object of analysis. Nor is it the nom de plume of objectivity” (Cipolla et al. 2017, 6). Queer feminist science studies scholars argue that “disciplinary scientific practices are inextricably conditioned by particular political economies and ideologies that regulate: a) what counts as legitimate scientific knowledge; and b) which kinds of people, bodies, and institutions can conduct scientific research in the first place” (Cipolla et al. 2017, 6).

This means that certain knowledges, such as those which are embodied and subjective, are excluded from what is considered legitimate, particularly when the producers of this knowledge have bodies which are particularly harmed by “heterosexist regulatory regimes” (Cipolla et al. 2017, 8), such as in context of healthcare for LGBTQIA+ populations. For my participants, there are many instances in which their own experiences as well as those of their friends serve as a knowledge base. This allows them to navigate the healthcare system, along with discrimination and inadequate care through self-advocacy, decision-making based on triangulated information, and receiving support around healthcare experiences which plays a role in the maintenance of their well-being.

While feminist science studies scholars argue for excavating the body and its materiality from under the façade of scientific objectivity (Haraway 1991; Kline 2010), other scholars offer even more critical approaches. In their critique of feminist science studies, Roy and Subramaniam (2016) argue for a “contextualized and situated materiality” rather than just assuming the body to be material (as the primordial body on which social and cultural forces act) and hence automatically posing a challenge to mainstream scientific discourse (36). Such a contextualized materiality means that we explore embodied knowledge within a particular social context, cognizant of the time, place and experiences of those who are producing and sharing this knowledge.

In the case of my participants, this contextualized materiality is that as LGBTQIA+ college students, they are likely to face barriers in accessing quality healthcare services. I argue that within such an environment, their conversations with friends about health function as a source of health information as well as spaces of support and care provision which they may not be able to access through other institutions or relationships. Hence, LGBTQIA+ college students create and share embodied knowledge through health-related conversations with their friends, with friendships operating as an important space for the sharing of health-related concerns, experiences, fears, and frustrations.

Moreover, even in instances where participants' knowledge aligns with technical medical knowledge, they still benefit from health conversations because of the experiential nature of the information being shared. For instance, participants report that even as they undergo a particular procedure, it is useful for them to know the details about it beforehand which they obtain from friends they trust as sources of this information.

Revelations from Interviews: Mental Health

These health conversations and the sharing of embodied knowledge by participants also reveal two significant aspects of LGBTQIA+ college students' health experience. Firstly, mental health conditions often operate as long-term illnesses which impact the everyday lives of this population. Moreover, these conditions need to be understood from beyond a pathologizing lens to understand the mental health impact of receiving inadequate care and having to navigate discrimination and/or lack of access when seeking healthcare.

This is a particular concern during the COVID-19 pandemic, since the mental health of college students has been reported as worsening (Lee et. al 2021), making it more essential for them to be able to receive good mental healthcare. This is especially important for LGBTQIA+ students, since sexual and gender, as well as racial and ethnic minorities are likely to face disproportionate impacts of the pandemic (Krouse 2020; Wilder 2021; Phillips II 2020; Moore et al, 2021; Kamal et al 2021), while at the same time having more limited access to quality healthcare during the crisis (Bojdani 2020; Garcia et al 2020; Litchman and Rigel 2020). As several participants' narratives have revealed, facing difficulties in accessing quality healthcare as well as discriminatory and unhelpful experiences with providers negatively impacted their mental health, even acting as deterrents to pursue health services in the future. This aligns with existing medical literature which shows that lack of access to quality healthcare as well as discriminatory experiences with providers can be significantly detrimental to the health of LGBTQIA+ individuals (Bradford et al 2013; Albuquerque et al. 2016).

Revelations from Interviews: Invisible Labor

The second important aspect of LGBTQIA+ college students' health experiences which emerged through this research was that they have to perform invisible labor when seeking healthcare which their non-LGBQTIA+ counterparts may not have to undertake. For instance, having to search for a healthcare professional who can provide LGBTQIA+ sensitive or trans specific mental health care.

Aside from mental healthcare, LGBTQIA+ students also have to engage in self-advocacy to counter the heteronormative assumptions of healthcare providers simply to ensure that they receive adequate care. Hood et al (2019) argue that “heterosexism is ingrained in the way many health care providers are trained in medical school and, in turn, engage in health care provision” (807), and it is only by “training health care providers and support staff to actively avoid making heterosexist assumptions” that we can increase the comfort LGBTQIA+ students experience when seeking healthcare (808).

These two barriers faced by LGBTQIA+ college students are themselves an example of the type of embodied knowledge which is created through conversations between friends, and eventually with me as the researcher when details of those discussions are shared with me. Within their conversations, LGBTQIA+ college students and their friends are able to help each other cope with difficult health experiences, as well as to inform each other about various issues surrounding health.

The Other Side of Sharing Knowledge

While sharing embodied and experiential knowledge can positively impact the well-being and health-related decision-making of LGBTQIA+ students, it can also have the effect of deterring them from seeking care or trying certain treatment options. Analyzing misinformation in health communication, Krishna and Thompson (2021) assert that conversations with friends and others in one’s social circle can reinforce attitudes towards certain treatments as well as health behaviors. This produces and maintains people’s resistance to trying them.

This is because friends’ advice and sharing of their own experiences on a subject can act as a discouraging force for individuals. For instance, while some participants reported conversations with friends where they motivated each other to seek healthcare, there are instances where the opposite happens. For instance, Karen, who is 25, white, a ciswoman, bisexual, and an undergraduate student, described how one of her friends suggested that she exercise instead of seeing a professional when she was struggling with her mental health,

> “It was actually Franny who told me to exercise. It's... before you go, try to go to a psychologist to get medicine, or a primary care physician and tell him that you're having this anxiety, you're having that anxiety... Umm exercise. Do something with your body at least three times a week for an hour a day and make your body move.”

While Karen’s friend did not suggest any harmful activity to improve her health, she did provide discouragement regarding visiting a healthcare provider, which could lead to harmful consequences for Karen in the future, as Karen revealed that she did not end up visiting a mental health professional because she wanted to try to improve her health with exercise, but was continuing to experience high levels of anxiety during the time of the interview. In other cases, experiences shared regarding medications can have a discouraging impact on friends, deterring them from trying available treatment options. Mary, who is 27, white, non-binary, lesbian, asexual, disabled, and a graduate student, describes her experience of using friends’ experiences to make decisions about her health,

> “Like if it [certain medication] worked really poorly for someone or if it screwed them over, I usually rather avoid it. Like I had one that I actually recently got off of because I realized how badly it had worked for someone else I knew. And connected it to what was going on in my life, so there's a lot of them that I just don't want to try because I have seen that, especially if there is a possibility for like permanent damage.”

Mary’s narrative indicates that sharing of experiences about medication can play a role in influencing decision-making of friends, despite the fact that individuals can respond differently to the same medication.

Despite its many benefits, sharing of embodied and experiential knowledge sharing is likely to have such negative potential. This is because LGBTQIA+ college students rely in on it precisely to fill a gap left by institutions due to lack of access to quality healthcare, as well as to counteract their mistrust in the U.S. healthcare system more broadly (Jaiswal and Halkitis 2019), and local healthcare facilities (such as those at USF) more specifically.

However, participants have also reported many instances of positive intervention from friends, such as being encouraged to seek healthcare despite challenging experiences with providers. Hence, I argue that embodied knowledge and the care work of friends remain significant in helping queer college students maintain their health and well-being. The next chapter provides concluding thoughts, as well as some directions for future research.

CHAPTER FIVE

INTERSECTIONS OF HEALTH AND FRIENDSHIP

The analysis of LGBQTIA+ college students' understandings of friendship, their health experiences, and their health-related conversations with friends reveals that health and friendship intersect closely in the lives of these students. I began this research with the understanding that LGBTQIA+ students discuss their experiences with their friends and that this produces knowledge which challenges the proclaimed objectivity of scientific and medical knowledge, as queer feminist science studies scholars have argued (Cipolla et al. 2017). I also conceptualized friendships between those are marginalized as sources of support (Hughes 2019).

However, I have found that LGBTQIA+ students are strategically building intimate emotional connections with their friends. They are curating who they have in their lives as friends, as well as at what emotional level they connect and interact with these individuals. For example, when these students engage in "baby steps" of emotional vulnerability, they are being strategic in their negotiation of interpersonal space, ensuring that they will find trust, safety, and comfort in their interactions and conversations with others. In building these emotional, intimate connections which allow for vulnerability and the sharing of personal experiences, LGBTQIA+ students are actually creating networks of care.

These networks consist of different friends, often from different friend groups, who are not necessarily connected to each other. Each friend and friend group provides a specific type of care and support to LGBTQIA+ individuals. While some of these friends also belong to the LGBTQIA+ community, others do not. This means that these friends share different identities and experiences as well, other than belonging to the LGBTQIA+ community.

Since LGBTQIA+ students are likely to be operating within a climate of discrimination by the healthcare system, as well as a dearth of other forms of social support such as family or other communities, they lack support around their health and health-seeking. I argue that this gap, left by institutions and other social relationships, is fulfilled by their friends. This is done via the emotional support and care exchanged among friends.

There is healthcare, and then there is care around health. This type of care involves the sharing of health experiences to commiserate, seek information and advice, as well as support and encouragement. Friends are caring for each other in a way which helps them manage their own health as well as understand their health experiences. Hence, friendships provide individuals with care around health that they are not likely to receive from other avenues. This care is essential for LGBTQIA+ students as they navigate health, such as in terms of access as well as simply having to manage one's own health.

Care is provided through health conversations and health-related interactions among friends. I found that health conversations are in fact a site of production and sharing of embodied knowledge. It is precisely the experiential nature of this knowledge which is significant for LGBTQIA+ college students, because even in instances where this knowledge aligns with scientific, medical knowledge, it is beneficial to them, particularly because it creates a sense of collective, shared experience, and provides them with a sense of community.

Hence, I argue that the sharing of embodied knowledge is itself a form of care which friends provide each other. This particular kind of support and care are essential for the emotional and subsequently physical well-being of these students. Health conversations as the site of embodied knowledge production and sharing are thus an ‘extension’ of LGBTQIA+ students’ health and well-being itself.

Moreover, it is because friendships are voluntary and such emotionally intimate relationships that they fulfill unique needs around health, particularly the non-medical and non-technical aspects of health and well-being maintenance. This is especially the case for LGBTQIA+ students because they are less likely to be able to rely on other sources of health support, such as family, while also having to navigate discrimination when seeking healthcare from professionals. At the same time, it is the intimacy of health conversations which allows these students to create deeper and more meaningful connections with friends.

Limitations and Future Directions

My study is limited as I had a small sample, which was not racially and ethnically balanced. It would be useful to explore, with a more diverse sample, the more intersectional aspects of health and friendships, such as what role identities play in the forming of intimate connections. Forming networks of care through friendships may be more complex for LGBTQIA+ students of color, since they may find it difficult to find care in relation to health from those who do not share the same barriers in in seeking quality healthcare. Alternatively, they may rely more on other forms of community for care and support around health. Further work would be required to explore the specific experiences of LGBTQIA+ college students of color.

Moreover, my research is constructed on a culturally specific notion of friendship – as relationships which are voluntarily formed and dissolved, and are emotionally intimate. Since not all cultures conceptualize friendships in this way, it would be useful to explore how health and friendships intersect outside of this construction of friendships. As such, international students' experiences and meaning-making around health and friendship would be particularly interesting to explore, to understand if friendships play similar roles in their lives for the maintenance of their health and well-being.

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APPENDIX

INTERVIEW GUIDE

Demographic information, gender identity and sexual identity, age, where are they from, pronouns, how long they have been enrolled at USF, graduate or undergraduate student.

I. Background Information on Friends

a) Can you tell me about your friends, different friend groups and social circle?

II. Health Discussions

b) How do you get access to health information? Who do you go to? (Do you also talk to friends?)

c) Who do you talk to about health-related experiences?

d) What do you talk about when discussing health with friends? Can you tell me about some specific discussions?

III. Friendship and Health

e) What is your experience of sharing health-related experiences and information with friends? (Do your friends support you with your health concerns? How? Do you support your friends with their health concerns? How?) Can you tell me about some specific experiences?

IV. Prior Experiences with Healthcare

f) Can you tell me about some of your specific experiences with healthcare providers? (Experiences of discrimination related to identity?)

V. Impact on Health Behaviors and Decision-making

g) How do you feel about your health-related discussions with friends? (Do you act upon what your friends tell you in relation to health? Can you give me some examples of that?

h) Does sharing your health-related concerns and experiences impact your relationships with your friends? Can you give me some specific examples?