EAT WELL, SLEEP WELL, AND EXERCISE:

Latinx Self-Care Practices at San Jose State University

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Project Summary

This research was designed to learn what health-seeking behaviors look like among students at San Jose State University (SJSU) who self-identify as Latinx. The expectation was that, compared to their non-Latinx counterparts, Latinx students would more often describe health disparities that would influence how they sought care and from whom. Additionally, I expected to find a greater variation in overall self-care practices between the two groups due to ethnic and cultural identity.

With the assistance of student researchers enrolled in an *Ethnographic Methods* class in the Fall of 2018, we recruited, and interviewed students at SJSU who varied in age, gender identity, college classmen status, and ethnicity. Through in-depth semi-structured interviews we asked students about being the first of their families to enroll into university; we asked about health insurance coverage; asked if they had ever used Student Health Center (SHC) services to learn what health-seeking behaviors are like at SJSU.

I found that self-care practices do not differ much among students, Latinx or not. Students rarely spoke of not having access to medical services as children or now as adults. Students are also busy. Those who spoke of experiencing stress identified school as the main source and for students who were employed work was an additional source of stress. Food and exercise were linked directly to notions of health as were practices in mindfulness. Differences were few and included if they referred to alternative medicine as homeopathic or as home remedy. The most significant difference was that non-Latinx students more openly discussed seeking mental health services than Latinx students.

From an outreach perspective this study emphasizes a need to invest in awareness in Latinx communities about mental health, as well as invest in the accessibility of mental health services in Latinx communities. Research could also be continued by a study on the trust of the medical profession, especially in mental health to include notions of stigma, fear, and misconception. Latinx students rarely mentioned seeking mental health services even though they acknowledge it as part of overall health and wellness. They often made references about "wanting to" or were "curious about" using such services. Research could also be continued by studying how the SHC may leverage social marketing with an emphasis on personal stories to drive students to trust and use SHC services.

Executive Summary of Chapter 4: What Self-Care Looks Like

Food and Diet, Avoidance and Control

In response to how students practiced self-care, food and diet was a common topic. Latinx and non-Latinx students alike described what foods they both consumed, to remain healthy, and what foods they avoided when they felt sick. Student narratives on food and diet were commonly tied to notions of what being healthy was. Food was also commonly mentioned as part of *home remedies* when self-treating for a cold, mainly in the form of herbal teas and home cooked foods.

Physical Activity and Exercise

Student participants often coupled self-care descriptions involving food and diet together with physical activity and exercise. Whether in the form of both structured exercise, such as going to the gym and running, or more informal ways, such as walking to and from school as well as choosing stairs over elevators, both Latinx and non-Latinx students spoke of physical activity and exercise as connected to notions of health and wellness. An able-bodied student moved often according to how many times weekly they spoke of "trying to" engage in physical activity and exercise.

Mindfulness

Many student participants described mental health as part of overall health maintenance. Hiking trails in the Santa Cruz mountains and dancing in a studio at SJSU was closely related to notions of re-setting the mind in preparation for the upcoming school and work week, as well as an escape from the stresses of daily life as a college student. Mindfulness was also in the form of disconnecting from the social world, through physical and virtual self-isolation.

Time

To control food and diet, physical activity and exercise, and social worlds, for students, was control over their health. That control, however, appeared to be at the mercy of time. Time dictated when and what a student ate; too little time meant grabbing something accessible and low cost, limiting healthy food options and consumption. Responsibility and duty to school, work, activities on/off-campus, and family often determined the use of time.

Executive Summary of Chapter 5: How Healthcare is Experienced

Convenience

Students spoke of convenience as often tied to time and what kept them from using SHC services. For students who commuted to campus the thought of looking for parking solely to use SHC services was enough to deter them. Parking was an inconvenience for students who commuted to campus. If a student dedicated time to seeking care off campus, commonly mentioned was the convenience of parking at medical centers. Students spoke highly of web tools offered by private medical facilities that allowed for direct communication with advice nurses or physicians or mental health experts. Both sets of students spoke of the inconvenience of filling out paperwork at the SHC and the lack of web tools to facilitate convenience.

Interpersonal Connections and Relationships

Students value efficiency and thoroughness from medical staff. Some students who have used the SHC mentioned appointment availability with the medical staff they know and like to be an issue. Some students spoke of having developed both a liking to their physicians and an ability to communicate with them on a personal level. Students who used mental health services described the importance of seeing one person with consistency.

Quality Customer Service

Students value quality service, rating previous health care experiences poorly if there was a long wait time and a short doctor consultation; positively if it was a short wait time and a long doctor consultation. Student participants spoke of trust in medical staff, questioned SHC service capabilities, and wondered if "actual doctors" could be found on campus. Other student narratives around the topic of *quality customer service* were about services doctors provide, unnecessary fees, and treatments.

Executive Summary of Chapter 6: What Care with Others Looks Like

Share Experiences

Students highly valued shared experiences. Important to Latinx students were ethnic/cultural background of those who they sought advice from. All students valued the advice of those who had experience with navigating higher education as well as the medical system. If someone

within a student's social support system had experienced navigating mental health services, they were often mentioned as a source of knowledge.

Honesty and Straightforwardness

Students often spoke of seeking affirmation and reassurance from family and peers and emphasized having an appreciation for candid advice. The more a student valued a person the more they valued that person's advice on any one topic and if there was a straightforwardness with how they shared that knowledge, students sought them often.

Independence and Self-Reliance

Both sets of students spoke of seeking care advice only when they felt it was needed; often preferring to seek solutions to their issues on their own. Although mentioned not wanting to burden their social networks, students emphasized valuing their independence and self-reliance.

Proximity

Often a primary go-tos for advice were those closest within a social network; roommates; significant others; friends; fellow students, and colleagues who they already value. Proximity was not only relegated to physical space but also social and emotional proximity. Siblings, best friends, a supervisor at work who became a mentor were all mentioned as highly valued go-tos for students.

Expert Knowledge

Student participants assigned their social network connections with specific knowledge and expertise. To differentiate knowledge and expertise acquired through institutions from those gained through life experience I split expert knowledge into two sub-categories, formal and informal.

- Formal knowledge - Friends and fellow students majoring in health-related subjects; extended family members or parents of friends and fellow students working in health-related fields; a parent or legal guardian directly related to a health or medical field for work.
- Informal Knowledge - Family members with experience with the medical world as a patient themselves; friends and siblings with experience in higher education

and with navigating medical system; older relatives viewed as wise gained through life experiences

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Chapter One: Introduction

As part of a partnership with the Student Health Center (SHC) at San Jose State University (SJSU), I conducted a research project on student health-seeking behavior. My research builds on the concept of *care*, which I use to interpret student self-care practices and healthcare service experiences. I use the narratives of both Latinx and non-Latinx student participants collected through in-depth, semi-structured interviews in collaboration with students enrolled in ANTH 149 *Ethnographic Methods* in the Fall of 2018. This project report is the result of an analysis of those interviews with two objectives. The first objective was to present the SHC with a research-driven report on how a population of students perceives and practices *care*. The second was to identify potential gaps between SHC services and the end-user to inform their outreach moving forward.

Current research highlights the concern around care and healthcare-seeking in the Hispanic community. The United States Census Bureau estimated in 2018 there was a Hispanic population of 59.7 million in the United States, with 15.3 million living in California (U.S. Census Bureau, 2018). According to the U.S. Department of Health and Human Services, Hispanic populations have higher obesity rates and higher rates of diabetes and hypertension than their non-Hispanic white counterparts (Office of Minority Health 2018). Exacerbating the issue is a lack of health insurance within the Hispanic population, which has been found to have the highest uninsured rate of any other ethnic group in the U.S. (Office of Minority Health 2018). That number increases among low-income Hispanic communities, specifically among Spanish-preferring populations (Heintzman et al. 2016). As the Hispanic population continues to grow in the United States, understanding how to best align health care services with not only their health care needs, but their views on health-related care will be of greater importance.

In recent years, access to healthcare and insurance has undergone important changes. This study took place eight years after passing the Affordable Care Act (ACA), at a university where Latinx students surpassed their non-Latinx white counterparts in enrollment by twelve percent in the Fall of 2018 (SJSU Institutional Effectiveness and Analytics). College students across the country who did not already have health insurance found they had health coverage and augmented access to medical services after the enactment of the ACA. In their health-seeking narratives, student participants spoke of navigating health care systems for the first time; a daunting task for many, who, until then, had depended on their parents or guardians to manage their doctor's appointments. Navigating health service websites and the process of filling out paperwork were tasks that for some students became determining factors for whether or not they used SHC services at SJSU.

In the following section, I introduce where my research took place and the people who make up the study. I give my research context by introducing SJSU's *Treat Yourself Well* initiative and describe some of the ways SJSU engages in health and wellness outreach to its students. Lastly, I explain the significance of my project and describe my final deliverable. I situate a growing populations' thoughts and practices on self-care and healthcare through views expressed by some SJSU students during a time where access to healthcare is not a state given right, and where healthcare coverage is a highly charged issue in American politics. I insert *busyness*, a concept developed by Charles N. Darrah (2007) to view what seems to be contemporary college life and the role duties and responsibilities play in influencing a student's health-seeking behavior. I place the self-care narratives of students in a time where *wellness* is more than a concept but rather a buzzword for what it means to be healthy, both physically and mentally. Lastly, I view the topics of self-care management, institutional healthcare experience,

and cultural views on care through the lens of access: who has it, who does not; who is familiar with its inner workings, who is not, how does access influence self-care practices and health-seeking behaviors; and what does any of this mean in terms of health outcomes and how we will address it for a Latinx population estimated to grow up to 111 million by 2060.

People, Place, and Time

SJSU was more than just my research site; one could say it was my backyard. I was not only familiar with SJSU as a graduate student but precisely as a self-identified member of the Hispanic/Latino/Mexican-American/Chicano/Latinx student body. The first two terms, Hispanic and Latino, are the umbrella terms under which several identities exist and the official top-down label for this growing population in the United States. The term "Hispanic" was adopted by the U.S. Census Bureau in the early 1970s to account for people of South American, Central American, Puerto Rican, Cuban, and Mexican ethnic origin, but it has always been contested as many peoples from these regions do not primarily recognize Spanish heritage (e.g., Indigenous peoples, Brazilians, African diaspora). However, because this is the preferred term of the U.S. Census Bureau, many important attributes of this contested population are reported using these terms (and many other organizations continue to use it for reasons of compatibility).

Although the term Hispanic and/or Latino is interwoven throughout my report, it is to present information on studies whose team/authors chose to use the labels when describing their sample populations. I am careful, however, not to use those terms interchangeably. In fact, in the interest of acknowledging the self-appointed identity of some student participants, I will set aside the terms Hispanic/Latino when referring to my sample population and use their ethnic label of choice. Latinx as an identity is a contemporary term. To speak of a Hispanic/Latino student body at SJSU in the 1970s as Latinx when the term was not used as it is today, to me does not seem

appropriate or accurate. Furthermore, today, Latinx is not necessarily the preferred term of many populations in the U.S. with Hispanic/Latino origins. It is specific to a younger generation of English-speaking youths who are described to be much more fluid than previous generations in terms of self-identity. Very few student participants in my study self-identified as Latinx. The students who tended to use the term Latinx use it to discuss not only their own ethnic identity but that of others as part of a community, young and old, both on and off university grounds. They included within their own ethnic identity the broader and larger Hispanic/Latino community they are members of even if that community as a whole does not self-identify as such.

SJSU is no stranger to a large Latinx student body and has a rich history of working closely with the Latinx community. The Chicana and Chicano Studies Department at SJSU (formerly Mexican-American Studies) was created in 1968 and is currently only one of five graduate programs of its kind in California. SJSU is also no stranger to its very own Spartans actively engaging in issues relevant to student life on campus. In 1963, students voted to willingly pay an additional fee to collect the funds needed to build a Student Union, a process that was repeated in the 1980s to fund what would become the Aquatic Center and the Event Center. Today, within the student union, among a long list of resource centers there exists the UndocuSpartan Resource Center, the Gender Equity Center, the African American/Black Student Success Center, and the Chicanx/Latinx Student Success Center (CLSSC). As a research site, I focused mostly on the CLSSC as the center of my study. As a research population, I included both students who self-identified as Hispanic/Latino/Mexican-American/Chicano/Chicanx/ Latinx and students who self-identified with non-Hispanic/Latinx ethnic origins and culture.

The CLSSC or *centro* (center) as those who make up the space know it as is a place to study, to have lunch, to relax/hang-out, to meet with friends, to hold study groups, and to learn of

a variety of resources and events on campus. During midterms and finals, the centro is open late and has food and drinks available for students studying for exams and writing papers. Among the many resources available to students at the centro, one service is advising with faculty from within the Chicana and Chicano Studies departments. On certain days faculty will volunteer their time to speak to students on a one-on-one basis. Throughout a semester, the Chicana and Chicano Studies department will hold events either within or in conjunction with the centro.

The "x" is all-inclusive but also combative. This self-identifier was born from within the group and a way of reclaiming an identity set upon them. The use of both Chicanx and Latinx in the centro's name is an all-encompassing signifier and welcome mat. Students who tie their identity, either by birth or through their parents, to Central America mingle amongst students whose ties are with Mexico. At any given moment conversations in English switch into Spanish and vice versa. However, it is not only ethnic identity the "x" encompasses. Gender identification is allowed its fluidity within the "x" and for many who self-identify as Latinx shed and push back hetero-normative labels. M. deOnís (2017, 81) explains that the use of identifiers such as Chicanx and Latinx "gender-neutralize the terms, while also providing a term for those who are transgender or queer." The "x" as a modifier finding its way in many labels. The use of the term *Womxn*, for example, is becoming commonplace within Latinx communities pushing back against the genderization of labels and terms. As Lilly from the CLSSC one day poignantly said to me when discussing the term *Womxn* and its increasing use, "It's taking the *men* out of *women*!"

The students who come through its doors are as much a variety of self-identity as the resources they offer. The *centro* is an all-inclusive space, reflected in its name, Chicanx/Latinx. The "x" in what was formerly Chicano/a and Latino/a or now less commonly used,

Chican@/Latin@, has not only generated recent scholarly conversation on what it means to be other than American but literature as well. Of the students I interviewed, three worked for the centro as interns where the majority of their work was in the form of front desk duties. They were the faces one first came across when entering the space. Each student I spoke with was either a Chicana and Chicano Studies or Sociology major. In their narratives, they talked of agency and autonomy, and did so confidently. They described busy lives on and off campus in a matter-of-fact way that almost painted their personal experiences as merely part of college life. They also spoke of identity as a marker for why they did what they did as it relates to care and health-seeking behavior.

Health and Wellbeing at SJSU

The SHC provides a variety of health care services to enrolled students at SJSU. Their staff is made up of medical doctors whose focus ranges from internal medicine to family practice, family medicine, and dermatology, as well as experienced Nurse Practitioners and health experts from various fields. The SHC also acts as a resource center for SJSU faculty who require that students receive a physical exam, tuberculosis screening, and any other form of immunization for both academic and internship programs, as well as for international student travel. There is a pharmacy that will fill prescriptions both from doctors within and outside the SHC and offer non-prescribed over-the-counter medication as well. As part of the SHC, the Department of Wellness and Health Promotion (WHP) provides a variety of programs and services for students, staff, and faculty. The services and programs supported by WHP are in the form of both counseling and workshops. Support groups made up of students and staff are available to tackle a variety of concerns such as alcohol use, sexual health promotion, and body image concerns. Whether it is through learning ways to relieve stress or how to get quality sleep,

WHP provides services that promote overall wellness and self-care practices for the SJSU community. A large portion of programs, workshops, consultations, and counseling services are found through and operated by Counseling and Psychological Services (CAPS).

To help support and promote student wellness and health SJSU joined the nationwide Healthy Campus 2020 pledge, calling it the *Treat Yourself Well* initiative. Healthy Campus 2020 is an offshoot of the U.S. Department of Health and Human Services (HHS) which began in 2010. The intent was to create a ten-year timeline to meet "goals and objectives for health promotion and health prevention" (ACHA 2018). *Treat Yourself Well* began in the Fall of 2017 with programs and workshops aimed at promoting health and wellness on campus. The workshops, held on various dates and times, included topics about managing stress, dealing with notions of body-image, nutrition, healthy cooking and healthy eating, to sexual wellness. This initiative to promote and support healthy habits and lifestyles is designed to focus on what SJSU has identified as eight dimensions of wellness: student success; health; wellness; health promotion; engagement; diversity, and community. The SHC acknowledges a student's tuition cost includes their services and as such, benefits from understanding the decisions students make when choosing or not choosing to engage with services offered.

The Questions That Guide

One aspect of my study was to learn the differences between how SJSU students, Latinx and non-Latinx, engaged and viewed the SHC and its services and to present those findings to SHC staff and associated partners. If an SJSU student is not engaging with the health services provided on campus, it does not mean she or he is not managing their health in any other way. What that any other way looks like was what this project intended to discover by examining the health-seeking behaviors in students at SJSU. Studies on where care is sought and where it is

received bring to light potential barriers to care that influence health-seeking behavior. Studies such as those by Kaiser Permanente and Veterans Affairs have highlighted an important issue: a portion of its patients who could potentially benefit from online medical services are directly not engaging with those tools. Not only do I ask why not, but I also ask what those patients are doing instead.

Shifting the lens onto what patients are doing versus what they are not doing benefits the institution by building an understanding of its clientele. These studies by Kaiser Permanente and the Department of Veteran Affairs do not reflect on themselves as institutions of potential problems for why some patients do not engage with tools offered, and instead, lay the issue on the shoulder of the patient. If Latinx populations make up a part of those demographics not engaging in online medical tools to manage their health, could they assume they are not doing anything at all? What my research project intended was to draw out student attitudes about the SHC to help inform efforts by the SHC to reach out to them.

I designed this study in collaboration with the SHC to examine the differences between students who used SHC services the school provided and the students who did not. To learn who students go to when addressing the issue of care and how students accessed those kinds of information that facilitate care, I asked: "what health-seeking behaviors look like among self-identified Latinx students at SJSU and how do they differ from their non-Latinx peers?" To learn what factors may be influencing the use of student health service, I simply asked: "what factors affect students' consumption of SJSU SHC services?"

Project Significance and Deliverable

Studies have attempted to look into one aspect of how patients engage with technologies said to augment their healthcare needs such as those by Haun and colleagues (2015), Lau and

colleagues (2013), and Hsu and colleagues (2005) where they highlight Hispanic and African-American as being the population less to engage with self-management tools. *Why* that is was left open to further research. Unlike the research participants who made up the studies just mentioned, student participants in my study were not chosen for having been diagnosed with hypertension or diabetes or any other medical condition. My research interests were in understanding the choices in healthcare services, both on and off-campus, available to SJSU students and to better understand how those same students practice care and engage in the maintenance of their health. For self-identified Latinx students at SJSU who do not engage with health services on campus the question of *why* must consider any number of possible answers. Understanding SJSU Latinx use of health services both from within SJSU and institutions outside of school is first learning what their healthcare-seeking behaviors look like. The same notion applies to their non-Latinx counterparts.

This report described an applied anthropology project designed to identify a range of health-seeking strategies amongst students at SJSU. My study was conducted with the university's newly built SHC in mind. Learning how students, both Latinx and non-Latinx, view healthcare and the SHC, is an insight that can inform the needs of future students. Although the SHC did not actively collaborate in my research they had a mutual interest in learning if a lack of utilization of its services were present among any group of SJSU students. My report to the SHC was in the form of an executive summary highlighting the question, if indeed a population of SJSU students is not utilizing SHC services, what factors might help explain this? Additional questions that guided my research included the differences between those students who used health services the school provides and students who did not; where students may have gone to when addressing the issue of care (e.g., non-SJSU facilities, family, friends, apps, websites); and

how students accessed the kind of information that facilitates healthcare. I also wanted to understand SHC stakeholders' efforts in the promotion and engagement of the services they offer with students and what perceived barriers to access may have existed. Even though my research was conducted with the SHC and SJSU as a final audience, many of the observations and findings in this project could be applied to similar educational institutions and the health services offered in the state of California and beyond.

In summary, I have investigated the health-seeking behaviors and self-care practices, as well as have attempted to learn about the healthcare service experiences of students at SJSU. In understanding what those practices, actions, and experiences have been like, I have better understood what students value. Time, quality of service and interpersonal interaction between patient and health professional, in/convenience of the school setting, and trust are some of the aspects of healthcare experience that students place value in not only as patients but as customers. My emphasis on presenting Latinx student narratives comes from a place of personal experience with seeking care from informal health practitioners as an alternative to a formal one. As such, I recognize my own bias, sympathy, and curiosity with the Latinx experience.

An analysis of related research and literature in the next chapter framed my approach to this study. The literature on care and self-care shows, self-health management is far more complicated than responsibility and culpability falling onto the patient/customer. Following the literature review, the methods section reviews the use of interviews for students to share their self-care practices and health-seeking experiences. Chapters four through six capture the analysis and interpretation of student narratives to highlight what they value and discuss what factors motivate/influence health-seeking among my sample population. The conclusion captures the

final reflections on my research, where I feel there is room for further research and describes my findings to be presented to the SHC.

Chapter Two: Literature Review and Theoretical Approaches

I shared with people a story anytime I presented my research to explain why care and care practices came to pique my curiosity. The abridged version is that my young mother, then new to the U.S. from Mexico, sought the care services of informal practitioners, known as *curanderos* and *hueseros,* after I dislocated an elbow as a result of falling off a tree as a child. In reflecting on that incident, I wondered if it was for financial reasons or reasons of access that my mother took these steps. Perhaps it was a matter of cultural belief and practice that my mother put faith in traditional healers and not medical doctors. Was it maybe that a young mother not knowing how to navigate a medical system in a new country relied instead on experience with a form of care more familiar? I recently learned that as a child, my mother dislocated a shoulder, and my grandmother, doing as my mother did for me, sought the services of a *huesero* to pop it back in place. In respect to my research, I asked who else with a similar cultural background and upbringing had experienced this type of informal care? Do they still engage in this type of care, and if so, why?

The *huesero* working out of his garage was more concerned with popping my elbow back into place than with my comfort. The result was an elbow in working condition for a twenty-dollar donation, and a child in tears clinging to his mother. My experience would have significantly differed had my mother took me to see a medical physician for my dislocated elbow. Perhaps I would have been given anesthesia with my arm wrapped in bandages afterward. If my mother's medical insurance covered the procedures, it would have been a little or no cost to her. In either case, my elbow would have been taken care of. My young mother sought to alleviate my discomfort and pain as quickly as possible by seeking the services of an informal

expert, not because she did not care for my comfort, but because *hueseros* were the type of care more familiar to her than formal medical experts.

The following analysis reviews literature that includes theoretical suggestions for investigating *care.* Based on descriptions of self-care practices, healthcare experiences, and health-related advice-seeking, questions arose about how students define, view, and experience care; questions arose about healthcare experiences to understand how positive or negative care encounters influence or determine health-seeking behaviors, and questions arose about the role social networks and support systems play in care practices. Participants' care-practices were characterized by family and friends, identity and culture, and defined further by larger, broader institutions and governmental policies. Annemarie Mol (2006) discusses the concept of care through her work and presents her insight into the *logic of choice*. In this notion, a free-market offers the passive-patient choice and freedom. She places that idea against a *logic of care* that turns the passive-patient into an active member of a medical team. That team performs care outside the doctor-patient encounter that includes a patient's entire social network.

Emily Yates-Doerr (2012) adds to the discussion of care with her work in Guatemala examining how patients discussed managing their weight day-to-day. She pays close attention to how nutritionists and patients talk about weight-management plans that appear to push against health narratives that place blame and responsibility onto a patient's shoulders. Susan Greenhalgh and Megan A. Carney (2014) discuss the notion of laying at the feet of minorities in the U.S. the responsibility of owning one's level of health. They argue that blaming the individual ignores structural barriers that keep populations unhealthy. They describe the idea of the *biocitizen*, someone who has achieved the idyllic thin and toned body that dominant health and wellness narratives have declared the image of a healthy body. For first-generation, and recently migrated

Latinx community members alike, becoming a good biocitizen is a new unreachable status. The students and community members with whom Greenhalgh and Carney (2014) work are believed to understand well already what a healthy lifestyle and body is supposed to be. However, the economic and social barriers in trying to achieve the ideal are not universally understood or experienced.

To present care as a means of production I referenced the work of Jan English-Lueck (2010) and Jan English-Lueck and Miriam Avery (2017), who suggest corporate care does not so much improve individual health and wellness as it maximizes worker output. Thinking about care in this manner allows us to regard care practice in the Silicon Valley tech world as one that is meant to enhance the body. Their work is both of the people who work, live, and play in Silicon Valley and of a region placed within a broader Bay Area. Silicon Valley has a reputation for toying with the alternative and the diverse to create a culture believed to be unique to the region. Their work encourages us to think about the concept of tinkering to enhance health and wellness as Silicon Valley innovators tinker with technologies.

My own work is a small-scale examination of how care is practiced and experienced by students at SJSU, many of whom are first-generation Americans attending university and many are the first in their families to do so. I situated each section of this literature review within the context of the cultural practice of care by SJSU students following the Obama administration and the passing of the Affordable Care Act. Lauren Webb and colleagues (2015) assess the transitional phase from pediatrician to adult care and note that college-age youth find themselves in a transient phase both in their professional and personal lives. As such, they are more likely to be uninsured in comparison to both older adults who have more access to health insurance through employers, and children who have more access to private health insurance through their

parents or state-funded programs (Webb et al, 2015). As of Fall 2018, post ACA, college-age students previously uninsured found themselves with augmented healthcare coverage. How they navigated systems of healthcare and consumed care services off-campus may have reflected how and if they sought similar services at the SHC.

How Latinx students sought health care in comparison to their non-Latinx counterparts was of interest to my study. I attempted to maintain the notion of culture with each of the following sections. In the final section, I provide a short overview of Latinx health in the U.S. as well as present the work of Courtney Andrews (2019), who discusses her work with Mexican-born women in Alabama. Cultural consonance, Andrews (2019) explains, is a better measurement of health outcomes versus the acculturation model commonly used to assess health in immigrant communities. As both a theoretical framework and a methodology, cultural consonance relies on the narratives of a community to learn how well they define and understand shared meanings. How well a community adheres to cultural expectations is a better indicator of favorable health outcomes than high acculturation alone. Andrews (2019) describes how high acculturation results in adverse health outcomes for immigrant individuals who do not meet the cultural expectations set by the community they identify with and are a part of.

Care Redefined

Care may appear as a universal concept and practice. However, upon a closer look, it is defined, thought of, and practiced differently. What follows are three ways of thinking about care. Each informs how I examined what student participants said about their care practices and their care experiences as (1) an on-going act that expands outwards from the doctor-patient bubble; (2) a means for production leading individuals to tinker, to augment, to enhance

themselves to remain competitive in a culture that values youth and innovation; and (3) a method of engaging with identity and culture through care practices and preferred remedies.

Annemarie Mol (2006) encourages us to think about care not as a one-time thing but as an ongoing process. The people she writes about live with diabetes and require long-term care. Much of the responsibility for their care falls on them in the form of managing food consumption and regularly monitoring their blood sugar levels. Mol (2006) describes the difficulties patients encounter with managing their disease in their day-to-day. No matter what a team of health experts (that include the patient) accomplishes on one day, they are not always mirrored the next. Through interviews with patients and doctors as well as through observations in consultation rooms, she learns of the types of day-to-day difficulties that come with managing a chronic disease. Mol describes situations where patients are not able to check blood sugar levels at certain times due to obstacles their work may present or inability to manage what they eat at a certain moment, such as being served some type of food at a family function. She discusses how patients describe to their doctors the failed attempts at managing their disease at home or work and notes their doctor's reactions. Mol (2006) describes lives with inconsistencies and contradictions that create difficulties in managing life with diabetes and overall health.

Care is not done simply. It is a far more complicated thing. Mol (2006) describes care as open-ended and without boundaries; care that is not a product to exchange hands, and not transactional, but instead based on reciprocal interactions with various hands working together. Patients are not passive but active participants who share the stage with multiple actors to engage in their care. The logic of choice is based on the notion that patients are forced into passivity and that as customers are given a medical market of choice that offers free-will through the power of consumerism. The argument Mol (2006, 28) makes against the logic of choice is that care is not a

product, an object that exchanges hands for the right price and consumed by the customer/patient.

For the people living with diabetes that Annemarie Mol (2006) writes about, care is not one that involves biking, hiking, running, working out, yoga, cooking, etc. Rather, care comes off as duller, and unattractive even mundane practice in everyday life. This could mean anything from wearing the proper pair of socks and the appropriate pair of shoes to go for a walk to deciding ahead of time if they will have a slice of cake at a niece's wedding (Mol 2006). It also means learning how to properly use blood sugar monitoring devices at home and at the workplace, as well as learning to inject insulin on their own. Marketing advertisements for blood sugar monitoring devices depicting presumed diabetics hiking in the mountains free from the constraints of their disease, Mol (2006) explains, seem to alert the patient that, ultimately, it is they who have the choice on what type of care they want to experience. For the patient living with diabetes wanting to become independent of a team of nurses who inject insulin and lab technicians who check blood sugar levels means doing it for themselves, periodically throughout their day. Additionally, Mol (2006) emphasizes the notion that as social creatures our days are rarely spent alone. She describes care as one that expands outside the consultation room to include a patient's entire social network and support. The logic of choice implies individual and autonomous decisions in how a person cares for themselves outside of the clinical setting. Mol (2006) explains that "there are collectives to which we belong that frame the care we receive, or the care that might be good for us." To understand what those collectives are like, who make up the whole, and how they may influence or determine types of care-seeking, involves learning about an individual's self and social care practices. Those practices are found and carried out

through the mundane, day-to-day living made up of social interaction, food consumption, and physical activity, dictated by factors such as access, and time.

As A Means for Productivity

With SJSU situated in the heart of Silicon Valley, students are primed to be the future of its labor force. The Silicon Valley worker is one that works long hours, is in constant pressure, and is heavily sought after by organizations. Jan English-Lueck and Miriam Lueck Avery (2017) combine two decades of ethnographic fieldwork in Silicon Valley companies to discuss corporate-care. In their work, they describe the Silicon Valley tech-worker as a knowledge-worker stretched thin among multiple teams engaged intensively with their projects. English-Lueck and Avery (2017) highlight the types of investments companies make in the health of their workers to maintain productivity and avoid the costly response to illness. They explore health policies in the U.S. that have not only led to issues of access but also to show how American companies have reacted to such plans. English-Lueck (2010) and Avery (2017) explain that corporate care in Silicon Valley does more than just provide free meals, massages, yoga and fitness classes, gym memberships, and other services, in offering on-site care companies maintain healthy workers, and most importantly sustain productivity. Corporate care is born from the need to keep the worker healthy in all aspects of their lives, from the free choice of food to on-site massage, and work-life counselors with the overarching goal of maintaining productive and competitive workspaces (English-Lueck and Avery 2017). What this means for the knowledge-worker in Silicon Valley is an array of services as perks built into the organizations that compete to recruit them. English-Lueck and Avery (2017, 43) note that as perks become extravagant, the knowledge-worker refines her taste and moves into a category of elite worker, that not only redeems those perks but may come to expect them. However, ultimately, those

rewards are meant to reinforce productivity as an individual's practice of care and wellness now become company business (English-Lueck and Avery 2017, 43).

The Silicon Valley tech worker is both health-conscious and work-oriented, willing to adopt a project mentality and applying it onto themselves to tinker with. With interviews and observations of inhabitants of Silicon Valley, Jan English-Lueck (2010) describes a region/culture built on rebellion, late capitalism, and health and wellness. Both of which, she argues, are closely tied to productivity. Being well or staying well is not enough to thrive "in a culture that celebrates youthful innovation," where "appearing aged or looking tired is a liability" (English-Lueck 2010, 114). The undertaking the Silicon Valley tech worker navigates is one built on the concept of being better than well, what English-Lueck (2010) describes as more akin to enhancement, and augmentation, than maintenance, and repair. Augmentation, in this context, is the cultural practice of enhancing oneself using technology, foods, pharmaceuticals, and body modifications for the goal of becoming more productive (English-Lueck 2010). Competitiveness thrives in Silicon Valley business and is believed to spur creation and innovation. The "burden of the individual worker," English-Lueck (2010, 94) explains, is "to stay healthy and productive" by adopting a discipline that "serves both the workers' self-interest and the interests of the broader economic system." Care, in this case, is more than healthy habits to maintain health and wellness, but body enhancement to be better than well, all of which not only supports a competitive edge but sustains productivity.

Self-care, as it is experienced in the U.S. is heavily influenced by work. More and more organizations are offering less and less in health insurance. As the cost of medical coverage moves further out of reach for many Americans, self-care practices move to the forefront. English-Lueck (2010) explains that as Silicon Valley knowledge-workers gain more

responsibility for managing their projects, their responsibility for managing their productivity also increases. However, to be productive means to be healthy. English-Lueck (2010) describes Silicon Valley knowledge workers as adopting self-management plans that keep them competitive within their teams, within their companies, and within their fields. As part of that self-management is emotion work, what English-Lueck (2010, 125) describes is the disciplining of the body and the mind, as well as behavior to parallel emotions with expected social settings. Steve Ferzacca (2000, 30) suggests that encounters between health experts and patients shape an "ideal, normative, clinical self" steeped in “American middle-class values that link self-discipline and productivity” as a combination essential to good health. SJSU students are schoolmates until they graduate and join the workforce. Multitasking, in the case for most student participants in-between work and school make it difficult to focus on the body. How exactly does one without leisure or free time engage in self-care and well-being? Achieving the ideal of a healthy body that typically accompanies care and wellness narratives is challenging for many reasons. Those reasons go beyond will power and self-discipline. Mol (2006) notes that contemporary health and wellness narratives place responsibility on individuals to choose healthy lifestyles, to make behavioral changes that strengthen, and maintain both physical and mental well-being.

Notions of what constitutes care and wellness are unequally achievable. It is not only that they are misunderstood due to language or cultural barriers. Greenhalgh and Carney (2014) show that concepts of what is considered healthy are not always lost on individuals. There is far more at play that determines how and if we engage with contemporary care and wellness narratives that blame poor health outcomes on individual failure. For those who have the means, contemporary care and wellness—*eat well, sleep well, and exercise*—translates into time and leisure that are inaccessible to many. To address health disparities is to look at broad social and

cultural forces that influence both positive and negative health outcomes. That is why health narratives that target individual behavior to choose a healthy lifestyle are often ineffective (Mol 2006). How a person talks about living with an illness may expose barriers to access and other social stressors one may experience. Listening to how a person narrates their experiences is key to understanding factors influencing health care choices. (Mol 2006. 78-81)

Latinx Health in The U.S.

Tapping into the stream of Latinx student narratives at SJSU on health management and health-seeking behavior, presented an opportunity to understand better the health care needs of a population of students on campus, who on the national level, continue to grow as a minority group. The literature on Latinx health in the U.S. dives into the immigrant experience in the U.S. and revolves around the issue of health disparity. In these studies, acculturation is not only the metric used to measure how well a person assimilates into a new culture; it is how Latinx health is measured. The "Latino Health Paradox" is the idea that recently migrated people into the U.S. experience better health conditions than do their children as first-generation Americans. This is based on the concept of acculturation: the more an individual assimilates into the broader culture, the more they adapt cultural traits that may lead to worsening health (Acevedo-Garcia and Bates 2008. However, there are studies that encourage us to look past a Latinx health paradox that seems to tie the issue of health disparities only to adopting the host culture. We are encouraged to begin thinking of different ways of approaching Latinx health. Greenhalgh and Carney (2014) offer one way to address the dominant narrative in health care that lays responsibility at the feet of minorities.

Public health narratives allocate dietary health as the responsibility of the individual, where descriptions on lifestyle and nutritional awareness dictate the process by which programs

address dietary-related chronic illnesses. To achieve an ideal weight, it is calculated through their Body Mass Index (BMI), a metric used by physicians to evaluate healthy ranges of body mass. A person now has a number that becomes a goal. Achieving ideal BMI numbers, however, is not always easy to do. Yates-Doerr (2012, 138) criticizes the use of an individual's BMI to measure success and suggests that BMI turns people into a set of standards and deviations, bodies easily calculated and controlled. We are reminded that individuals bring more than just themselves to the consultation room. Care is one that encompasses the patient and all that surrounds them, "friendships, networks of support, expression of compassion and empathy...the nutritionist, the family, and the broader community" (Yates-Doerr 2012, 152). The clinical exchanges Yates-Doerr (2012, 137) studied encouraged a framework that examines medical practices engaging in compassion, concern and relationality within constraints of hierarchy and control. Yates-Doerr (2012, 146) observed nutritionists exchanging the pronoun "we" for "you" in her research on weight-loss programs in Guatemala. The practice was meant to encourage changes in a patient's diets. While a small gesture, Yates-Doerr explains, both the nutritionist and the patient experienced the journey of weight loss, its successes, and its failures, together.

Echoing Annemarie Mol (2006) and Yates-Doerr (2012), Greenhalgh and Carney (2014) argue that putting the problem of obesity onto the shoulders of individuals disregards broader social structures and barriers to healthcare access. They highlight a need to change the dominant public health narrative to one that better understands and addresses forces that drive high obesity rates. Their work suggests that Latinx populations already own their obesity, explaining further that among Latinx communities, there exists a general understanding of what constitutes a healthy lifestyle (Greenhalgh and Carney 2014). They also note that Latinx communities make clear their attempts to integrate healthy practice into their lives and already accept failures to be

their failures. The war on obesity creates what they call a biocitizen. They define a biocitizen as one who devotes significant time to dieting and exercising to maintain a medically normal weight and takes responsibility that others in their social environment also become good biocitizens. Being a good biocitizen means being a part of a community of good Americans "who eat a certain way, move a certain way, and maintain a certain weight" (Greenhalgh and Carney 2014, 6). The notion of a biocitizen is an altered or extreme version of assimilation and acculturation. It is not enough that many Latinx community members already face barriers in gaining citizenship and accessing healthcare, without putting that new status to the test. Additionally, the notion that is assimilating into the host culture somehow translates into better health outcomes, Greenhalgh and Carney (2014) suggest, is also inaccurate.

Acculturation is not a means to a healthy immigrant population. Instead, it is cultural consonance, which is what Courtney Andrews (2019) suggests from work with Mexican-born women in Alabama. Andrews (2019) describes cultural consonance as a theoretical framework and method of inquiry that measures the extent that individuals adhere to, and understand, "agreed-upon cultural standards" (169). For the women in Andrew's (2019) study navigating life in the U.S. as migrant women means trying to reach a goal, what they call *la buena vida*.

To achieve *la buena vida* (the good life) means an emphasis on access to essential household goods or a personal focus on being/doing good. It also means developing a focus on long-term family goals. Understanding and adhering to those shared ideas for how life should be lived, for the women in Andrews (2019) study meant they could see themselves and be seen by others as being successful in life. Andrews (2019) describes meeting those cultural expectations as achieving high cultural consonance. Low cultural consonance meant a failure to live up to those shared ideas (cultural expectations) and lead to a feeling that life had not worked out.

Those feelings, in turn, led to stress and poor health. What Andrews (2019) shows, is that immigrant communities who have high acculturation (how well they have assimilated into the host culture), but low cultural consonance (meeting the cultural expectations), are at risk of developing poor health. The opposite goes for individuals who have low acculturation but high cultural consonance, what the Latinx Health Paradox seems to base its suggestions from: the more an individual is closely tied to their cultural origin, the less they have adopted, for instance, a diet higher in processed foods. How an individual's life aligns or does not align with the group's cultural expectations, have a real effect on the body. For the women in Andrews (2019) study, living away from their home origin places them in an in-between state. They are strangers in a foreign land where access to health care does not come easily. Strength and resilience, however, comes in knowing their children are afforded opportunities they themselves were not as children.

Self and Selfhood

According to some research, there exists a misalignment between healthcare narratives and healthcare practice, breeding a viewpoint of us (patient) versus them (health professional). However, where the misalignment exists may not always be apparent to either a patient or health expert. Rebecca Seligman and colleagues (2014, 63) describe a system of ideas and values from people who live with a disease that seems to clash with those of health care service providers. That system is informed by how people talk about living with an illness. Their work with low-income Mexican-origin participants living with diabetes was an investigation of cultural influences on experience, beliefs, and practices. Seligman and colleagues (2014) discuss the cultivation of a self that does not always parallel health practices based on a set of values within the medical world. Through describing life with diabetes, study participants expressed a form of self-hood that counters medical discourse and resists implications that blame the individual

directly for their disease—a selfhood set on self-care practices that push back on individual responsibility, and self-discipline. The diabetes self-care behavior they describe is one that includes caring for the social and emotional aspects of health within the constraints of daily life (Seligman et al. 2014, 71). It is in successfully managing regular constraints, rather than meeting the requirements of medical recommendations for good health, that Seligman and colleagues (2014) understand the effects of diabetes on self-hood. Like Andrews (2019), Seligman and colleagues describe patients who understand diabetes management as closely linked to family, social, and emotional experience. That action cultivates selfhood that points outward to include a patient's relationships and interactions with the social world (Seligman et al. 2014,73). These authors share the same thinking that care does not happen in isolation and argue against the dominant narratives that still seem to put responsibility only on the individual.

Steve Ferzacca (2000) discusses the notion of selfhood born from the repetition of doctor-patient encounters. In his study of veterans living with diabetes, Ferzacca (2000) describes the medical practice of cultivating the self as one carried out through the process of repeated medical center visits. Repeatedly engaging with health experts, Ferzacca (2000) notes, for these veterans, the constant reminder of living with a disease left little room to see themselves as more than just patients. Dominant in medical practice are Western themes of individualism, self-discipline, achievement, and success, and a strong work ethic (Ferzacca 2000, 34). These themes echo what English-Lueck (2010) notes about being healthy means being productive and useful.

Ferzacca (2000) worked with retired veterans in their sixties. There was a clash in engaging in social values that as Americans they shared but felt that in retirement had gained some leeway. Rendered bodies that are measured and read, the men in Ferzacca's study understood their medical charts, and their daily lived experiences offered different stories; one

stated medical facts and the other regular life constraints. Ferzacca (2000) describes the use of both strategies used to help lower glucose levels before a doctor's appointment and the ready-made explanations for why they were not. Under constant medical gaze at the clinic and home cultivated a self-built on their disease and not necessarily them as individuals. The care practices the men employed, Ferzacca (2000) explains, were hybrid health-management plans, created and tailored by each patient. These self-management approaches were in response to medical suggestions whose design did not include each of the men's own day-to-day realities or what the men felt were unique diabetic conditions (Ferzacca 2000, 39).

Conclusion

Care is on-going; it is not practiced alone; care is connected to health, while health connected to productivity; health outcomes are linked to culture, and collective views on what success looks like; care is related to ritual and the production of the self, and self-care practices and health-management approaches are not universal. That care is and is not all these things gave me space to interpret student narratives on care. The literature on care also helped confront any assumptions I may have brought to the research as a self-identified Mexican American student at SJSU. Although students in my study were not asked about living with a disease, they were asked about practicing care with others and asked to describe what that care looks like. It was not enough to hear about students' care practices if through their care narratives, I could not learn how they viewed, defined, and experienced care. In learning about student care practices, I thought about public health narratives around the topic of care that pin *health* and *wellness* only on the individual, and not broader social ills that produce unhealthy people. The next three chapters include student narratives on self-care practices, care experiences and care with others. Student descriptions touch on notions of customer vs. patient; on opinions of personal

responsibility for one's weight management as it is connected to food and exercise; on ideas of what they value; on notions of tinkering for better mental health; on thoughts of reacting to illness versus prevention; and the cloud that continuously looms over all of them, time.

Chapter Three: Methodology

In order to collect data to answer the questions guiding my research on student's views on care, their self-care practices, and health-seeking behaviors, I organized the study in three phases: (a) student participant recruitment and screening; (b) semi-structured interviews with student participants; and (c) qualitative analysis. Each stage was designed to recruit participants and collect and analyze data on student healthcare-seeking behavior across several theoretically interesting subgroups. In what follows, I describe and explain the reasoning behind each of these sampling, recruitment, data collection, and analysis techniques I have mentioned. I begin by introducing the research team, Dr. A.J. Faas's Fall 2018 *Ethnographic Methods* class, and the role they played in data collection. Then, I identify my research site and participant population. Next, I explain the quota sampling strategy that includes the use of a screener questionnaire. That is followed by my recruitment efforts where I describe how I contacted various schools within SJSU for permission to reach out to professors within those departments. After, I discuss my semi-structured interview methodology as well as the process of sorting, rating, synthesizing, and reporting data gathered by student researchers. The last portion is a discussion about my analysis method as well as what will be my final report and deliverable to the SHC.

Research Site and Population

I chose San Jose State University as my research site as it was much more than just accessible. As a student at SJSU, I received email communications from the university, which combined with early exploratory research, I learned of the university's Healthy Campus 2020 pledge and its roll-out of the Treat Yourself Well initiative. With a peaked interest, I became attuned to SJSUs efforts to encourage health and wellness practices on campus. The school had a newly built Student Health Center catering to students' health needs, both physical and mental, which also served as a space for students to study, meet, or hang out.

SJSU conducts headcounts of students enrolled at the beginning of Fall semesters for seven ethnic categories. In 2018, SJSU had a headcount of 9,185 enrolled students categorized as Hispanic, making up twenty-eight percent of the total student body. When compared to thirty percent of students who were a mix of five ethnic categories, that is a substantial number. The largest ethnic group enrolled in the Fall of 2018 was Asian, with 13,791 or forty-two percent of the total student body. However, these are numbers based on different ethnic origins grouped and categorized as one larger group (e.g., Asian, Hispanic, White, Other). Student organizations on campus were abundant, which included several Latinx organizations. Adding to a mix of ethnic identity at SJSU was the fact that so many students commuted to school daily, where a range in age and financial independence could exist. SJSU was an ideal site to investigate not only student self-care practices but also SHC service consumption.

Student Researchers

I refer to my study as my own in that I describe each step of my research methodology as something I designed and solely took on, but I was hardly alone. The sections that follow show the role that academic advisors, faculty and department chairs, along with directors, student researchers, and most importantly, student participants, played in what is this final report. The interpretations of student narrative on care and self-care practices within the context of health and wellness are mine. How those narratives were collected and organized were a team effort. Before the start of Fall 2018, my academic advisor, Dr. Faas approached me with a proposition: to dedicate a team of students, both undergraduate and graduate, to the recruitment of participants and the collection of interviews. Having taken part as a student researcher myself as an undergraduate, I understood the benefits that come with real hands-on research experience. I

felt honored, but mostly, relieved that I would have a team of students assisting me in the daunting task of carrying out a research project with a large sample size.

The student researchers from Dr. Faas's *Ethnographic Methods* course were a mix of undergraduate and graduate students in various majors, though mostly anthropology majors. Before recruiting and interviewing student participants, they received advanced training in ethnographic research methods, analysis, ethical conduct of research with human subjects, and took part in a series of focused workshops on the study, data collection instruments, and analytical procedures. All student work took place under the supervision of Dr. Faas. The nearly forty students in the course were each required to identify, screen, and recruit two study participants for semi-structured interviews. Additionally, each student was required to conduct two participant observations of events and spaces throughout the SJSU campus as they related to health and wellness. Some students chose to attend a variety of workshops offered by both the SHC and Student Wellness Center (SWC) while others observed students on campus interact with a specific space. Student researchers wrote about their observations with some supplementing their descriptions with photography. The beginning of the semester was dedicated to familiarizing student researchers with the interview questions, designed before the start of Fall 2018), which they assisted in tweaking the wording for clarification. Their input was instrumental in solidifying interview questions and how the instrument would be used. In preparation for interviewing student participants, the team of student researchers first practiced on each other. To check on their progress and to answer questions brought on through their fieldwork, I sat in with the class of thirty-five or so students on several occasions throughout the Fall 2018 semester.

Sample

To understand variations on how students viewed and practiced care between two main subpopulations (i.e., Latinx and non-Latinx students) I had to identify and categorize possible independent variables that could influence behavior. Students, however, are complex in makeup and it was not enough to only split them into two categories. I had to consider variations such as age and financial independence. Would a full-time sophomore living on campus, financially dependent on a parent or guardian, practice care differently than a part-time junior living off-campus economically independent of a parent or guardian? I had to consider what differences existed between first-generation and non-first-generation college students. I asked if trust in institutions would be an issue, if so, who would tend to be more or less trustworthy? I had to consider students who had used SHC services and students who had not-used SHC services to learn of possible factors determining consumption. I had to think through healthcare experiences and ask how a positive or negative experience with SHC services factor in a student seeking care on campus? What factors played a role in a first-generation Latinx student seeking care off-campus, and how do those same factors, if at all, affect a non-Latinx first-generation student seeking care on-campus? With so many variations to be mindful of with these two categories, I would not be able to attend to all of them. I had to focus on what was feasible for my study, as such I narrowed the categorical makeup of SJSU college students to:

- Latinx/non-Latinx
- Upper-level/Lower-level Classmen
- First-generation/Non-first-generation college student
- Feminine/Masculine/Non-Gender Binary
- Have/Have Not Used SHC services in the past twelve months.

As of the start of the 2018 Fall semester, I had identified the sample target. To find and track the sample target required a matrix to capture student participants in a quota sample made

up of relevant demographics. A quota sample matrix meant filling in categorical boxes or *quotas* with students who met my criteria by collecting information at the moment I met them for interviewing. For student researchers, it meant collecting information first to see what categorical box a student participant fit into before following up with an interview. Quota sampling, although similar to stratified sampling, is non-probabilistic sampling, where I chose a sample I felt "really represents the range of variables" for the selected population (Bernard 1994:95). Bernard (1994, 94) suggests that despite the disadvantage of non-probability sampling (generalizing beyond a sample), quota sampling, when backed up with ethnographic data, is often considered a highly credible technique, and as such employed here. Designing a quota sample matrix allowed me to visually see my study sample in quantity as well as visually track recruitment efforts. I could visually see what quotas had not been filled within the matrix which later determined where a more focused or narrowed recruitment effort was needed to fill in those quotas.

Participant Selection (Screener Questionnaire)

I designed a screener questionnaire using Google Forms to select students who met the criteria for selected categories in my study (See Figure 1. Electronic Screener Questionnaire in Appendix A). It became the first step a student would take in participating in the study and the first part of each of the interviews the research team conducted. The instrument consisted of twelve questions/prompts that identify key demographic and categorical information on each student participant. The information collected with each questionnaire was as follows: the date it was filled out (not necessarily the day an interview was conducted); their school year as of Fall 2018; age; a question on either parent completing a college degree; units enrolled in Fall 2018;

housing as of Fall 2018; a question on living with a parent or guardian; employment as of Fall 2018; race/ethnicity; gender identity; and SHC use within the last twelve months.

Student researchers administered hard copies of the screener questionnaire, where they later manually input a participant's demographic information based on their answers onto an Excel spreadsheet (See Table 1: Interview Quota Matrix in Appendix B). I administered an electronic version of the screener questionnaire at the time of the interview using a tablet. Each student participant tapped the screen with their fingers to answer “yes” or “no” questions or choose an answer for multiple-choice questions. Each student participant typed directly onto the screen for self-identification questions. The electronic Google Form automatically collected each respondent's information and generated an Excel spreadsheet (See Table 2: Sample of Participant Screener Data in Appendix C).

We set out to interview a minimum of five interviews for each cohort in our quota matrix in order to: (1) increase our likelihood of achieving "saturation," or the point at which we stop receiving new information (Guest et al. 2006); and (2) enable descriptive and basic categorical analysis that would be indicative, if not wholly representative, of variation in my study variables. Once one quota sample category was complete, we no longer accepted participants who met that sample category. Due to the class having almost forty enrolled students actively identifying and recruiting students, some cells filled up quickly.

I eventually removed the non-gender binary from the quota sample matrix at the end of the 2018 Fall semester as no participants included themselves in that category. Doing so eliminated eighty possible student participants bringing the quota sample matrix down from an initial 240 to a total of 160. Student researchers continued their recruitment process until seventy-two of the quota sample categories were filled by the end of Fall 2018. During that time,

I worked independently attempting to recruit on my own students not only willing to participate, but who self-identified as Latinx. My recruitment efforts carried over into the Spring semester of 2019 where I conducted more interviews with students. By the end of the interview portion of my study I added eight interviews to the quota matrix for a final count of eighty interviews.

Recruitment

In order to enlist participants, I explored a variety of tactics. I started by emailing department chairs for permission to contact faculty in their departments. Before the start of the 2018 Fall semester, the Interim Administrative Director for the SHC assisted in drafting a letter introducing myself, my research project, and my interests. It was administered to various departments across campus via email. Dr. English-Lueck, a member of my M.A. committee, also sent emails to departments within the School of Social Sciences to either pass along to faculty within those departments or for permission for me to directly contact professors. In some cases, I received emails from department chairs allowing me to contact professors directly and in others from faculty themselves. Those emails lead to me to speak in front of a dozen classes in various departments to several students. On a couple of occasions, the class sizes were so large I used a microphone to ensure all students could hear my message. It went on like this for the first three or four weeks of Fall 2018, speaking in front of roughly five to six hundred students.

I posted fliers across the SJSU campus with a contact email attached for students interested in participating in the research project. The leaflet I designed would take on two different looks. The first, I created during the summer months in preparation for the 2018 Fall semester and was the first flier to circulate the SJSU campus. A fellow schoolmate and colleague designed the second flier (See Figure 2. Recruitment Flier in Appendix D). The second design remained as a recruitment flier and posted on message boards outside various departments across

the SJSU campus as well as inside student resource centers inside the SU inviting students to participate. Using SJSU's mobile social networking and SJSU resource app, SAMMY, I periodically posted a digital copy of my recruitment flier with a statement introducing myself and my research interests. In my student participant recruitment efforts, I reached out to those in my social network where word-of-mouth recommendations began to come in. I reached out to SJSU's college radio station KSJSU to help create an on-air promotion. But after a short email exchange with radio directors and DJs, our communication ended abruptly. Lastly, I turned to Lily Piñedo Gangai and the CLSSC where I was able to post a digital copy of my recruitment flier on their weekly newsletter *OJO*. Lily would become instrumental in putting me into contact with students interested in participating as well as providing the *centro* as a resource and space for interviewing and down the road a focus group.

Semi-Structured Interviews

Students who met the study criteria were asked to sit for a semi-structured interview that took approximately one hour to minimize fatigue for both myself, inexperienced student researchers, and the respondent (Adams 2010). Semi-structured interviews were well suited for the task of open-ended follow-up questions with SJSU students as research participants who may not be as candid about the topic of health if sitting with fellow students in a focus group (Adams 2010). Another benefit of the semi-structured interview for this research project relied on the fact that the focus of the study fell on what Adams (2010) referred to as, “program recipients,” in this case, SJSU students who may also be consumers of SHC services or in an applied example, clients. Brinkmann (2013, 47) argues that qualitative interviewing best lends itself most naturally "to the study of individual lived experience."

The semi-structured interview consisted of a series of questions about the types of healthcare issues they have experienced in the past twelve months. We asked participants about healthcare services they were aware existed, whether they had access to them, and alternative healthcare methods they have considered. The interview instrument was split into four domains of inquiry with a series of questions related to each section. I wanted to understand from students their self-care practices, health care service experiences, experience with and knowledge of the SHC, and lastly, social support around care. Each section would help answer the questions of *what health-seeking behaviors look like among self-identified Latinx students at SJSU and how they differ from their non-Latinx peers,* and *what factors affect Latinx students' consumption of SJSU SHC services*. Data collected from these interviews presented different healthcare-seeking behaviors among a sample of SJSU students that could inform both SHC staff as well as other public health providers. To avoid recording identifying information in connection with data collected a standard consent notice was obtained before administration of the semi-structured interview. During the initial phase in which a student participant and myself selected a time to meet on campus, an electronic version of the consent form was attached to an email correspondence just before meeting in person. For interviewees with whom I did not correspond with via email before our meeting, a hard copy was given to them in-person at the time of the interview.

Data Analysis

The coding and analysis process mirrored the systematic process that LeCompte and Schensul (2010) outlined when discussing "chunking data." I read through interviews and coded the text while "looking for linkages, similarities, and differences" of themes as they relate to possible answers to the research questions that guided the study (LeCompte and Schensul 2010,

199). An example of this could be visits to the SHC for any one issue mentioned repeatedly among participants. Another example of a topic that could be repeated may surround the issue of healthcare insurance. This process of identifying themes through data "reduction, summary, and interpretation" assisted in developing composite descriptions of healthcare-seeking behavior profiles that spoke directly to questions guiding the study (Ladner 2014, 14). Because this study was meant to understand health-seeking behaviors and discover self-care practices, data-driven coding, as Brinkmann (2013) explains, best suited the analysis process. Noting patterns that presented themselves in student narratives helped illuminate values, practices, and possible constraints that influenced students' healthcare-seeking behavior. Significant statements were selected and moved to a table where they would be condensed into codes and descriptions and categorized by developing themes (See Table 3. Themes in Appendix E)

The codebook took on two different iterations with the previous example the final version. This was due to an opportunity to present my research project and initial findings at an event put on by the Anthropology department in the Spring of 2019. I chose twenty transcribed interviews across four categories that included both male and female, Latinx and non-Latinx, upper-division classmen, who were 1st and non-1st generation students who had and had not used SHC services. Carrying out this initial analysis of transcribed interviews helped solidify codes that I later used to attempt reaching “saturation” or as Guest and colleagues (2006, 65) explain, "the point in data collection and analysis when new information produces little or no change to the codebook."

Student Researchers’ Interviews: Reading, Sorting, Rating, Analysis

The seventy-two interviews conducted by student researchers were a glimpse into their very own social networks. Student participants that made up their collection of gathered data

were classmates, roommates, friends, and friends-of-friends with whom their level of interpersonal relationships varied. It was also a glimpse into the extent that student researchers went into when conducting their interviews. Each transcription was more than just an interview. It was a conversation. Each voice in each transcription had something to say about a student's knowledge of health services on campus as well as their self-care practices and healthcare experiences. Chalking it up to inexperience with the interview process, both student researchers, myself included, at times could not help but add to the conversation and interject our thoughts and opinions on both the study and the topic. However, moments do exist when adding personal experience to an interview may elicit further thought from an interviewee.

Due to the volume of data I had in the form of transcribed interviews, I had to decide which interviews would make the final analysis. To do that I needed to read each interview from beginning to end. When reading transcribed interviews, I looked for patterns that stood out, that had something to say about a student's health-seeking habits and their views on what constitutes care. I also had to think about the transcripts that said very little about my topic of interest. What were these students saying by saying very little? Even though some student participants asked for clarification to questions they did not understand, I wondered if perhaps the interview guide was unclear and questions somewhat hard to follow. I asked if access had anything to do with rather short responses to interviewer questions, specifically questioning if having grown up with access to medical attention there was little to say about a given in their lives? To sort interviews, I had to rate each interview as I read them. I developed a rating system (See Table 4. Interview Quality Sorting in Appendix F) to determine if an interview held substantial weight. Transcribed interviews with several pages of a student's narrative tended to qualify better than their lighter counterparts. Thirty-one interviews made the final cut based on a scorecard that rated the

substance of a participant's narrative. With the amount of data I had at hand, I had to narrow a focus and reading and sorting for quality helped with that.

Conclusion

Each of the methodologies I described allowed me to learn a bit about SJSU students' overall experiences and not just their health-seeking behaviors or self-care practices. Dedicating an entire class of students to the collection and analysis of data was invaluable. I had at my disposal a team of researchers who gathered more data than I could left to my own devices. Each transcription was a conversation about care practices and health care experiences, and although not every conversation directly answered my research questions, they perhaps spoke to other underlying concepts. Concepts of access, customer service/value, concepts on "working the system" for personal gain and the everyday "busyness" of college life that need further exploration (English-Lueck 2007). Because these experiences could only have been brought to light through the means of in-depth interviewing, semi-structured interviewing as a methodology only made sense. For this study, I focused on what the concept of *care* meant to students at SJSU and how those meanings and definitions varied among categories. To understand how SJSU views and promotes the broad concept of wellness, I explored efforts by the SHC and the Wellness Center (WC) to meet the goals set by the Healthy Campus 2020 (HC2020) initiative. Were its efforts with promotions to encourage engagement with its resources a success?

Chapter Four: What Self-Care Looks Like

Although students share being mindful of all things mentioned, implementing them on a day-to-day basis became the challenge. Self-care is a challenge for some students. What determines what they do versus what they say they do is in the small things of everyday life as a student at SJSU. Factors that determined approaches to care emerged as student participants shared their day-to-day activities as students, as workers, as members of student groups and in families. It is in our day-to-day health care practice that Mol (2006) explains we base our definition of care. To understand what day-to-day care looks like among students, I asked about general and broad self-care practices they engage in. The question prompting answers about diet and exercise is geared towards understanding wide-ranging self-care practices: Can you tell me how you practice care for yourself or about the different types of care you practice? Although care-practices such as exercise were said by students to maintain the body healthy, their practice seemed geared more towards mental well-being than physical. Students did share sleeping better at night if they had done something physical during the day. However, students seemed to emphasize the benefits that exercise had on their mental state. They cite needs for physical activity to combat stress or relieve anxiety related to school, work, and social pressures. Thus, we can think of student participants' self-care practices as practices in mindfulness, both reactions to and prevention of stress associated with busy lives where time is always a factor.

Physical Activity/Exercise

> "...because it's not just, like, physically, it's, like, spiritually and mentally...it helps me relieve stress...I feel like it's a coping mechanism with stress...and then, it's like you forget about it."

Twenty-year-old Leonora is a dancer. A self-identified Hispanic/Latinx - African-American female, and first-generation college student. For her, dancing is more than just a way

to get exercise, she explained, it is a practice in self-care. Dancing is a tension reliever for Leonora, a way to cope with stress. She described her dance routines as allowing her to forget momentarily any pressure she feels she is under. Leonora expressed dancing as a spiritual practice. Aulino (2019), from her work with caregivers in Thailand, described the method of caring for others as ritual; as something the body learns to carry out through discipline and repetition, a practice determined by "[performing] the mundane activities of maintaining other bodies." The tradition of caring for others, Aulino (2019, 35) explained, is "performance of tasks in full again and again, with perfunctory rhythm and automation in the repetition." Aulino (2019) noted that those acts are understood as "the routine action of ritual." Even a person who claims to have no rhythm can learn to waltz. By moving the body repeatedly through the motions of the dance to the appropriate music (practice), the able-bodied person can waltz. Leonora has danced since she was three years old. To her, dance is not the same as working-out; she explained that she needs to do more in terms of working out. Dance appears to be more to Leonora than just exercise. It may well be the ritual of practicing care for herself. For students who do not already practice some form of activity as is dancing, other types of physical exercise will do. However, no matter the action a student describes, they appear to consistently be reactions to rather than the prevention of stress and mental fatigue.

> "...Running just really helps me; it just really takes a weight off of me. So, it's usually when I have [a] test, after test coming up, or I'm just really, really stressed, or there's a big performance coming up...That's when I'll go for a run...But it's the time constraint; there's just not enough time in the day...So, usually, it's when I feel like I need to, as opposed to when I want to."

Francesca is a first-generation college student and self-identified Latina. In her interview, Francesca explained that as part of the long-distance team in high school, running was part of a daily routine. Now, as a college student running is relegated to times when she feels stressed or

overwhelmed by school, work, and activities on campus. As a member of a dance group, she sneaks in two hours of physical exercise three times a week. Although Francesca described her self-care practice as one that focuses on her physical well-being rather than her mental well-being, she described a need to run to destress. If Francesca was able to, she would run when wanting to and not when needing to. Francesca, too, is a dancer and is part of a dance troop at SJSU. She did not describe dance as Leonora does, as a ritualistic practice in mindfulness. Instead, being active in her dance group means practice, means managing the dance ensemble, and means added stress. For her, running is the physical act of destressing.

Since the focus of this study was the health-seeking behaviors of students and not the daily life of students, my questions built around self-care practices. Those practices come in different forms, from running to dancing to reading, to writing, to cannabis use. Nonetheless, the students I spoke with described lives that appeared to leave little room for play. Many students do not speak of managing any illness in their lives. However, they do illustrate the multiple hurdles they go through in their day-to-day to maintain healthy bodies and maintain healthy minds. Time appears to dictate all they do. Daily, students juggle schoolwork, jobs, and their social lives. To describe their self-care practices is to explain what their day-to-day looks like. Self-care is a practice not always built into their schedules. Instead, it is integrated into their lives in various forms. For students who describe their self-care practices in the form of exercise, the implementation of that physical activity is not always easy. If time allows for it, great. If not, maybe tomorrow. For students who do find the time, however, exercise is not just for the body but the mind. It was not enough to describe what they felt were benefits from eating well and exercising on the body but what effects they had on their mental well-being. Even so, practicing care for the sake of being healthy did not always seem to be a student's focus or goal.

Self-care was more of a reaction to illness than a preventative practice. Leonora described her immune system as being used to her busy schedule. She spoke of it as knowing when to hold off getting sick that when she finally did "break down," it would be severe. Emilio spoke similarly about time as a marker for when his immune system would break down. Carrying around Emergen-C packets and Dayquil tablets, midterms seemed to be a time in the semester where stress put a strain on the body, and Emilio would become ill. He described a time where he booked a study room in the library. He would break-up his reading every thirty-minutes to do some form of calisthenics. The pressure to prepare for midterms was enough for Emilio to press forward with studying regardless of how his body was feeling, understanding clearly what his responsibilities and duties are as a student and as an employee. As an older brother, Emilio takes on immense pressure to ensure he meets what is required of him for each of the roles he takes on. The notion of taking time for himself is something Emilio did not discuss. At twenty-years-old at the time of his interview, Emilio is a first-generation college student. A self-identified Mexican, Mexican-American, and Latinx "man," he described his life as one where both time and self-care are limited.

As of Fall of 2018, life as a San Jose State University student does not appear to be the care-free experience Hollywood has associated with college life. Perhaps the busy lives that participants describe are more of a common theme amongst students at public universities. Maybe the student narratives I chose to examine are more common in upper-classmen than they would be for the first year or second-year students. The themes I presented may be unique to first-generation college students. However, Francesca, Emilio, and Leonora's non-Latinx and non-first generation peers did not allow me to make such a claim. Holly, Tiffany, and Sanai

spoke similarly about engaging in exercise to benefit mental wellbeing. They also described responsibilities extending past the university's walls and managing life with little time.

Holly is a twenty-one-year-old senior as of Fall 2018. She self-identifies as white and is a non-first generation college student. For her, self-care is walking to and from SJSU, getting her nails and hair done, and maintaining busy through employment. She described walking as a time to take everything in and as something she has control over where her mental mood determines the intensity of her walk. Holly described beautifying herself as bringing on the feeling of being pretty. Employed since the age of sixteen, Holly describes working as affording her a sense of self-worth. Staying busy is important to her, and only when she reaches what she feels is her "max stress level" will she address what she feels. Twenty-two-year-old senior and non-1st generation college student, Tiffany, self identifies as Latino/White. Self-care for her is an act in mindfulness. Journaling her thoughts, she vents her feelings through paper and pen. She explained it is essential for one to take time for oneself in what she described as "a crazy world." Time dictates how often she has an outlet: a way to decompress, to let things out, to clear her head. Twenty-two-year-old Sanai described journaling to address when she feels stressed. A senior at the time of her interview, Sanai self-identifies as Indian. Although the non-1st generation college student mentioned keeping herself moving as a way of practicing care for herself, she spoke more about being mindful of stress, addressing it through meditation. It is through the combination of eating well, staying active, and getting enough sleep that Sanai practices care for herself.

Dylan is a twenty-three-year-old junior who described his form of care as one that focuses on his mental health. "Self-affirmation" he explained is a way for him not to give in to stress, anxiety, and depression, all stemming from a semester of school. Although he goes

through periods where he does little to no exercise, on average, two to three times a week, Dylan engages in some form of it. For Dylan, physical activity and exercise allow him to feel clear-headed. He explained that during a day at school, his mind is clouded and exercising helps clear his mind. It also helps with sleep. If he can mentally and physically exhaust himself, he can sleep better. Dylan tied exercise to his mental well-being, which is a top priority for him. How he can handle a stressful school semester is determined by his ability to clear his mind through means of exercise and proper sleep. In this sense, Dylan's mindfulness is his self-care practice. Physical exertion for a healthy mental state.

> "...I think it just makes you more knowledgeable...about what you are doing for your personal health...the more you get involved, the more you learn, the more you can take better steps towards that."

Other than mentioning his age, Logan did not discuss time affecting his daily approach to self-care in the way other students do. He considered his health his responsibility, a duty to himself, that the more he engages in it, the better he can manage it, control it. Logan is a thirty-two-year-old junior at the time of his interview and not the first of his immediate family to attend college. He claimed that he can no longer get away with certain habits, that his age now dictates what he must do to stay healthy. Food/diet is one way in which to control what his body can do. Logan explained that what he does is relatively basic, consuming a balance of vegetables, carbohydrates, and meat proteins. How he eats and how he maintains physically active are all part of being responsible for oneself. Leo is a twenty-six-year-old Senior and non-first generation student who ethnically identifies as mixed. He lists his self-care practices in order, from one to three: eating healthy, working out, and being out in nature with the last one his favorite activity.

Being outdoors for Leo means hiking trails or spending time at the beach, but also a practice in mindfulness. Exploring, hiking new trails, is a way for Leo to escape school and work.

> "...A good way for me to relax, and reset, and get away from everything that's going on...I think once my workload started to increase, like, working and going to school, that's when I kind of really enjoy nature because I go to get away from, like, electronics, and computers, and work."

Leo described being outdoors on weekends as an effective way to reset and recharge himself, preparing him for the coming school/workweek. In this sense, Leo's self-care practice is a practice in mindfulness, one that focuses on mental well-being and, by extension, physical health.

Food/Diet

The socioeconomics of student participants is unknown, and so are access points to healthy foods if they exist. I think of student food narratives through what Mol (2006, 67) describes as public health efforts that measure and correlate health and disease with activities people engage in. Activities deemed good for the body that result in healthy outcomes become the ideal; the collective then is encouraged to partake in those specific activities and avoid activities correlated with a disease (Mol 2006). The hope, Mol (2006, 67) explains, is that if all individuals adopt a healthy lifestyle in the form of healthy eating and physical activity, the overall health of the collective will increase. That diet and exercise was an overwhelming response to the question, "can you tell me how you practice care for yourself or about the different types of care you practice," may not come as a surprise if we consider what Mol (2006) has to say about individual choice and care. Without explaining exactly how the act of eating healthily translates into energy, some students described the feeling of being heavy after eating what they considered to be unhealthy food.

If we think through what English-Lueck (2010) has to say about food consumption as a care practice, again, food/diet as a response may not come as a surprise. From the standpoint of the San Francisco Bay Area, diverse in people, and in food, eating natural and organic connects to Californian identity and politics (English-Lueck 2010). Organic food movements have roots in the Bay Area. Its purveyors ushered a food revolution that would eventually find its way into significant markets (English-Lueck 2010, 48). Food consumption is measurable through calorie count and considered nutritionally valuable based on fiber, sodium, carbohydrates, and fat. Food also has a function. In eating healthy, Arturo described feeling better and more energetic. Francesca discussed having control over what foods she consumes. Carolina credited her weight to her diet. English-Lueck (2010, 229) describes *functional foods* as "foods designed, or claiming to have disease-reducing and health-promoting properties." Students spoke of consuming more vegetables, more fruit, and more water than they already do to maintain health.

Carolina is a first-generation, female college student who identifies as Mexican-American. Twenty-three-years-old and a senior as of Fall 2018, Carolina attributed her fluctuating weight to her diet. In sharing this, Carolina did more than accept her physical makeup; she owns up to it. She explained having a love/hate relationship with exercise, where some months are better than others with staying focused and dedicated to exercising and eating healthy. She attributed inconsistency with exercising and motivation to the body acting on its fruition, describing the body as always changing and moods influx. Carolina has to learn to adjust to what the body requires or asks of her. Carolina described her body as functioning on its own, dictating what she does to please its mood.

> "...that's another thing, is just knowing what's going into your body as opposed to when you're eating out and it tells you it has this ingredient, but you don't really know if it does or whatever...So, I really like to know that I'm having control of what I'm putting

> inside my body, especially for breakfast, since it is the most important meal of the day."

Francesca is a first-generation college student and self-identified Latina. Even though she did not describe cooking as practicing care for herself, it is an essential step in preparing herself for her day. As a full-time student, working part-time and heavily involved in her dance group, she spends much of her day on campus. Francesca is conscious of what she eats. For her, breakfast is the most important meal of the day, if not because contemporary food/diet narratives say so, but because she chooses what foods she will prepare and consume. What little control she feels is lost throughout her busy day, what time appears to dictate, she regains each morning with a routine by herself, for herself. Breakfast is an essential meal she has authority over. For Francesca, meeting her daily duties and responsibilities comes at the price of what foods she consumes. Thirty-one-year-old senior and non-first generation Asian/Chinese, Tom explained that to take care of himself is to take care of his diet. Tom's food/diet practice is in the daily choices he makes throughout his week with a focus on controlling what he described as binge eating. Actively choosing healthy food options affects his mental well-being as he appears to struggle with overeating. Tom shared that he does not consider himself healthy. The act of "making good food choices," he explained, is him acknowledging he is mindful of what he eats. The concept of binge eating as it relates to him seems to have come down from someone or someplace outside of himself. He described himself as having to grapple with this label or concept that feels new to him. He admitted to feeling better.

Conclusion

Ethnic identity was left open for student participants to answer; I did not provide a list of options to choose from. To learn that a student was a first-generation American came from self-disclosure during their interviews. The students who described food and exercise as practicing

self-care are American college students attending an American school. Without an extensive cross-cultural look into care practices around the world, SJSU students spoke of American notions of self-care practices. Even for students who self-identified as first-generation Latinx/Americans spoke of parents born in countries outside of the U.S. practicing western concepts of medicine. That Vick's VapoRub, an American product, is a household product in Latinx homes has become an ethnic identity marker. Is it unique that students at San Jose State University list diet and exercise first when describing how they engage in self-care practices? No. Public health experts in the medical world have for long related the benefits of eating well and exercising. What foods we consume and what physical activities we practice varies amongst us all. That we agree they are connected to positive health outcomes, however, is what is interesting. A healthy diet meant consuming fruits and vegetables and eating less fast food. It involved cutting out sugary drinks and drinking more water. In eating healthy, students describe feeling better and more energetic. What healthy eating looks like appeared to be common knowledge, and although student participants do not specify how they learned such notions of what constitutes healthy food consumption, their narratives were very similar.

Chapter Five: How Healthcare is Experienced

When a recent visit to a doctor's office met convenience, interpersonal relationships, and quality customer service student participants described the healthcare experiences as a positive one. Even though students value each of the aforementioned, however, together were not always enough to determine if they often sought care for feeling sick or stressed. The true determinants to health seeking for both Latinx and non-Latinx students, were what I call severity, time, and navigating the medical system (e.g. making appointments, dealing with health insurance, getting tested).

- Severity - meant waiting out symptoms and only if they became severe would a student participant take further action.
- Time - tied in with severity, sometimes meant taking over-the-counter medication rather than making an appointment to see a doctor.
- Navigating Medical Systems - although most student participants were aware their tuition covered student health services at SJSU, familiarity with the process that granted them access to services was not as extensive amongst them.

Neglect/Severity

Arturo, a twenty-four-year-old senior at the time of his interview, described writing off what he thought was just a sore throat. Giving it time to heal, the first-generation college student took over-the-counter medication and made sure to stay hydrated. He also kept what he felt was a healthy diet. After a few days and no improvement, the pain in his throat had worsened. Eating became a painful act. Unable to eat, he became weak. Adhering to the directions of over-the-counter medication, he gave it more time. A week and a half in this condition and Arturo begun to spit up blood. Taking a flashlight to his throat, through the reflection of a mirror, he determined it looked infected. Arturo decided to seek help. His first step, call mom. She recommended that he seek urgent care. Not sure which medical facility to turn to Arturo Googled urgent care facilities. He explained that some websites made clear what insurance was accepted

where others did not. He went on like this, searching through one site and another, calling one facility and another, until he finally found one accepting Medical. The rest, he explained, was straight forward. He showed up to urgent care, where they diagnosed him with strep, and gave him the medication he needed.

Student participants often spoke of neglecting their discomforts or waiting to see if their symptoms became more severe before seeking medical attention. Although neglect seems like a strong word to describe a student's action or lack of response to address feeling sick or stressed, doing nothing was often used as a synonym for not seeking medical attention. A synonym for ignoring discomfort/pain/illness and other symptoms and for waiting for feelings to get better or worse before taking action. A synonym for doctor avoidance; for self-assurance that it will be ok; as well as for other references about doing nothing if services were not available. Neglect does less than wait out a symptom; it does as it implies, nothing. That student participants referred to actively using over-the-counter medication or home remedies as doing nothing points to my idea of the *formal* and *informal.* Medical institutions make up the official, where home remedies and even over-the-counter use the casual.

When asked if they had ever treated themselves for an injury or illness, overwhelmingly, student participants said yes. I categorized self-treatment under neglect/severity as it was a part of the process of student participants waiting for symptoms and discomfort to either subside or worsen. Neglect implied ignoring illness altogether, but together with severity, it became more of a waiting period, a time that may involve self-treatment. Typically, those treatments were in the form of over-the-counter medications that also included ointments and topical creams for bumps, bruises, and abrasions. Self-treatment of injuries or illnesses with over-the-counter medications in some cases became the home remedy. Regardless of ethnic identity, herbal teas were

synonymous with a home remedy. The go-to-treatment for most student participants, however, were over-the-counter medications. Emergen-C, Nyquil/Dayquil, Advil Cold/Flu, Thera-Flu, and Vicks Vapor Rub often made the list of products used at home as self-treatment. For students with access to family members with knowledge of herbal teas spoke of using herbal drinks to treat a cold symptom, but not practicing the act of making them. Instead, it was, "my mom makes this tea" or "my aunts are herbal experts" or "my parents know a lot about herbal remedies." This could say more about a participant's dependency on their parents or guardians as early twenty-something-year-old college students, regardless if they lived at home or with roommates. Whatever the case, student narratives of using home-remedies brought up the question of how family knowledge surrounding home-remedies was adopted and practiced by student participants.

Customer Service

Carolina seemed to speak fondly of her experience with private insurance. She described an easy appointment process and quality customer service. Now enrolled in Medi-Cal, Carolina felt she had no control over what doctors she can see and what facilities she can use. She expressed frustration with missing the initial step of finding and choosing a clinic of her choice and getting stuck with a clinic she described as "packed" and "stressful." Carolina, along with other student participants, spoke of care as a service. She seems to value excellent service for money rendered. Carolina grew up seeing a private doctor, a pediatrician, in a small clinic. Having experienced that level of medical care, she spoke of a willingness to pay out-of-pocket for medical services if it means quality attention. At one point in her interview, Carolina described visiting Mexico where access to private medical service was less than half the cost of any service offered in the U.S. She appeared to be learning how to play what I think of as a game

with insurance companies and care facilities to ensure she got the most of her coverage. Navigating care institutions and care systems for myself has at times been confusing, frustrating, and a bit daunting. Carolina explained she had two options, call and deal with a nurse or doctor over the phone as opposed to making an appointment in a packed facility and find a way to pay-out-of-pocket. For Carolina, if paying a fee out-of-pocket ensured quality care, whether, in the U.S. or Mexico, it was something she would consider.

Maryam, feeling sick a couple of weeks before her interview, explained that she simply took time off for herself, giving herself a day of rest. She explains that getting sick is something that is a normal part of life, that "it's not a big deal." Maryam described the body as a marker, a warning system of an oncoming threat. Feeling sick could simply mean one has had a long day. She explained that one needs to give themselves a day to see whether the feeling is prolonged, or it worsens, at which point one should then seek medical attention. Two days, she explained, ought to be enough time to understand if one is full-on sick. Every three weeks, she seeks counseling sessions where she meets with someone on campus to discuss aspects of her life she does not get into detail over. Content with her experiences with the SHC, she described a staff that listens to her, that takes care to ensure all the information she needs is available. As a client, she appreciates the notifications about upcoming appointments she receives. If Maryam did not have the resources available to her on campus, she would find a way to seek the medical attention she needs somehow, somewhere. Maryam needs to maintain health as it affects all aspects of one's life, especially for her as a student.

Mistrust

Emilia described two fears: (1) that a negative mindset towards therapy or counseling will not give her the results she feels she can benefit from, and (2) the medicalization of her

mental health. She is torn between a world she studies in school but has not experienced for herself and dealing with her emotions on her own. Emilia understands a potential benefit to talking with someone but fears not being heard. She self-proclaims being cynical about psychology, pointing at its narrow focus on the individual and ignoring the social and the economic. In her interview, Emilia shared that her family's financial state was a significant stressor for her. She described this as an “outside source of stress.” Emilia fears therapy will miss the source of stress by focusing too closely on her mental psyche and not what she may be experiencing outside of school.

Emilia developed a bad taste for seeing doctors, explaining there has been too much focus on her weight. Although Emilia self-proclaimed, she is a little overweight, something she is ok with and accepts. Annual check-ups were conversations about weight loss. She shared a story when at fifteen-years-old she was anemic and was told by one doctor it had to do with bad eating habits and being overweight. A second doctor determined not only that Emilia was anemic but that she also had some form of blood disorder. She felt her pediatrician was not listening to her, that only one thing was the focus of her problems and nothing else that could surround the issue. Emilia started developing migraines and felt there was more going on with her physically than just her weight. What Emilia had experienced with her pediatrician most of her adolescent life, seems to bleed into her decision to seek mental health care as an adult. Emilia shared that all she asks is that she be listened to. She feels that no one, not even a person with a medical degree, she explains, can know her body more than she knows it herself. The idea of sharing her life story to a stranger for them to examine makes her uncomfortable. It is the main reason for her hesitation in seeking mental health care.

Access

Iris, unlike Emilia, shared something different when asked what she would do if the resources she needed had not been available to her. Although she acknowledged that having access to medical care is a necessity, even a right, she is grateful to be under her parent's medical insurance. Convenience is still a major determinant of whether Iris seeks medical attention. Iris sees the value in seeking medical attention, whether it be physical or mental care one needs. Although each tried medical attention on campus, Iris did because of convenience where Maryam because of necessity. Insured under her parents, Maryam mentioned being covered by the school. They both speak of how important they feel it is to seek medical attention. Iris views it from access as a right. Maryam from cost and value expert advice. Originally from India, Maryam explained that in the U.S., she would never self-treat herself for anything. If access to medical services is available to her, then that is the option she seeks. I combine her responses to questions on self-treatment and the use of web-based or app-based systems for diagnosis or treatments to try and illustrate Maryam's feelings toward seeking medical expertise. Iris highlighted access as an issue in contemporary times. She asked what we (as a society) do about people who do not have the option to sign up to “Obamacare” or the opportunity to be under their parent's plan. Even so, time and convenience are still significant determinants for how or if she will seek medical attention. She spoke of having her prescriptions mailed to her for comfort and the convenience of the SHC on-campus versus the thirty-minute drive to her health provider. She also spoke of having no time to get things checked out when there is a “lump” or “bump.” Both Iris and Maryam see value in seeking care but from different perspectives. One does it for fear of developing cancer. The other acknowledges she should take advantage of available resources.

Arlene started by explaining what she actively does when she feels she is getting sick. She likes to be proactive. Whenever she feels something coming on, she emails her doctor directly with questions about what she is feeling. The most recent time this happened was a few weeks before her interview. She was having trouble sleeping due to the stress she was under. She contacted her neurologist directly and shortly after began a melatonin regiment to help her fall asleep. Arlene's proactive practice, and coupled with her access to her doctors, can be viewed as a self-care practice. Having sought health care ten times within the twelve months of her interview, Arlene disclosed that she is very content with her health care provider. Insured with Kaiser, something she explained she is privileged to have; “everything” is accessible to her. She explained that as a patient with Kaiser, she can use an account online that makes emailing her doctors easy. Although Arlene described Kaiser's services as “great,” her satisfaction with their services come from her positive experience with a specific doctor. She explained she felt cared for by this doctor. As such, the quality of care experienced was high. At this point in her interview, Arlene was asked to explain what she would do if the services she just described were not available. She found it difficult to answer the question since not only has she always had access to care, she feels lucky to be under her dad's health insurance. She could not imagine what it would be like not to have that access. The student interviewee had to pose the question as a hypothetical scenario for Arlene to answer the question. Employed part-time and without health coverage, she explains that she would look towards resources that provide free healthcare. She also acknowledged that as a student, she has the option of the SHC, something she views as convenient. Convenience, in whichever way that may be for a student (e.g., hours of operation, already on campus, parking is not an issue) is an influencing factor and, at times, a determinant if a student will seek care from the SHC.

Conclusion

How care is experienced is dependent on the person receiving care and the person providing it, each of which understands care practices differently (English-Lueck and Avery 2017, 41). Health experts are considered just that, experts. Relying on experts to explain the medical term of what ails us strips any real knowledge over our own body and how it works. We only know what we feel and not necessarily why and what to do about it. This puts the health expert in a situation of power over the patient directly by acquired medical knowledge and medical practice. Seeking healthcare in places other than conventional medical institutions may take some of that cultural power health experts in white lab coats have over a patient and give it back to the patient. What of the health expert in everyday clothing working out of her garage? A *curandera* (healer) by those who perceive her as such, follow her recommendations about how to heal what afflicts them. Is the power dynamic a patient encounters in an examination room with a doctor the same as in a garage with a traditional healer? How we come to trust institutions is born from both experience and what we are told about those institutions. Leonora mentioned Kaiser as being a trusted name with a built-in reputation. Working against the SHC is what little Leonora knows about it, but it goes further than that. If SJSU and the student health center had the same reputable name that comes with Stanford or UCLA, then perhaps she would not doubt its services. Not that she would still seek their functions, but because of name recognition, she would not question if actual doctors worked within the student health center. Additionally, and what I feel is the main factor in determining student health center use is convenience. The student health center must ask itself who their primary target is? Is it students who live on campus? Students who live off-campus, but within walking distance? How does the student health center meet the needs of students who live off-campus and commute? And more

importantly, is the SHC interested in identifying those needs? Lastly, although the student health center serves every student willing to walk through its doors, does it have any interest in learning who the students are not using its services and why?

Chapter Six: What Care with Others Looks Like

In sharing how and with whom they practice care with, student participants described what they value in their lives and what they value in those who make up their social support systems. Students explained tapping into their social networks first before reaching out to medical experts for health-related advice and care. Only when their sources of knowledge were exhausted would students seek the advice and care from an institution. I categorize different types of knowledge to follow how students seemed to categorize their social support systems, breaking up people into clusters and assigning them titles (e.g. friends, family, colleagues) and values based on knowledge, expertise, and experience (e.g. medical students, mental health patients, age).

That kinship plays an essential role in the lives of student participants is evident when they described who in their social support networks they went to with health-related questions. Mom and dad were almost always at the top of the list of people students sought general advice from. Mom overwhelmingly beat out dad. Siblings and extended family members, cousins, uncles, and aunts, typically older and who have shared or similar experiences with student's own experiences, were next on the list. Participants also spoke of practicing care with non-blood related individuals. For some, that practice may have been in the form of exercise, going to the gym together, doing yoga together, running, walking, or hiking together. While for others, that practice may have been in holding their versions of group therapy sessions. Some students shared dealing with health issues on their own; however, in most cases, they typically fell back on others for both advice and care.

Experience and Familiarity

Arturo valued age, maturity, and experience. Likewise, he valued interpersonal relationships, face-to-face interactions. He described the act of talking with his mother in person over the phone as one that allowed him to see her facial reactions he took as cues that she cared for his well-being. Arturo explained he found therapy in conversations with people. His mother had personal experience dealing with mental health and he felt comfortable discussing delicate topics with her. Student participants seemed to value shared experiences. Often it was mentioned that what made a person a go-to for advice or someone to "vent" to is whether or not they had experienced what a student is going through. Shared experiences were not age discriminant. Arturo mentioned going to his older sisters for advice on navigating the healthcare sphere due to them experiencing it in their own lives. A fellow student or friend in the same age bracket as that of a participant may have turned into someone they trusted for advice if that friend had gone or was going through something like themselves.

Francesca was part of a minority of student participants who did not mention mom as a go-to for general or health-related advice. "My brother, everything. Hands down." That is how she responded when asked who in her social support system she went to for help. His advice to her was straight to the point, she explained, an aspect about their relationship she valued and admired.

> "Yeah, I can talk to him about anything. You know, even things that you normally wouldn't talk to the opposite gender about, I'm totally fine with him."

Although she appeared to view certain aspects of life traditionally, maybe even culturally, such as discussing "gender-specific topics" with the opposite gender, the shared experience as students at SJSU helped strengthen a bond they had forged as children that as adults superseded

any notions of cultural-norms. In some cases, merely studying in health-related majors added value. Leonora exemplified this notion. She was part of a dance group on campus where some of her teammates were physical therapy majors. She explained she trusted their advice and suggested “they know a lot more about anatomy” than she. Lenora, like other student participants, appeared to break up a broad social support world into groups. Who she sought advice from depended on two things: who she felt knew her well and who she felt had general expertise. For questions on physical health related to dancing, Leonora sought the advice of teammates in her dance group. Likewise, she valued those who know most about her, regardless of formal training and education. She explained she refused to seek formal expert advice for psychological needs. Instead, when she experienced a stressful day, she turned to mom. She found therapy in talking with her. That her mother knew her allowed Leonora to confide in her. She described mistrusting that a stranger could know and understand what she had gone through. Leonora did not seem to believe in talking to formal experts about her problems. Leonora's narrative was an example of the complexity behind the care practices of student participants. What they have experienced felt unique to them, yet, to know someone with similar experiences, if not the same experiences as their own, was highly valuable.

Holly is a twenty-one-year-old senior at the time of her interview. Like her Latinx counterparts, Holly had particular people in her life she went to for specific aspects of her life; mom being the first on her list. Holly rusted in those closest to her, those who had a familiarity with her. For what she considered “feminine issues,” she listed an older sister as go-to. Holly explained taking advice from people she valued sincerely, noting that if she went to them for help, it was because there was seriousness behind the matter. For more intimate issues, however,

she trusted in her boyfriend. Their close relationship was perceived to afford him familiarity and knowledge about her.

> "...We talk all the time...he knows me pretty well, too, so like if I'm not feeling well like he knows if I'm myself or I haven't been eating healthy. He knows the most about my life."

Those with experience and familiarity with student participants personally did more than make up their social networks; they made up their very own support groups. Dependent on their needs, like departments within an organization, student participants had an individual or a set of individuals set in place whom they trusted for advice. Tiffany seemed to be an example of this. Because of proximity, mom and brother at home for when she fell ill. Because of their familiarity with her and their bluntness, her best friend or roommate for general advice. For persistent health-related issues, however, she emailed her doctor or talked to an advice nurse.

That student participants had multiple individuals they turned to for advice and with health-related questions spoke to how care was not always and maybe even rarely, practiced alone. Turning to others could also have been due to the fact that although they varied in age they were for the most part in their early twenties, in college, and may have still depended on parents or guardians financially. Relying on friends, roommates, and classmates could have simply meant that was who was available to them at that moment in time. For students, navigating college life is a process, as was secondary school before that, and will be adult life as working professionals. If we think about our social support system as Annemarie Mol (2006) suggests we do about care, as an on-going process, with people coming in and out of our lives at different times offering advice and forms of care, then the old adage holds true, it really does take a village to raise a child.

Informal vs. Formal

Emilia described a social support system made up of various go-to persons dependent on her situation or need. She described herself as “a very social person” and, as such, required different points of view from various sources. “Validation” and “genuine support” she considered to be the “the little things” she sought from certain people. Emilia's mother is at the top of her list of people she turns to for “emotional support” even though there are limits to what she can share with her. She explained that because of her mother's limited schooling in her home country Emilia split her advice-seeking based on what her issue may be. For emotional personal problems (the informal), she can turn to her mother, but not for schooling (the formal). Instead, Emilia relies on someone outside her family whose expertise she values. In Emilia's case, her work supervisor. Close in age with Emilia, her supervisor is a graduate student working on her master's degree. Emilia explained that she and her supervisor share a similar background. She is Latina and educated. Finishing school in the same major as Emilia, she trusts what her experience can speak to about her own life. Emilia values the formal knowledge that comes with expertise navigating an institution successfully as her supervisor has the university.

Tom practices care with his family. At least that is what he shared when prompted to discuss those in his social support system with whom he practices care. He explained that when both his parents and siblings ask for advice, he is more than willing to “provide his services,” as he puts it. However, the advice-giving is not necessarily reciprocal. Tom shared that it is not his family that he turns to with questions of his own. Instead, Tom relies on the internet.

> "I usually just go online and look it up...I mean, I'm usually if I can fix it, I wouldn't ask for outside assistance...in terms of people I mean...I feel in some ways that the internet these days are more helpful than humans are."

He seems to value independence and self-reliance, explaining that he is of the mindset that if he can “fix it” himself, there is no need to seek any one thing from any one person. In this way, Tom feels the internet is more helpful than humans are. But when prompted further to describe who he goes to for health-related questions, he asserted that it is his family. How he described what that looks like, however, seems almost transactional. Tom explained he only goes to family to receive a second opinion for a decision he has already made, and not so much to seek advice or answers to questions he may have. Tom's responses to questions about his social support system appeared short and vague. It is possible the interview questions themselves were obscure and hard to understand. It could have been the inexperience of the interviewer to prompt Tom to further elaborate on his responses or Tom only having little to share on that aspect of his personal life. Whatever the case, Tom described seeking online information as more of a go-to than his social support system, something I assumed early in my research study would be a more common response by student participants. It has, however, been the opposite. What does seem consistent and almost obvious is that student participants highly value experiences. When those experiences come from a trusted professional, such as Logan's father, they tend to hold more value.

Logan did not describe his father as a doctor, but instead as someone who has access to medical professionals and their opinions.

> “...I actually talk to my dad a lot about care because he has worked in hospitals for the last...thirty-five-years. So, he has a lot of experience with medical people and he can get opinions from doctors easily.”

It almost seems natural then that Logan would seek his brother for any “psychological advice” as his brother holds a Ph.D. in psychology. Along with valuing expert knowledge, Logan also has trust in who he goes to with questions. He mentioned never hesitating to call his doctor for

"serious issues." What a serious issue is he did not elaborate on. Logan trusts and values the formal expertise that comes with both experience and education/training. “...My dad, just for the knowledge that he has...or my mom, because she has been around, and knows a lot.” His father, although not a doctor, has access to medical doctors. His mother has gained knowledge for merely having experienced life longer than he. His brother earned a doctorate in psychology. His doctor, however, above all, is the go-to for anything out of his immediate family's range of expertise. Logan created a hierarchy of expert knowledge, with his personal doctor at the top of the list. Having grown up with continuous access to this myriad of specialist expertise, Logan learns to highly value and trust the advice that comes with it.

Leo described a social support system similar to that of Logan, where he seeks expert knowledge from a specific person whom he feels holds particular expertise. He listed both his parents at the top of the list of people he practices care with, mainly in going to them with health-related questions and for advice. He mentioned a fellow nursing student who Leo suggested is knowledgeable about health-related issues. Lastly, he said his social group as a go-to with questions surrounding specific health issues. Like Logan, Leo created a hierarchy of experts that bounce back and forth between what I call formal and informal knowledge. Leo's parents are at the top of his list of people he turns to, not because they are medical professionals (formal), but for merely being his parents (informal). His uncle, the doctor, is someone Leo goes to often for advice, followed by a nursing student and friend. His group of friends who he did not assign some form of expert knowledge as he did his uncle or nursing student friend he values for proximity. Even though they are at the end of the list, they are the ones with whom he has the most contact. As such, they are who Leo turns to with questions about what is normal and what is not as it relates to health.

Who student participants turn to for health-related advice is determined by a few things: (1) severity - how serious they feel the health issue is; (2) proximity - who they are in direct contact with while experiencing a health issue; and (3) formal and informal expertise/knowledge acquired through a profession or experience. Combined, students place people in their social worlds into categories of not only friends, family, and colleagues, but formal and informal experts. They value both profession and experience. The hierarchy of expert knowledge they draw on ensures they will receive the advice they feel is best for them for any health-related concerns they may have. Leo is an example of how severity played an important role in determining who he turned to that last time he sought advice from someone in his social support system. “Yeah, so, I actually sought advice from my friend last before my uncle, because it wasn’t anything important.” Leo, feeling he was a “bit overweight,” turned to an informal source versus a formal one to seek advice on how to manage his health concern. He would eventually learn through blood work results that he had high sugar levels. He explained that he needed to cut back on his sugar intake. At this point in his interview Leo shared that although he highly valued the advice from his social network, he was concerned they were not candid enough.

> “Yeah, sometimes I think they might be too nice or too not, like, honest enough, and I’m like, ‘Yo, tell me what I want to hear. Like, I wanna make a change. So tell me something that’s going to freak me out.’”

Leo's need for advice that is frank may influence his need to have a mixed group of knowledgeable experts, whether formally gained through profession or informally through experience. To prove that student participant's care practices are far more complex than this study can show, in the end, even with what appears to be a robust social support system, Leo admited that people are not his first source of information he turns to. Instead, it is the internet.

> "I forgot to mention. The first thing I do when I feel ill, is I Google something. Like, and that's my first source. Very close relationship with Google. I know how to ask. I know how to search things. I know to go where to go for images."

Leo seems to place the internet above all in his social network. The ultimate formal resource above all informal social ties and connections, but most importantly, providing what he may feel is unbiased and straightforward information.

Conclusion

Students identify who in their social worlds possess the formal or informal knowledge they depend on when seeking advice about care. They also arrange their social support system by various aspects of their personal lives, from friends to colleagues, to schoolmates, to advisors, to supervisors, etc., with each value according to what they bring to the table. Emilia turns to her mother for emotional support but is limited in what she can advise her on with her academics. Her work supervisor, a vision of Emilia's self or ideal self, becomes more valuable the more she builds a relationship with her. Emilia has created a support system that works best for her. Her mother, her supervisor, her friend, the people she turns to. Each valuable in their way based on what they offer in the form of knowledge, both formal and informal. Students value the pieces of advice if they know and trust the source from which they come from. That may sound self-evident, but it is essential to remember. The research I presented, although each different in how they were carried out and how each author interpreted what they found, one specific aspect seems to tie them all together, and that is that care is rarely practiced alone. Even in cases such as Arturo's, who waited on his own for his condition to reach its worst phase (spitting up blood) before acting eventually went to his most trusted source for advice, mom. Fiercely independent or not, we are social creatures who depend on others at many points in our lives. Lastly, we live in a time where technology continues to advance how we seek and practice care. Tom, for

instance, seems to feel the internet is far more useful than people. That may speak more to Tom's relationship with the internet and his social circle, but it does bring up the question of how to leverage technology to reach students not using student health services? We cannot forget the impact a personal statement about having used a particular service has on someone. Google can offer hundreds of sources for us to sift through to find answers we feel are satisfactory, but one story from a friend, colleague, co-worker, classmate, or family member seems to carry a lot of weight.

Chapter Seven: Conclusions

San Jose State University students are busy. Time appears to rule over them all. All student participants were asked about employment, about living with a parent or a guardian, and about whether they were first-generation college students. I hypothesized that how a student answered each of those questions would factor greatly into notions of access and knowledge. Many of the students who participated in my study worked part-time. Navigating school life and work-life always made it into descriptions of day-to-day self-care practices. Second generation non-Latinx students spoke more confidently about navigating the medical system (e.g. making appointments, understanding health insurance, asking for services), while Latinx students more often leaned on a parent or guardian to navigate the system for them or show them how to. Employment, however, was not all this group of students had in common. The set of student narratives I interpreted are from a mixed group of self-identity (e.g. ethnicity, age, gender) and experiences with not using the SHC, the theme that tied them together. Both sets of students described having access to medical doctors as children and both sets of students described a familiarity with navigating medical systems. Some, more than others, relied still on a parent or guardian for making a doctor appointment but for the most part, they all understood the process.

Health-seeking behaviors among Latinx students at SJSU were not drastically different than their non-Latinx counterparts. Latinx and non-Latinx students alike, spoke of food/diet as a form of self-care practice. Always tied to bodyweight management, food/diet and exercise together, were referred to as the "obvious" forms of staying healthy. Physical activity varied among all students with some describing regimented exercise plans at the gym and others more informal parking far outside campus to walk the distance. As for how this group of students reacted to feeling sick they spoke of "self-treatments" which often meant over-the-counter

medicine use. Although Latinx students spoke more often of turning to home remedy use, their non-Latinx peers too spoke of consuming herbal teas or chicken soup for a cold. Latinx students, however, tied home remedies closely to ethnic and cultural identity, often describing herbal teas and chicken soup as *té con limón*, and *caldos de pollo*. Latinx students gave the home remedy a sense of cultural tie that expanded past their age and American identity. Even though Latinx students seemed to connect home remedies much more closely to ethnic and cultural identity, non-Latinx students spoke more of the concept of homeopathic medicine use. The difference was in how they referred to home remedy use

Students described treating illness and physical discomfort, muscle strain and soreness, minor injuries like cuts and scrapes with cold and pain medication as well as topical creams and ointments. Over-the-counter products varied only slightly, Vaporub versus Tiger Balm, Icy Hot versus Epsom Salt, Advil versus Tylenol, Emergen-C versus Alka-Seltzer. For both sets of students, the severity of an illness or physical injury or discomfort always determined self-treatment and if a student sought care services. Latinx students spoke more fondly of products than their non-Latinx counterparts. Vicks Vaporub often referred to as *vaporu* by Latinx students, seemed to tie ethnic and cultural identity with over-the-counter medicine use. Although both sets of students spoke of mistrusting the pharmaceutical industry and mentioned herbal remedies as ”alternatives” to western medicine; over-the-counter medicine use was common amongst them.

Both sets of student participants highly valued their social support systems. Latinx or non-Latinx, both sets of students spoke of turning to others for care either for illness treatment or for mental health-related “venting.” They trust and turn to specific groups or individuals, identified and classified based on acquired knowledge and expertise for general advice and

health-related questions. Those with formal knowledge expertise advise them on physically related topics as they relate to health. The informal crowd, those whose expertise comes from life experiences and whose knowledge was acquired outside of college and medical institutions advise students on issues closely related to mental health. Mental health, although acknowledged as an aspect of overall health, non-Latinx students more often shared self-care practices that address mental health specifically. References about ways to decompress and practicing mindfulness included hobbies and activities such as painting, playing an instrument, shopping, entertainment, digital disconnect and social media cleansing, meditation and breathing exercises, cannabis use, taking time for oneself and self-reflecting. Both sets of students spoke of school as a source of stress. For students who also worked, they spoke of the stresses of their employment. Turning to friends and family when feeling sick or stressed was common. What Latinx students referred to more frequently as "venting," non-Latinx called "informal group therapy." Latinx students spoke more of mistrusting medical institutions than non-Latinx students and rarely spoke of addressing mental health on its own, but instead included it as part of overall health. They more often referred to ailments of the body than the mind and rarely spoke of seeking mental health services. Description of actively addressing mental health seemed to come more from non-Latinx students irrespective of gender self-identity. Although both sets of students spoke of turning to their social support systems "to vent," non-Latinx students spoke more often about seeking professional mental health services while Latinx students trusted more in friends and family.

Word of mouth was an effective means of communicating or disseminating knowledge. Students, both Latinx and non-Latinx alike, spoke of considering SHC use if a friend or fellow student had experiences with those services. Latinx students more often mentioned distrusting

medical experts and explained not feeling that mental health services were designed for "their way" of expressing themselves. Those ways could be more closely related to ethnic and cultural identity, as one Latinx student mentioned the physical space of SHC did not facilitate comfort or trust while another described the process of one-on-one as not facilitating a conversation through which meaningful thoughts could be expressed. However, there were some exceptions to this. Latinx students with family or friends who had experience with seeking and using mental health services were more likely to disclose "wanting" to seek and use similar services but remained hesitant in doing so.

What's Next?

Based on the results of this research, future research at SJSU or at a similarly diverse public university could entail:

- Studying how SHC could leverage social marketing with an emphasis on personal stories to drive students to trust and use SHC services.
- Studying students who go to general practitioners or internal medicine doctors versus students who go to urgent care. Navigating the medical realm sometimes meant leveraging certain aspects of the medical system to work in someone's favor.
- A study on the trust in the medical profession, especially in mental health to include notions of stigma, fear, and misconception. Latinx students rarely mentioned seeking mental health services even though they acknowledge it as part of overall health and wellness. They often made references about "wanting to" or were "curious about" using such services.
- An examination of the many ways students decompress that could include alcohol and drug use. In describing self-care practices students spoke of the effects each of their activities, whether diet, exercise, or cannabis use had on their mental state. Mindfulness drove many acts of self-care practices.
- Studying the metrics of health and wellness that direct San Jose State University's Treat Yourself initiative in measuring its goal of a Healthy Campus 2020. How do students measure and compare their health against their peers and what constitutes a healthy body and mind?
- In a more reflexive approach for the Student Health Center, asking questions surrounding broader topics of health disparities and where they exist amongst SJSU student

populations can help guide thinking about student health care overall and help the SHC evaluate their hours of operation.

- Future research on the topic of student health care should consider such realities as student debt, long commutes, and high cost-of-living as direct and negative impacts on student health. Questions about inadequate funding not only affecting resources but the ability to serve students effectively sidelined by distance and time need special consideration.

The Anthropological Difference

Anthropology encouraged me to be reflexive in my research; to understand the interpretations of student descriptions of self-care practices and health-seeking behaviors in the time in which they were narrated were all mine. To take on the topic of health-seeking behavior among Latinx students at SJSU meant placing the topic of care within both historical and contemporary context. How had other researchers grappled with the topic? What has been the history of Latinx health in the United States and what was its current state as of Fall of 2018 when I approached it? What was currently happening in the U.S. and at SJSU that the topic of care deserved my attention? What did I expect to learn, and why? To attempt to answer these questions meant research of the topic itself, the people, the place, and time. This was a study of self-identified Latinx SJSU students who identified with a much broader and larger Hispanic population in the city of San Jose, in the state of California, in the United States. How the greater influenced the smaller needed consideration.

As an anthropology student, I made use of ethnography. What that meant was me trying to learn how a subgroup of people within a larger society understood and interpreted a behavior under study. For me to try and understand how a student practiced self-care meant to try and understand how a student defined care; to understand that also meant understanding societal and cultural influencers defining care. I examined transcriptions and compared them to each other to try and flesh out interpretations both mine and those from student participants. “Eat well, sleep

well, and exercise," the catchphrase for how a student practiced self-care. The method of in-depth semi-structured interviewing allowed for follow-up questions that enticed further descriptions and narratives. As a student, I had access to an institution as a research site where functions meant to drive SJSU's health initiative were abundant. I was a part of the group under study as were student researchers. Messaging on health and wellness were directed at us as they were to student participants, and although participant-observation was tricky as we did not follow students around to observe their day-to-day, SJSU invited us to experience activities, workshops, and classes on the topic of health and wellness at SJSU. Participating in these engagements offered an understanding of health and wellness from an institutional standpoint while in-depth interviewing allowed for a local understanding on the same topic.

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Appendix A Figure 1: Electronic Screener Questionnaire

Student Health-Seeking Practices at San Jose State University

As part of a research project on the health-seeking practices among San Jose State University students, this questionnaire is designed to identify different demographics of students who have and have not used services offered by the Student Health Center.

* Required

1. School year, as of Spring 2019 *

   Mark only one oval.

   - ◯ Freshman
   - ◯ Sophomore
   - ◯ Junior
   - ◯ Senior

2. Age

   _____

3. Did either of your parents complete a college degree? *

   Mark only one oval.

   - ◯ Yes
   - ◯ No

4. Units currently enrolled, as of Spring 2019

   _____

5. Housing, as of Spring 2019

   Mark only one oval.

   - ◯ Live on campus
   - ◯ Live off campus
   - ◯ Other: _____

6. If living off campus, do you live with a parent or legal guardian?

   Mark only one oval.

   - ◯ Yes
   - ◯ No
   - ◯ Other: _____

7. Employment, as of Spring 2019

   Mark only one oval.

   - ◯ Full-Time (30 or more hours a week)
   - ◯ Part-Time (less than 30 hours a week)
   - ◯ Not Employed

8. Race/Ethnicity *

   _____

9. Gender *

   _____

10. In the past 12 months, have you visited the Student Health Center for health related services? (cold/flu info, clinical services, immunizations, physical therapy pharmacy, women's health or any other health-related service available at SHC) *

    Mark only one oval.

    - ◯ Yes
    - ◯ No
    - ◯ Other: _____

11. In the past 12 months, have you visited the Student Health Center for non-health related services? (student lounge, meet other students, study space, free breakfast, etc.)

    Mark only one oval.

    - ◯ Yes
    - ◯ No
    - ◯ Other: _____

12. At the conclusion of this study, we would like to invite participants to join a focus group interview where we present our preliminary results and analyses and solicit your feedback. Would you be interested in participating in a focus group at a later date? If so, can you please provide your email address?

    _____

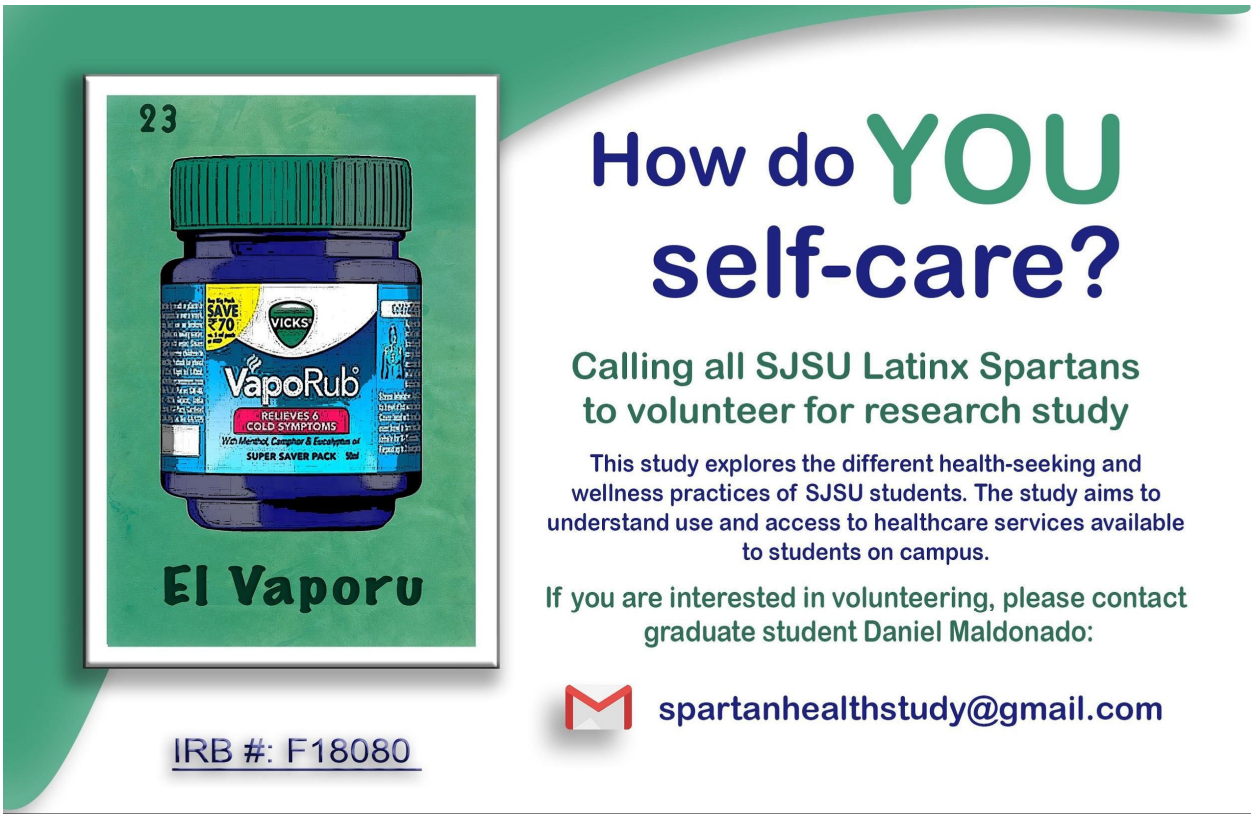
Appendix B Table 1: Interview Quota Matrix

	Latinx First Gen., Lower Div.	Latinx First Gen., Upper Div.	Latinx non-First Gen., Lower Div.	Latinx non-First Gen., Upper Div.	Non-Latinx First Gen., Lower Div.	Non-Latinx First Gen., Upper Div.	Non-Latinx non-First Gen., Lower Div.	Non-Latinx non-First Gen., Upper Div.
Fem. Has Used SHC		(1004)		(20)		(74)		(4)
		(8)		(32)	(73)	(25)	(68)	(12)
		(19)		(51)		(52)		(30)
		(53)				(49)		(64)
		(18)				(9)		(71)
		(45)				(1005)		
Fem. Has Not Used	(36)	(1006)				(44)	(38)	(5)
	(35)	(14)	(56)			(6)	(55)	(34)
	(59)	(23)						(26)
	(28)	(11)						(42)
	(1008)	(13)						(27)
		(29)						
		(65)						(17)
Masc. Has Used SHC		(21)				(22)		(43)
		(2)				(33)		(40)
		(41)		(72)		(16)		(60)
		(24)						
Masc. Has Not Used		(1007)		(63)	(47)	(15)	(3	(67)
		(7)		(46)		(48)	(58)	(10)
		(69)				(66)	(61)	(70)
		(57)				(62)		(54)
		(37)						
		(39)						
		(50)						

Appendix C Table 2: Sample of Participant Screener Data

Participant ID	School year, as of Fall 2018	Age	Did either of your parents complete a college degree?	Units currently enrolled, as of Fall 2018	Housing, as of Fall 2018	If living off campus, do you live with a parent or legal guardian?	Employment, as of Fall 2018	Race/Ethnicity	Gender (if prefer not to say, please indicate)	In the past 12 months, have you visited the Student Health Center for health related services? (cold/flu info, clinical services, immunizations, physical therapy pharmacy, women's health or any other health-related service available at SHC)	In the past 12 months, have you visited the Student Health Center for non-health related services? (student lounge, meet other students, study space, free breakfast, etc.)
1	Sophomore	18-22	Yes	9	Live on Campus	NA	Full Time	White/Irish American	Cis Male	Yes	Yes
2	Junior	21	No	15	Live off campus	No	Part Time	Mexican American	Male	Yes	No
3	Junior	19	Yes	14	Live off campus	No	None	Black/African American	Male	No	No
4	Junior	22	Yes	12	Live off campus	No	Part Time	Indo-Fijian	Cis Female	Yes	Yes
5	Junior	23	Yes	12	Live off campus	No	Part Time	Filipino	Cis Female	No	No
6	Junior	24	No	9	Live off campus	Yes	Part Time	Chinese American	Female	No	No
7	Junior	24	No	12	Live off campus	Yes	Part time	Hispanic	Cis male	No	No
8	Junior	23	No	12	Live off campus	No	Part time	Hispanic/Latina	Cis female	yes	No
9	Junior	22	No	15	Live on Campus	N/A	Part time	Black/African American	Cis female	yes	yes

Appendix D Figure 2: Recruitment Flyer



Appendix E Table 3: Themes, Codes, Descriptions

Domain: Self-Care Practices		
Theme	Codes	Descriptions
Self-Care Practice	*Physical Activity/Exercise*	Descriptions of ways of being active that include exercising, going to the gym, working out, running, dancing, hiking, walking, doing yoga
	Food/Diet	Statements made about diets, consuming fruits and vegetables, salads, soups as home remedies, herbal teas, avoiding sugary drinks, fried foods, eating well during the week, having breakfast, meal prep/planning, staying hydrated and drinking more or lots of water
	Frequency/Consistency	Comments about attempts of frequency and consistency with eating or physical activities, exercise, and mindfulness
	Mindfulness	References made about ways to de-compress and practicing mindfulness that include hobbies an activities such as, painting, playing instruments, thrifting (shopping), entertainment, digital disconnect, social media cleansing, meditation, breathing exercises, cannabis use, taking time for oneself, self-reflecting; References made about resting, sleeping, napping, getting more rest, not enough rest, resting as treatment, waiting out illness/discomfort/pain, getting a good night's sleep, sweating it out
	Engagement/Ritual	Descriptions of engaging in acts or performances of self-care that involve more than talking or listening but actions as well; shooting pool with friends; smoking with friends; using hand gestures to describe experiences versus only words; using language that is appropriate for the situation, the context, the place, the people
	Checking-Out	Descriptions of losing oneself in books or tv shows to mentally check-out as a form of

		mindfulness
	Medicine	General references made about medicine, medicine use, medicine avoidance, medicine perceptions, knowledge about medicine, over-the-counter and prescription as well as value and trust in medicine
	Environment/Space	Statements about one's environmental wellbeing; referencing one's environment as a place of refuge or adding to one's wellbeing or of making changes to one's environment; addressing one's own wellbeing can also address their environment and those within that space; moments that involve others around a ritual of hanging out or just being together where conversation is the care practice
	Language	Descriptions of language use according to/determined by space or environment
	Healthy/Good Feeling	References made to how one feels as a result of practicing good eating habits or physical activities such as exercising as well as feeling energized
	Marker of Time	Comments about markers of time in one's life where behaviors/practices began whether physical activities or food/diet practices
Stressors	*Obligations/Responsibilities*	References made about stressors in one's life from obligations/responsibilities to school, to family, friends, and colleagues as well as work obligations; as well as obligations to oneself where self-care becomes an act or obligation, a part of one's daily routine
	Body Weight	Statements made about weight management, diets, weight gain, weight loss
	Sacrifice	Statements about going to work or studying for midterms regardless of how one feels; sick or not obligations must be met; responsibilities do not end when one is sick

	Burden/Self-Reliant	Statements made about self-esteem and not being a burden on others and self-reliance or managing one's own problems
	Time	References made about time conflicts and usage of time; of time stretched thin; time allocated to self-care; sacrificing time or other obligations/responsibilities for self-care; descriptions of time as a finite resource
	Questionable self-care	Descriptions of actions or behaviors one engages in that may at first seem like self-care practices but maybe negative to one's overall health; as demand on one increases so does the form/type of care
Domain: Health Care Service Experience		
Theme	Codes	Descriptions
Self-Treatment	*Home Remedy/Treatment*	Statements that address treating illnesses and discomforts, muscle strain and soreness, minor injuries, scrapes and cuts at home that include home remedies such as herbal teas, soups, as well as ointments such as vaporub (*vaporu*), tiger balm, icy hot and Epsom salt, online resources for self-treatment, stretches, consuming over-the-counter items such as Emergen-C, Alka-Seltzer, and cold medicine
	Upbringing	Comments about the way one was raised or acknowledging one's behavior are due to one's upbringing as well as comments about upbringing as the explanation for why things are the way they are
	Self-Affirmation	Comments made about reaffirming practices when facing stress or stressful situations.
	Neglect	Referencing doing nothing about not feeling well, discomfort/pain/illness, ignoring symptoms, waiting for feelings to get better or worst before taking action that also includes avoiding seeing a doctor and self-assurance that "it will be ok" as well as references made about determinants for seeking care services; this includes doing

		'nothing' if services were not available
	Severity	Referencing doing nothing about not feeling well, discomfort/pain/illness, ignoring symptoms, waiting for feelings to get better or worst before taking action
	Avoidance	References made about avoiding care or seeking doctors or one's own medical research for treatment
Mind/Body	*Connect/Disconnect*	Comments about the body acting independently of the mind such as it is known to get sick during finals or midterms or of stress leading to physical exertion; one leading to the other; as well as references made about physical activities and exercise being good for mental health
Determinants of Care-Seeking fo Physical or Mental Health	*Obligations*	References made for seeking care services as obligations for work such as getting physicals and TB shots
	Fear and Mistrust	References made about not trusting medicine, big pharma, doctors, therapists, the medicalization of one's self, impersonal relationships as well as personal relationships with doctors, and perceptions that doctors and mental health professionals "don't know or understand one's body" as well as comments about mistrusting web-based diagnosis or health-related information
	Access/Level of Insurance	Statements about access to care services that include time conflict, convenience, cost/fees, making appointments, and enrolling as well as always having had access or access as a non-issue; as well as statements about health insurance whether one has coverage or not and how that determines the types of acre one seeks as well as if it will be sought; references to feeling privileged to having coverage
	Healthy	Comments made about rarely needing medical attention due to being healthy and not needing to access health services

	Severity	Comments made about the severity of an injury or illness or pain and discomfort as well as references made about seeking care from emergency rooms or urgent care
	Time	References made to time, as in not getting relief of pain or discomfort or physical improvement from an illness within a certain amount of time
	Professional vs Personal	Descriptions of who and where a student seeks care, either from personal social networks or institutions
Care Experience	*Negative/Positive*	Statements made about both positive and negative experiences with health services outside of SJSU's SHC such as fast and friendly, negative experiences such as long-wait time, filling out forms, and also include alternatives such as seeing doctors in Mexico or paying for private practices as well as online services, such as kp.org, kp portal, online advice nurse, skyping w/Dr and informational podcasts
Domain: SHC Service Experience		
Theme	Codes	Descriptions
Care Experience	*Negative/Positive*	Statements made about both positive and negative experiences with health services at SJSU's SHC such as fast and friendly staff, easy to navigate, easy to find; negative experiences such as long-wait time, confusing website, annoyance with filling out forms, cold and impersonal; experiences with learning if services fit with one's expectations/life
Value	*Personal/Shared Experience*	Statements that reflect value in experience/shared-experience, personal and of/with others, word-of-mouth as well as socializing with others familiar with or identifying as one's own identity; code-switching or using a second language

	Wisdom/Expert knowledge	Statements that reflect what one values that includes family knowledge and wisdom from older family members as well as knowledge from friends and authoritative figures that include school advisors, supervisors, friends who are older, friends who are parents as well as internet-based information
	Quality/Efficient/Thorough Services	Statements placing value on price, accessibility, convenience, efficiency, quality of service, friendliness of staff, and privacy
	Medicine	Statements that reflect what one values in medicine (over the counter and prescription),
	Choices	Descriptions of having a choice on who in their social network they can turn to, depending on what they need; different people for different topics/issues/problems
	Validation	Discussions about receiving a sense of validation from people, friends, family, colleagues, professors, advisors, health practitioners
	Dependency	Statements made about depending on parents or guardians for health insurance or dependence on them to navigate institutions such as making medical and health-related appointments
Self-Reliance	*Independence*	Statements about self-reliance that include independence, autonomy, agency, financial independence, work/jobs, living away from home, control over one's body, knowledge about one's body vs what doctors or professionals know, telling oneself it's going to be ok, understanding limitations of knowledge from family members
	Agency	Discussions about controlling one's life, time, care practices, behaviors; ability to act on one's behalf; self-care behaviors as actions of agency
	Identity	References to one's own identity or markers of their identity; behaviors and practices as

		they are connected to identity; communicating with others depending on setting and affiliation (talking with professors vs parents)
Determinants of SHC Use	*Time*	References made about time conflicts, inconvenience, knowledge about services offered and service quality at the SHC, as well as fees that determine use
	"Busyness"	Descriptions of busy lives as determinants for SHC use; wanting/needing to use the SHC vs no time to do it; busyness as a lifestyle maybe not chosen but as a result of college life
	Convenience/Access	Comments made about convenience as a determinant for using SHC services such as choosing to seek services outside of campus where forms must be filled due to already being in the system; easier to show insurance card than fill out forms
	Perception/Doctors	Statements on how one perceives the effects of medicine on the body, of exercise on the body, of food and water, of cannabis use, of how a doctor views or thinks about one's body or mental health, as well as perceptions about the services doctors provide, unnecessary payments and treatments
	Navigating System/Website	Statements about navigating websites and the medical system such as enrolling making appointments, navigating websites, determining who accepts what insurance, filling out paperwork
	Severity	Referencing doing nothing about not feeling well, discomfort/pain/illness, ignoring symptoms, waiting for feelings to get better or worse before taking action
	Neglect	Referencing doing nothing about not feeling well, discomfort/pain/illness, ignoring symptoms, waiting for feelings to get better or worse before taking action that also includes avoiding seeing a doctor and self-assurance that "it will be ok" as well as

		references made about determinants for seeking care services
	Sexual Health/Wellness	References to using/seeking or knowledge of services for sexual health/wellness; condoms, STD testing, pregnancy tests, etc.
Domain: Social Support		
Theme	Codes	Descriptions
Advice Seeking	*Family*	References to family members with questions on health-related issues as well as for general advice
	Mom/Dad	Descriptions of reaching out to mom and dad as number one go-to-source of info
	Roommates/Friends	Statements about roommates and friends as go-to's for general as well as with health-related questions
	Colleagues/Schoolmates	References made about co-workers with shared experiences and schoolmates majoring in health/public health-related fields as well as parents of friends/schoolmates/co-workers who's parents/extended family members who work in health/public health-related fields
	Physical vs Mental Health	Comments made about who they seek advice from depending on what aspect of health they seek; example: Mom for physical health advice and Friends for mental health venting
Limitations	*Knowledge*	Statements about limited personal knowledge and from parents, from friends, from colleagues, from one's self on services offered, navigating the medical system, filling out forms, enrolling, making appointments
	Time/Free Time	References about having to move forward with obligations/responsibilities in spite of being sick; no free time to address being sick
	Anticipation	Descriptions of not anticipating getting sick but simply becoming sick or references to know that at some point in time during the

		year one falls ill (flu season, allergy season, midterms, finals)

Appendix F Table 4: Interview Quality Sorting

Research Questions
RQ1 What do health-seeking behaviors look like among self-identified Latinx students at SJSU and how do they differ from their non-Latinx peers?
RQ2 What factors affect student consumption of SJSU SHC services?
Interview Questions
Self-Care
Q1 Can you tell me how you practice care for yourself or about the different types of care, you practice? a. How long have you been doing [*name activity*]? b. How frequently do you [*name activity*]? c. How does this affect your health or wellbeing?
Health Care Service Experience
Q2 What did you do the last time you got sick or depressed?
Q3 Approximately how many times have you sought care in the past 12 months for either a physical or psychological need?
Q4 Can you tell me about the last time you sought health and/or psychological care? a. Can you describe how you accessed this care?/How did you make your appointment?
Q5 How would you characterize the type and quality of care you received on your last health care visit? a. Can you describe the degree of satisfaction with the care you received?
Q6 If the healthcare resource you just described were not available, where else would you have gone?
Q7 Was there ever a time when you sought health or psychological care but could not access what you needed?
Q8 The next time you find yourself feeling sick or stressed, where would you go if you needed medical attention?
Q9 Have you ever treated yourself for an injury or illness?
Q10 Have you ever used a web-based or app-based system or patient portal for diagnosis or treatment?
Q11 What type of health insurance, if any, do you have?
SJSU Student Health Center
Q12 Approximately how many times have you sought health care at the SJSU Student Health Center in the past 12 months for either a physical or psychological need?
Q13 Can you tell me about the last time you sought health and/or psychological care at the SJSU SHC? a. Can you describe how you accessed this care?/How did you make your appointment?

Q14 How would you characterize the type and quality of care you received on your last visit to the SJSU SJC? a. Can you describe your degree of satisfaction with the care you received?
Q15 What would need to change for you to use the campus services more or at all?
Q16 Can you list the healthcare services available to you as a student at SJSU?
Social Support
Q17 Can you tell me about people in your life with whom you have practiced care?
Q18 Can you describe how this works?
Q19 When I don't feel well, I generally turn to _____ for advice. Tell me about this person and why you turn to them. What is your relationship with this person?
Q20 If you needed advice on a health-related issue and how/where to seek care, whom would you turn to? Why? Name as many as you like. a. Can you tell me about the last time you received advice from this person? b. Can you describe the degree of satisfaction with the care you received?

Interview Name	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20		Total
Latinx, 1st-Gen, Femanine																						
(1004)	1		1	1	1	1				1					1		1					8
(8)	1	1	1	1	1	1	1		1			1			1	1						11
(19)	1	1	1	1	1	1	1		1			1	1	1	1	1	1	1	1	1		17
(53)	1	1	1	x	x	x	1	1	1	x	1	1	x	x	x	1	x	x	x	x		9
(18)	1	1	1	1	1	1		1	1													8
(45)	1	x	X			1	1	x	x	x					x		x		x			3
(1006)	1	1	1	1	1		1	1				1	1	1			1	x	1	1		13
(14)	1	1	1	1	1	1	1	1	1	x	1	1	1	1	1	1	1	x	1	1		18
(23)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	x	1	1		19
(11)	1	1	1	1		x	x	1	x	x	1	1	1	1	1	1	x	x	x	x		11
(13)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	x	1	1		19
(29)	x	x	X	1	x	1	1	1	x	x	1	x	x	x	x	1	x	x	x	x		6
(65)	1	1	X	1	1	1	1	1	x	x	1	1	1	x	1	1	1	x	x	x		13
Latinx, 1st-Gen, Masculine																						0
(1007)	1	1							1			1	1	1	1		1		1			9
(7)	1	1	1	1		1	1	1			1	1	1				1	x	1	1		13

(69)	1	1	X	x	x	x	x	x	1	x	1	x	x	x	1	x	x	x	x		5
(57)	1	1	1	1	x	1	1	1	1	x	1	1	1	x	x	1	1	x	1	x		14
(37)	1	1	1	1	1	1	1	1	1	x	1	1	1			1	1	x	x	1		15
(39)	1	1	1	1	1	1	1	1		x		x	1	x	1	1	1	x	1	1		14
(50)	1	1	1	x	1	x	x	x	x	1	1	1	1	1	1	1	1	x	1	x		13
Latinx, non-1st Gen, Femanine																							0
(20)	1	1	1	1	1	1	1	1	x	1	1	1	1	1	1	1	x	x	1	1		17
(32)	1	1	1	1	x	x	1	1	x	x	1	1	1	1	1	1	1	x	1	1		15
(51)	1	1	X	1	x	1	1	1	x	x	1	x	x	x	1		x	x	x	1		9
Latinx, non-1st Gen, Masculine																							0
(72)	1	x	X	x	x	1	1	1	1	x	x	x	1	x	1	1	x	1	1	x		10
(63)	x	x	X	x	x	1	1	x	1	1	1	1	1	1	1	1	x	x	x	x		10
(46)	1	1	X	x	x	x	x	x	1	1	x	x	x	x	1	1	1	1	1	1		10
Non-Latinx, 1st-Gen, Femanine																							0
(74)	1	x	X	1	x	1					x			1	1				x			5
(25)	1	x	X	x	x	1	1	1	1	x	1	x	x	1	1	1	x	x	x	x		9
(52)	1	1	1	1	1	1	1	1	1	1	1			1	1	1		1	1			16
(49)	1	1	1	1	1	1	1	1	1	1	1	x	x	1	x	1	1	x	1	x		15
(9)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		20
(1005)	1	1	1	1	1	1	1	1	x	x	1	x	x	1	1		1	1	1	1		15
(44)	1						1			1					1							4
Non-Latinx, 1st-Gen, Masculine																							0
(22)	1	x	X	x		1				1												3
(33)	1	x	X	x	1	x	1	x	x	x	1	x	x	x	x	1	x	x	x	x		5
(16)	1	1	X	x	x	x	1	1	x	1	1	1	1	1		1	x	x	x	x		10
(15)	1	x	X	x	x	1	1	1	x		1	1	x	x		1	x	x	x	x		7
(48)	1	x	X	1	1	1	1															5
(6)	1	x	X	1	x	x	x	x	1	x	1	x	x	x	x	x	x	x	x	x		4
(62)	x	1	X	x	x	1	1	1	1	x	1	x	x	x	x	x	x	x	x	x		6

Non-Latinx, non-1st Gen, Femanine																						0
(4)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	x		1	1	x	x		17
(12)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	x		1	x		1	x		17
(30)	1	1	1	x	1	1	1	1	x	1	1	x		1	x		1	1	1	1	1	1		16
(64)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	x	x	x		1	x			16
(71)	1	1	1	x	1	1	1	1	1	1	1	x		1	1	x	x		1	x		1	1		15
(5)	1	x	X	x	1	1	1	x	1	1	1	1	x	x		1	1	1	1	x	x			12
(34)	1	x	1	x	1	1	1	1	1	x		1	x		1	1	1	1	x	x		1	x		13
(26)	1	1	1	1	1	1	1	1	1	1	1					1	1	1	x		1	x		15
(42)	1	1	X	x	x	1	1	1	1	x		1	x	x		1	1	x		x	x		x		9
(27)	1	1	1	x	x	1	1	1	1	1	1	x	x	x		1	1	1	x		1	1		14
(17)	1	1	1	x	1	1	1	x	x	1	1	x		1	x		1	1	1	1	1	1		15
Non-Latinx, non-1st Gen, Masculine																						0
(43)	1	1	X	x	x	1	1	1	1	1	1	x	x	x		1	1	1	x	x	x			11
(40)	1	1	X	x	x	x	1	1	1	1	1	x	x			1	1	x		1	1			11
(60)	1	1	1	1	1	1	1	1	1	1	x	x	x	x		1	x		1	x		1	x		13
(67)	1	1	X	x	1	x	1	x	1	1	x		1	x	x			x	x	x		1			8
(10)	1	x	1	1	1	1	x	x	1	x	x	x		1	x	x		1	1	1	x	x			10
(70)	1	1	1	x	1	1	1	1	1		x	x	x		1	1	1	1	1	1	1	1			15
(54)	1	x	1	1	x	x	x	1	1	1	1	x	x	x		1	x	x	x	x	x				8