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“We can be our best alliance”: Resilient health information practices of LGBTQIA+ individuals as a buffering response to minority stress

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Abstract. This article examines the resilient health information practices of lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) individuals as agentic forms of buffering against minority stressors. Informed by semi- structured interviews with 30 LGBTQIA+ community leaders from South Carolina, our findings demonstrate how LGBTQIA+ individuals engage in resilient health information practices and community-based resilience. Further, our findings suggest that LGBTQIA+ communities integrate externally produced stressors. These findings have implications for future research on minority stress and resiliency strategies, such as shifting from outreach to engagement and leveraging what communities are doing, rather than assuming they are lacking. Further, as each identity and intersecting identities under the LGBTQIA+ umbrella has unique stressors and resilience strategies, our findings indicate how resilience strategies operate across each level of the socio-ecological model to better inform understanding of health information in context.

Keywords: LGBTQ+, Health Information Practices, Minority Stress.

1 Introduction

Relative to their heterosexual and cisgender peers, LGBTQIA+ individuals experience greater health disparities [1] as a result of internal and external stressors produced by stigma and discrimination. These stressors suggest minority stress theory is informative to how LGBTQIA+ persons relate to health care. Minority stress theory holds that prejudice and stigma directed towards members of marginalized populations bring about unique stressors, and these stressors contribute to adverse health outcomes [2]. Research shows that members of LGBTQIA+ communities often actively manage these adverse health stressors via resilient behaviors [2]. Resiliency buffers the negative effect of stressors and allows LGBTQIA+ communities to avoid adverse health outcomes.

To examine how LGBTQIA+ communities are resilient against adverse health stressors, we used an information practices approach, which understands people’s information-related activities and skills as socially constructed [3]. By this definition,

health information practices include creating, seeking, sharing, and using health information. Health information practices may be a key strategy of resilience for LGBTQIA+ populations because health information practices allow individuals to confront and dismantle stressors through collecting, processing, and sharing information to help solve a problem and regain emotional stability [4]. Our research extends minority stress models and examines the resilient health information practices of LGBTQIA+ individuals as agentic forms of buffering against minority stressors. In doing so, our findings challenge views of LGBTQIA+ identities as monoliths and instead recognize that each identity and intersecting identities under the broader LGBTQIA+ umbrella have unique stressors and resilience strategies to buffer against minority stress.

2 Literature Review

2.1 Minority Stress

Minority stress theory describes excess stressors experienced by socially-stigmatized individuals whose position as a social minority results in reduced access to care and increased chronic stress [2]. Stress, defined under this theory, is the result of an "imbalance between the external and internal demands perceived as threatening by an individual and their assessment of the resources available to cope with them" [5] (p. 799). The theory posits that health disparities observed in LGBTQIA+ populations result from persistent stigma directed towards community members. Members of LGBTQIA+ communities experience minority stress through three processes: 1) through the external events that occur in an LGBTQIA+ person's life, such as harassment or discrimination; 2) the anticipation of harassment or discrimination, which leads to increased vigilance or concealment of one's identity, and; 3) the internalization of external negative beliefs and societal prejudice [2]. Through no fault of the LGBTQIA+ individual, such stressors often contribute to poor health.

Minority stress theory accounts for both distal stressors and proximal stressors. Distal stressors encompass objective stressors not dependent on an individual's perceptions, such as prejudice, discrimination, or microaggressions. For example, LGBTQIA+ individuals may experience heteronormativity, the belief that heterosexuality, based on the gender binary, is the default sexual orientation [6]. LGBTQIA+ individuals may experience heteronormative stressors in health care settings. For instance, when a woman who identifies as lesbian confides in her doctor that she is sexually active, the doctor may ask her to take a pregnancy test because they assume she is exclusively engaging in sex with cisgender males.

Proximal stressors are internal processes that follow exposure to these distal stressors, such as the expectation of distal stressors and the vigilance required of this expectation and the internalization of negative societal attitudes [2]. For example, LGBTQIA+ individuals may exhibit proximal stressors by hiding their sexual orientation, as concealment comes through internal psychological processes. The concealment

of LGBTQIA+ identities results in significant psychological distress, such as shame, guilt, and isolation from other LGBTQIA+ community members.

Importantly, however, proximal stressors are subjective and related to self-identity with a minority group. Within minority stress theory, distal and proximal stressors exist as chronic and socially-based experiences, resulting from sociocultural rather than individual conditions. Further, these stressors are unique to individuals with a minority status, as these individuals must adapt to stressors at a greater capacity than those who do not have a minority status [1]. Minority stress theory states that both distal and proximal stressors can lead to adverse health outcomes. These outcomes may include poor mental health outcomes, such as depression, anxiety, and substance use disorders, as well as poor physical health outcomes that are responsive to stress (e.g., asthma) [7].

Stigma and minority stress exist at each level across the socio-ecological model, which emphasizes multiple levels of influence on behaviors and holds that behaviors both shape and are shaped by the social environment [8]. The following levels influence behavior:

1. Intrapersonal: characteristics of the individual, including knowledge, attitudes, and skills. Examples on the intrapersonal level may include identifying as a trans woman or as a person of color.
2. Interpersonal: the individual's social network and social support system, including family and friends.
3. Organizational: organizations and social institutions with formal and informal rules and regulations, such as schools, workplaces, and community groups.
4. Community: relationships between organizations, social environments, and cultural norms.
5. Public policy: local, state, national laws and policies, and the media [9].

[1] examined the health consequences of minority stress on LGBTQIA+ youth across these levels and determined that experiences with distal stressors cause LGBTQIA+ individuals to be vigilant of their social environment to anticipate and avoid stigmatizing encounters. Repeated encounters with distal stressors led LGBTQIA+ individuals to ruminate, a maladaptive emotion regulation strategy characterized by a repeated focus on the causes and symptoms of distress. Individuals with a high degree of life stress develop increasingly ruminative tendencies, and LGBTQIA+ individuals tend to ruminate more than their cis, heterosexual peers. Further, [1] found that proximal stressors on the intrapersonal level included LGBTQIA+ individuals engaging in concealment behaviors, wherein the individual hides their identity to avoid future victimization. In addition to encountering minority stress at the intrapersonal level, LGBTQIA+ individuals face distal stressors on the interpersonal level. Stressors on this level may include intentional prejudice and discrimination but may also include unintentional actions such as microaggressions. For instance, when an individual asks a man who identifies as gay if he has a girlfriend, that individual engages in a microaggression as they are endorsing heteronormative culture and thus reinforcing heterosexuality as a cultural default.

LGBTQIA+ individuals also experience distal stressors on the organizational, community, and public policy levels. For instance, on the organizational level, LGBTQIA+ youth may experience discrimination at school when LGBTQIA+ student organizations are not permitted to form and operate on the same terms as all other student organizations. Further, LGBTQIA+ individuals may experience stressors resulting from cultural norms, such as heteronormativity, on the community level. Lastly, stressors on the public policy level, such as laws that prohibit public schools from including same-sex health topics into the curriculum, constrain the opportunities, resources, and well-being of LGBTQIA+ individuals.

2.2 Resiliency of LGBTQIA+ Individuals

[2] suggested that LGBTQIA+ individuals respond to minority stress with resilience. Resilience is the "process of positive adaptation to significant threats to well-being" [10] (p. 1436). Thus, resilience relies on the availability, accessibility, and strategic use of resources. These resources may exist at any level of the socioecological model, and factors promoting resilience may include the interaction of resources among the five levels. LGBTQIA+ individuals employ resilient strategies that are sustainable, developmentally appropriate, and reinforced by the environment [10].

It is further imperative to distinguish between individual and community-based resilience within minority stress frameworks. Individual-based resilience emphasizes personal agency concerning the qualities an individual possesses that help them cope with stress (e.g., sense of coherence and hardiness). Focusing exclusively on individual-based resilience limits efforts to develop effective interventions and policies, as not every LGBTQIA+ individual has the same resources or opportunities to enact resilience. Underlying social structures are often unequal, as the social, economic, and political structures that create opportunities for success in society are not equally distributed [7]. Thus, social disadvantages such as racism, socioeconomic status, and sexism limit individual resilience.

On the other hand, community-resilience refers to how communities provide resources that help individuals develop and sustain well-being [7]. Community- resilience focuses on resilience in ecological contexts, emphasizing social resources, such as friends who also identify as LGBTQIA+ or information sources developed by grassroot LGBTQIA+ communities, rather than individual traits. However, members of specific segments within LGBTQIA+ communities may not benefit equally from community-resilience due to structural inequalities within the community itself. For instance, racism, biphobia, and transphobia deprive individuals with select identities of community resilience. As our research will show, it is crucial to understand that LGBTQIA+ experiences intersect alongside other lived experiences, many of which face their own minority-based stressors [11]. As with all discussed forms of resiliency, several intervening factors on the intrapersonal, interpersonal, organizational, community, and public policy levels shape resilient health information practices. As such, the social and

cultural environment affects the information channels and sources an individual uses [12]. Thus, individual knowledge and attitudes, relationships with friends and family, socioeconomic circumstances, and physical and social environments affect individuals' health information practices.

2.3 Health Information Practices of LGBTQIA+ Individuals

LGBTQIA+ people face significant social and discursive barriers due to heteronormativity (i.e., the presumption that all people identify as heterosexual) and cisnormativity (i.e., the presumption that all people identify as a gender that matches their sex-assigned-at-birth) [13]. Furthermore, it is essential to attend to intersectionality and its relationship to the presumed monolith of the LGBTQIA+ identity. According to [11], intersectionality acknowledges that individuals do not experience a given identity singularly. Instead, they live with various experiences of social differences grounded within identities such as class, race, ability, and age. As a result of these barriers and intersectionalities, LGBTQIA+ populations often postpone seeking treatment or healthcare from health resources and health professionals at a 30% greater rate than cisgender individuals, thus increasing LGBTQIA+ individuals' risks to health and well-being [14]. These delays in seeking help often result in LGBTQIA+ individuals engaging in resilient health information seeking practices. LGBTQIA+ individuals seek, share, and use health information in various ways and for many different reasons; however, due to their marginalization and lack of acceptance from the larger society, there are barriers to information. These barriers are perpetuated by systems that discriminate against LGBTQIA+ individuals, driving them to consider new ways of seeking information that circumnavigates oppressive systems [14]. For instance, previous research focusing on health information practices and behaviors found that LGBTQIA+ communities engage with health information and health resources in ways that are socially and medically understood as harmful to one's health and well-being [15]. Additionally, while these engagements are distinct and vary by community, nearly all are produced by the ongoing marginalization and discrimination of LGBTQIA+ individuals [15].

There is limited research on the health information practices of LGBTQIA+ individuals. Thus, it is imperative to further research in the area using minority stress theory and models to examine how LGBTQIA+ individuals engage in resilient health information practices to adapt to and overcome minority stressors in their environments. The research questions below informed our approach to examining resilient health information practices of LGBTQIA+ individuals,

2.4 Research Questions

R 1. How do members of LGBTQIA+ communities experience minority stress on each level of the socio-ecological model?

R 2. How do members of LGBTQIA+ communities engage in resilient health information practices on each level of the socio-ecological model as a response to minority stress?

Semi-structured interviews with 30 community leaders in South Carolina informed our research.

3 Methods

This research is part of a more extensive investigation (University of South Carolina IRB approval number Pro0008587) funded by an Institute for Museum and Library Services Early Career Development Grant that examines the health information practices of LGBTQIA+ communities. As such, the methodology and findings discussed in this paper specifically focus on applying deductive codes to the data after we conducted semi-structured interviews with 30 LGBTQIA+ community leaders from South Carolina. Speaking with individuals in South Carolina elicits the social and structural barriers that are distinct to the area.

We selected community as our unit of analysis as LGBTQIA+ individuals are more effective when exhibiting community resilience. For the study, we defined community as possessing three criteria: 1) community members conduct the majority of their work in South Carolina; 2) their work is social and involves group-oriented engagements; and 3) members collectively possess LGBTQIA+ identities [16-17].

Informed by these criteria, we engaged in purposive sampling by identifying over 100 LGBTQIA+ groups and organizations in South Carolina and then asking them to self-nominate leaders for participation in the study. During the interview process, we engaged in snowball sampling by asking participants to recommend additional participants. Finally, we used theoretical sampling to identify participants from informal communities, such as social media-based LGBTQIA+ groups, which we may not have identified in our initial purposive sampling.

Before interviews, participants filled out a pre-interview questionnaire, providing demographic information. During interviews with participants, we asked about their involvement with their communities, their personal and community identities, and how they and their communities addressed health questions and concerns. We then asked participants to partake in an information world mapping exercise where participants drew people, places, and things that helped or did not help them address their health questions and concerns [18].

We used interview transcripts as the data source for this article. We analyzed the data using a deductive coding process to develop a provisional list of primary codes established in minority stress theory literature and informed by the above literature review. These primary codes include stressors, distal stressors, proximal stressors, and resilient health information practices, using definitions from [7]. We further coded

these four primary codes according to the appropriate level of the socioecological model in which they occur (e.g., intrapersonal, interpersonal, organizational, community, and public policy). We applied these codes to the interview transcripts using sentences as our unit of observation.

4 Findings

4.1 Participant Demographics

The majority of our study's participants were young adults between the ages of (18-25: n=11; 36.7%) and middle-aged adults between the ages of (35-54: n=7; 23.3%). The remainder of our study's participants were adults aged 55 and older (n=5; 16.7%) and teenagers between the ages of (13-17, n=4; 13.3%). For more information regarding working with LGBTQIA+ teens for this project, see [15]. Participants selected from a series of racial and ethnic identities with the ability to add identities not listed. The majority of participants identified as white (n=18; 60%), while (n=7; 24%) identified as Black, (n=2; 7%) identified as Black and white, (n=1; 4%) identified as Black and Afro-Caribbean, (n=1; 4%) identified as Aboriginal, Arab/West Asian, Black and white, and (n=1; 4%) as Black, white, and Egyptian. The majority of participants lived in the Upstate and Midlands regions of South Carolina.

Participants self-labeled their LGBTQIA+ identity. Among the identities participants labeled themselves as lesbian, gay, queer, transgender, genderqueer, and bisexual were most prevalent. For more information on demographics, refer to [15].

Participant narratives illustrated three significant findings:

1. LGBTQIA+ individuals engage in resilient health information practices on all socio-ecological levels
2. Community-based resilience characterizes collective health information practices
3. LGBTQIA+ sub-communities and LGBTQIA+ individuals with intersecting minority identities integrate externally produced stressors

We will illustrate these findings using participant narratives that exemplify our four deductive codes. We refer to participants in this section using their provided pronouns and self-selected pseudonyms to protect individual privacy.

4.2 Finding 1: LGBTQIA+ Individuals Engage in Resilient Health Information Practices on All Socio-Ecological Levels

In the context of their health information practices, participants engaged in resiliency against stressors on every level of the socio-ecological model. On the intrapersonal level, participants engaged in resilient health information practices by successfully adapting to knowledge gaps. Annalisa, a white, young adult who identifies as a cisgender female lesbian, explains how she successfully adapts to her knowledge gap by

just doing research on [my] own to try to make sure you're getting the correct standard of care. See what you actually need and try to talk to different people who have maybe gone through it and had a better experience than you to see what your baseline should be.

In this instance, Annalisa is showing resilience against an intrapersonal minority stressor, lack of knowledge, "because maybe you don't know and you think the doctor's doing things correctly, but maybe they're not addressing something." By researching to determine the general standard of health care "that a straight person could go in and get," Annalisa is displaying resilient health information practices on the intrapersonal level through the reliance on the availability, accessibility, and strategic use of resources, such as the internet and other community members to find answers to her health care questions.

On the interpersonal level, participants engaged in resilient health information practices by successfully adapting to interpersonal minority stressors. Whitney, a white young adult who identifies as a cis-woman lesbian, described the interpersonal minority stressor of LGBTQIA+ individuals having "families that aren't as accepting." However, Whitney engages in resilient health information practices on the interpersonal level by:

Being someone for someone. People have come out to me throughout the years. They've talked to me about their home life. I've met people's parents. They've all met my mom [...] being able to bring my mom down and have them [...] have someone that is a motherly figure, that does accept them, that was really amazing. Just seeing people feel the safety and acceptance that I feel.

While Whitney's community members may experience minority stress related to lack of acceptance by their families, Whitney helps them engage in resilient health information practices by encouraging interaction between members of their social network.

Other participants engaged in resilient health information practices by successfully adapting to stressors on the organizational level through their community organizations. Justin explained how his organization engages in resilient health information practices on this level. Salient identities of Justin include white, middle-aged, cis-male, and gay. During his interview, Justin said:

That's one thing that we have done is try to start providing resources and lists of things like friendly churches but also friendly health care providers, and especially addressing the needs of the trans community...so we are not trying to be the resource for everything. But we're trying to be the conduit to get people to the resource.

Through this example, Justin shows how his organization engages in resilient health information practices on the organizational level. His community group successfully adapts to stressors and provides community members with resources that sustain their well-being, such as lists of LGBTQ-friendly doctors, or refers them to resources that can help them maintain it.

On the community level, participants engaged in resilient health information practices by successfully adapting to community-level minority stressors. During her interview, Pat, a young adult who identifies as a trans woman of color, discussed cultural stigma surrounding queer girls, saying, “There is already shame around being a sexually promiscuous young person, but then to also add queering that just compounds the struggle.” As a result of these cultural norms surrounding queer youth, LGBTQIA+ people must engage in resilient health information practices. Pat explains, “I think that a lot of the structural prejudices that we face contributes most to why, or at least the specific kinds of ways, that we engage in unhealthy practices or health practices that are detrimental to us.”

Finally, participants engaged in resilient health information practices by successfully adapting to public policy-level minority stressors. One public policy stressor that arose in a participant's interview was same-sex education in schools. Vada, a white young adult who identifies as lesbian, explained that same-sex education is illegal to discuss in South Carolina. She detailed an example in which she was trying to “explain how sex education is better and it needs to be done in schools, and older women, in particular, were like ‘Well, we can’t legally do that.’” As a response to this stressor, Vada conducted panels for same-sex education in schools, which shows resiliency as she adapted to these constricting laws and took it upon herself to educate her LGBTQIA+ peers on sexual health.

4.3 Finding 2: Community-Based Resilience Characterizes Collective Health Information Practices

Participants engaged in community-based resilience through collective health information practices by utilizing social resources within their LGBTQIA+ communities rather than relying on individual traits. The health information practices participants engaged in are collective in that participants and their community members work together to adapt to stressors in their environments positively. For instance, Shateria Cox, a Black, white, and Egyptian gender non-conforming youth, recounted how she and her community members engaged in community-based resilience by providing social and informational resources that help other community members cope with stress and maintain their well-being. She stated, “We can be our worst enemy, and we can be our best alliance.” Shateria Cox expands on this by saying, “There’s a lot of websites run by our community that have information or values that may teach or help others learn about our healthcare.” She then goes on to include “friends, acquaintances from people that we’re aligned with.” Shateria Cox and her community members “use our own resources” and “ask somebody that’s already part of the community” as resilient health information practices. Shateria Cox continues to show community-based resilience as she says

I’m not afraid to ask questions, put myself in the conversation, or ask questions to somebody and teach somebody about - because I have something that you may not

know, and you have something that you could teach me. I could teach you something. You can teach me. We can all teach each other something. And I'm not afraid to ask questions and teach somebody. If they need to know something and they ask me, I'm going to tell them about something.

Engaging in dialogue and teaching others is an example of community-based resilience as Shateria Cox's community works together to provide and share resources (i.e., shared knowledge) regarding mental health. In this example, community members act as social resources. This community's health information practices are collective as community members are motivated by one common issue, an information need, and work together to bridge that gap by sharing the community's collective knowledge among one another. The use and sharing of social resources allow Shateria Cox and her community to cope with stress and develop and sustain well-being within their environment.

Alternatively, Tony Solano, a white young adult who identifies as a gay man, explains how his organization uses community-resilience to address minority stressors, such as stigma and access, to PrEP. His organization engages in this style of resilience by

Doing events where we would bring everybody together and would have a quick campfire about HIV and other STDs. And how to prevent them, stay healthy, how to recognize them, and most importantly, to be open with your sexual partner that you do have something you guys can discuss that. We also work with a couple of different vendors that give us condoms and other products that we're able to give out for free. So, if cost is an issue, we just remove that all together.

Tony Solano and his organization engage in community resilience as the organization collects social resources to address an identified stressor. They use social resources on the interpersonal level, in which members of the organization utilize collective knowledge to discuss prevention and recognition of HIV and STDs. This, in turn, allows Tony Solano and his community to mitigate both their community and individual risk of transmitting or contracting STDs. Lastly, they also use resources on the community level, where the organization works in partnership with other vendors to provide community members with condoms and other preventative measures against STDs.

4.4 Finding 3: LGBTQIA+ Sub-Communities and LGBTQIA+ Individuals with Intersecting Minority Identities Integrate Externally Produced Stressors

Our findings indicate that LGBTQIA+ individuals experience minority stressors that begin externally and become integrated at the community level. Stressors emerge iteratively so that a stressor's production on one level influences a stressor's production on another level, creating a blend of intrapersonal, interpersonal, organizational, community, and public policy level minority stressors.

Following Vada's discussion of no promo homo laws, Vada described a distal stressor on the public policy level regarding sex education in public schools. Vada states, "I also know that people who were raised here don't get a very good sex education in school...it's illegal to discuss same-sex relationships" in South Carolina. This stressor on the public policy level then trickles down to an organizational level, as public schools cannot incorporate same-sex education into their curriculum. This stressor then integrates into the LGBTQIA+ community on an intrapersonal level as LGBTQIA+ youth may lack knowledge about safe sex practices, "meaning that they have no idea how to be safe about it."

Tessie, a white, middle-aged female who identifies as a lesbian, also identified barriers as those impacting her and "barriers for the community," explaining why her community no longer hosts LGBTQIA+ resiliency groups. Tessie states, "If you're dealing with parents that tell you that you are an abomination, why would kids want to gather around that? That's internalized." In this narrative, Tessie indicates that prejudice - a distal stressor on the interpersonal level - integrates into the LGBTQIA+ community in the form of internalized homophobia - a proximal stressor on the intrapersonal level.

Other examples of stressors externally produced community-level health information practices include division between different identities within LGBTQIA+ communities. Shannon, a middle-aged woman who identifies as a Black and lesbian, noted this integration in her interview. She recounted an example of a woman at a PFLAG meeting who experienced discrimination due to her bisexual identity. Shannon recounted how this woman

went on this crazy tirade about how there's so much bi-visibility and bi-erasure, and she wasn't going to stand for it, and the gay and lesbian community always got all the resources and always got this, and bisexual people and pansexual people and other more sexually fluid people were always left out.

Distal stressors work at the interpersonal level in this narrative. The woman Shannon described experienced a distal stressor (i.e., an external event) in the form of erasure, as the social network excluded her for not identifying as either gay or lesbian. The women implied in this account that she was denied the resources afforded to other members in the social network who identified as either gay or lesbian.

Further, Whitney explains how externally produced stressors manifest within her community

We get backlash or discrimination based on who we're dating, who we're with, our preference. A lot of ways where LGBTQ people can't feel safe comes from people outside of that community. It happens in the community as well.

Whitney notes that distal stressors occur on multiple levels of the socio-ecological model, such as interpersonal, and are then integrated into the community itself. Whitney expands on this, saying

There's so much transphobia within the LGBTQ community, biphobia within gays and lesbians, homophobia from other places. It can be pretty polarizing at times when people grab onto their identity and don't support the other ones within that community.

In this example, Whitney indicates how externally produced distal stressors of prejudice become integrated into the LGBTQIA+ community, resulting in community members displaying prejudice against members of different identities even if those identities are within the LGBTQIA+ spectrum. Thus, while community members fall under the larger umbrella of LGBTQIA+, Whitney addresses the issue of intersectionality, in that falling under this broader umbrella does not guarantee that all needs and experiences are the same for each unique identity.

5 Discussion and Implications

5.1 Stressors are Integrated into LGBTQIA+ Communities

An emergent theme from our research indicates that while communities are central for collective, community-based resilience, stressors still exist within them. While LGBTQIA+ individuals experience stressors within their communities, these communities are not the producer of stressors. Intersectionality is critical to note as different identities under the broader LGBTQIA+ umbrella will experience different stressors and engage in different health information practices to adapt to these stressors. For example, racial identities produce different stressors, though individuals may share the same LGBTQIA+ identity. Shateria Cox noted this in her interview, saying

Since racism is a system, systematically Black people don't have any power in the United States...the economy was built to support the well-being of white folks and white supremacists. Very rarely see a black folk that has money or power or in office.

These unique stressors do not disappear in the LGBTQIA+ community simply because members share a common gender identity or sexual orientation. Instead, they remain rather prominent either through ignoring the needs of systemic racism or ignoring the racist histories latent within LGBTQIA+ activism. While members may share a larger identity of LGBTQIA+, their intersecting identities, such as race, differ, and so do their stressors. Shateria Cox highlighted the importance of addressing intersectionality within the larger LGBTQIA+ community, specifically naming Kimberlé Williams Crenshaw, the developer of the theory of intersectionality, to explain how "Black, queer, and trans folk are the ones that set everything out for everybody...regular gays ain't do shit for nobody. That was Black, queer, and trans folks."

As demonstrated by this quote, it is critical to understand that LGBTQIA+ people are not monoliths. Different communities, with varying intersecting experiences of social difference, will create, seek, use, and share health information in various ways. Further, the types of communities LGBTQIA+ individuals are involved in can factor into their information practices. For example, leaders of informal LGBTQIA+ communities, such as ones that do not receive grant funding, might not have to follow specific rules within how they do information practices as they can do so without a potential threat to funding. In contrast, receiving grant funding might prohibit certain information

practices for other communities. It is important to note that neither is right nor wrong per se, but these contexts inform their information practices.

For these reasons, practitioners must get a sense of the important identities other than LGBTQIA+, as these inform people's engagements with health information, and tailor information-based solutions to address stressors based on our knowledge that they are intersectional informed. For instance, when a trans individual seeks information from a physician, the physician should also consider other important identities, such as race and socioeconomic status. The physician should identify all important identities to ensure that the information they share is racially and financially appropriate, as well as appropriate to their trans identity.

5.2 Relationship between Health Information Practices and Resilience

Another emergent theme from our research demonstrates the relationship between health information practices and resilience. This finding shows that resilience operates agentically at every level of the socio-ecological model. This study furthers [19]'s work pushing back against deficit orientations within information practices and behavior research [20]. In their work, [19] emphasized the need to resituate the concept of information poverty to refocus the blame away from individuals experiencing marginalization. Instead, we should focus on the contextual conditions that create information poverty, thus acknowledging individual and community health information practices as responses to marginalization. Our findings revealed that LGBTQIA+ individuals and communities are already employing resilient health information practices. Thus, our findings show that there is nothing inherently wrong with LGBTQIA+ individuals, both medically and informationally. Therefore, the locus of blame should not be placed on the communities but on the social and structural factors elicited by the socio-ecological model that produces stressors and information barriers.

Understanding how these stressors and barriers operate will allow us to identify potential information-based interventions. One such intervention could involve shifting from outreach to engagement, as providing access to information on its own will not rectify information inequities experienced by LGBTQIA+ communities. Instead, practitioners should employ engagement models to partner with LGBTQIA+ communities, allowing the communities to dictate how practitioners can leverage expertise to promote community health. Additionally, interventions should leverage what LGBTQIA+ communities are already doing, rather than assuming that the communities lack information or resources. Thus, practitioners should serve as a connector - connecting LGBTQIA+ individuals to not only health resources and information but to one another. Finally, when developing interventions, practitioners should understand health information in context. For instance, when a person shares their LGBTQIA+ identity, people should consider how these identities may inform what types of health information are relevant to them. Further, practitioners should recognize that when an LGBTQIA+ individual receives health information, the practitioners' information and

how affirming they are of LGBTQIA+ individuals and health concerns are likely to be shared within and among communities. Moreso, when understanding health information in context, it is imperative to understand that LGBTQIA+ people are not monoliths. Different communities, with varying intersecting identities, under the broader LGBTQIA+ umbrella, will have different health information practices. Thus, practitioners need to recognize the unique, intersecting identities of LGBTQIA+ individuals to inform people's engagements with health information. These findings support previous research on community resilience and efficacy wherein efficacy frameworks traditionally influenced how health information professionals implement changes in behavior for LGBTQIA+ communities while failing to understand the complex experiences informing LGBTQIA+ health practices [21].

6 Limitations

As mentioned in our methods section, we interviewed 30 LGBTQIA+ community leaders from various age groups, racial and ethnic backgrounds, educational levels, regions, and identities within the broader LGBTQIA+ community. However, we do not have accurate representation from community leaders from "hidden" communities, such as Latinx LGBTQIA+ groups, working-class LGBTQIA+ individuals, and queer sex workers. Another limitation of our study is that we did not ask participants about minority stress in general during interviews; instead, we applied the codes deductively to the larger study. In future work, we could more deliberately ask these questions instead of framing them.

7 Conclusion

Health information practices are a vital strategy of resilience for LGBTQIA+ communities. As evidenced in minority stress literature and our findings, LGBTQIA+ individuals experience minority stressors on every level of the socio-ecological model. In turn, these stressors, which are externally produced, are integrated into LGBTQIA+ communities. These stressors emerge iteratively so that when a stressor is produced on one level, it influences a stressor's production on another level, thus creating a blend of intrapersonal, interpersonal, organizational, community, and public policy level minority stressors. However, members of these communities survive and even thrive despite this stress. Such survival in the face of layered and routinized stressors suggests a necessary reconstitution of how we understand the failure of health information practices to exist within LGBTQIA+ communities. We must note that the failure is not of their doing, but a failure to be seen and represented adequately by society at all levels of the socio-ecological model [22]. In turn, we must ask how health information systems can better facilitate the needs of LGBTQIA+ persons instead of assuming their failure to fit

within such frameworks necessitates correction on the part of the communities themselves.

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