Discursive power and resistance in the information worlds maps of LGBTQIA+ community leaders

Vanessa Kitzie
*University of South Carolina*, kitzie@mailbox.sc.edu

Travis L. Wagner
*University of South Carolina - Columbia*, wagnertl@email.sc.edu

Alexander N. Vera
*University of South Carolina - Columbia*, veraan@email.sc.edu

Follow this and additional works at: [https://scholarcommons.sc.edu/libsci_facpub](https://scholarcommons.sc.edu/libsci_facpub)

Part of the Gender, Race, Sexuality, and Ethnicity in Communication Commons, Health Sciences and Medical Librarianship Commons, and the Social Justice Commons

Publication Info

This Article is brought to you by the Information Science, School of at Scholar Commons. It has been accepted for inclusion in Faculty Publications by an authorized administrator of Scholar Commons. For more information, please contact digres@mailbox.sc.edu.
Discursive Power and Resistance in the Information Worlds
Maps of LGBTQIA+ Community Leaders

<table>
<thead>
<tr>
<th>Journal:</th>
<th><em>Journal of Documentation</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manuscript ID</td>
<td>JD-08-2020-0138.R1</td>
</tr>
<tr>
<td>Manuscript Type:</td>
<td>Article</td>
</tr>
<tr>
<td>Keywords:</td>
<td>Behaviour, Communities, Health, Maps, Postmodernism, Research methods, Social sciences</td>
</tr>
</tbody>
</table>
Title
Discursive Power and Resistance in the Information Worlds Maps of LGBTQIA+ Community Leaders

Abstract

Purpose: This qualitative study explores how discursive power shapes South Carolina LGBTQIA+ communities' health information practices and how participants resist this power.

Design/methodology/approach: Twenty-eight LGBTQIA+ community leaders from South Carolina engaged in semi-structured interviews and information worlds mapping – a participatory arts-based elicitation technique – to capture the context underlying how they and their communities create, seek, use, and share health information. We focus on the information worlds maps for this paper, employing situational analysis – a discourse analytic method for visual data – to analyze them.

Findings: Six themes emerged describing how discursive power operates both within and outside of LGBTQIA+ communities: 1) producing absence, 2) providing unwanted information, 3) commoditizing LGBTQIA+ communities, 4) condensing LGBTQIA+ people into monoliths; 5) establishing the community's normative role in information practices; 6) applying assimilationist and metronormative discourses to information sources. This power negates people's information practices with less dominant LGBTQIA+ identities and marginalized intersectional identities across locations such as race and class. Participants resisted discursive power within their maps via the following tactics: 1) (re)appropriating discourses and 2) imagining new information worlds.

Originality: This study captures the perspectives of an understudied population – LGBTQIA+ persons from the American South – about a critical topic – their health – and frames these perspectives and topics within an informational context. Our use of information worlds mapping and situational analysis offers a unique and still underutilized set of qualitative methods within information science research.

Introduction

While equitable access to health information is a preeminent goal among patients, practitioners, and information professionals, inequity along sociocultural lines remains. Lesbian, gay, bisexual, transgender, and queer (LGBTQIA+) populations face aggravated relationships with power that uniquely shape their engagement with health information. This paper presents qualitative findings informed by situational analysis of 28 information world maps created by LGBTQIA+ community leaders in South Carolina (SC) depicting how their communities create, seek, share, and use health information. These findings address the following research questions: (1) How does discursive power within and outside of SC LGBTQIA+ communities shape their health information practices? (2) How do participants resist discursive power on their information worlds maps?

Literature Review

Whether through correction or lack of inclusion, healthcare discursively marks LGBTQIA+ bodies as other. This demarcation produces spaces where LGBTQIA+ people must negotiate their relationships differently, both internal and external, with healthcare institutions. Our work envisions discursive power and resistance as operating when LGBTQIA+ people create, seek, share, and use health information.
Discursive Power and LGBTQIA+ Health

Discourses consist of the relationships between people, texts, ideas, and institutions within a particular socio-historical context. Power orders these elements based on proximity to the desired ideal; the meanings attached to this ordering constitute knowledge (Foucault, 1981). We define discursive power as the knowledge and practices considered normal or acceptable within society. For Western LGBTQIA+ people, historical relations to power – whether legal, economic, social, or otherwise – have occurred through intensified surveillance and demarcation as different from the norm. Bodies whose existence challenged Victorian era regimes of reproductive heterosexual familial structures became subject to correction through imprisonment, hospitalization, and death under the guise of medical science (Foucault, 1981).

Discursive power manifests as homo-bi-transphobia – i.e., fear, hatred, or discrimination against people who are gender variant and not straight – and hetero-cis-normativity – i.e., presuming all people are heterosexual, and a person’s gender matches their sex assigned at birth. Examples of homo-bi-transphobia include conversion therapy, a pseudo-psychological or religious practice that seeks to remove a person’s same-sex desires and replace them with a rigid, “pure” heterosexual identity (Waidzunas, 2015), and physical violence directed at people perceived to be transgender (Landers and Kapadia, 2017). Examples of hetero-cis-normativity include school sex education that only focuses on heterosexual, reproductive sex (McNeill, 2013), lack of healthcare accessibility and affordability for LGBTQIA+ healthcare issues (Lerner and Robles, 2017; Romanelli and Hudson, 2017), and lack of community competency among medical professionals (Gridley et al., 2016; Hayman et al., 2013; Oswałd et al., 2016).

These discourses and subsequent barriers to care produce constant stressors within LGBTQIA+ persons, resulting in poor physical and mental health outcomes, including higher rates of obesity, chronic illness, smoking, mental distress, substance use disorder, anxiety, and suicidality compared to non-LGBTQIA+ populations (Hughes et al., 2017; Katz-Wise et al., 2017; Romanelli and Hudson, 2017). People with varying identities within the LGBTQIA+ umbrella experience distinct health disparities. For instance, fear of violence or trauma associated with being a survivor of violence produces significant stress among transgender people (Landers and Kapadia, 2017).

LGBTQIA+ people in the American South may experience more pronounced stressors since these regions have more conservative views of sexuality and gender on average (Harless et al., 2020; Matthews and Lee, 2014). These views are expressed systemically in laws and policies. For instance, in SC, where this study is situated, it is illegal to discuss same-sex health issues in public schools (South Carolina Code of Laws, 1988), conversion therapy is legal (Majchrowicz and Wildema, 2018), and state leadership has rejected Medicaid funding, leading to the shutdown of medical offices and hospitals in rural areas (Floyd, 2019). These contextual conditions produce an environment where LGBTQIA+ residents experience heightened economic instability, unemployment, and lack of health insurance (Mallory and Sears, 2019).

Resistance to Discursive Power

Those coerced by discursive power can engage in tactical resistance. One tactic is repeating and reproducing dominant discourses to challenge them. Butler’s (1988) concept of gender performativity illustrates these “reversed discourses” (Foucault, 1981, p. 101) by framing gender as a “stylized repetition of acts” (Butler, 1988, p. 520). Because gender is citational and enacted, rather than innate, its performance is always subject to breakdown, illuminating that no “true or
false” version of gender exists. Breakdowns can motivate people to reflect upon their gender
identities and their construction in relation to discursive power.

Resistance can also manifest as a person (re)producing their narrative using "techniques
of the self" (Foucault in Habermas, 1994, p. 86), like keeping diaries. These techniques can give
people the freedom to escape from and imagine new ways of being that exist outside of
discursive power. An example would be using poetry as a method of emotion-driven expression
to counteract the value that white supremacy and patriarchy place on quantifiable, logic-driven
language (Lorde, 1984).

Within the LIS field, resistance also remains underexamined, with exceptions echoing the
aforementioned critical scholars. Radford and Radford (1997), for example, take up Foucauldian
notions of knowledge to consider how, if at all, feminism informs the stereotypes aligned with
female librarianship and what role their work offers in actually resisting discursive power.
Alternatively, Kester (1997) evokes Lorde’s ideas of black self-expression to assert that for queer
librarians of color, the mere presence and sharing of knowledge upsets paradigms of
librarianship. Trace’s (2008) idea of producing documents within social settings – in her case,
education – speaks to the potential for information creation to be a site of resistance, one whose
bounds show an ability to both adapt to and undermine the logics of knowledge production.

Research examining LGBTQIA+ health has not examined resistance. Traditionally, such
research has instead focused on health risks and deficits. Recent work adopting social
determinants of health approaches examines resilience or bouncing back despite adverse
outcomes (Gahagan and Colpitts, 2017). While resilience is a vital concept, it focuses on how
people consistently react to discursive power, rather than addressing ways to counteract such
power.

Information Practices of LGBTQIA+ Populations
Information practices are distinct from behaviors because they focus on how social and cultural
factors qualify creating, seeking, use, and sharing (Savolainen, 2008). These factors orient
people toward certain types of information and ways of interacting with it. Hawkins, Morris,
Nguyen, Siegel, and Vardell (2017) contend that LGBTQIA+ populations’ health information
practices are distinct from those of cisgender, heterosexual people due to their unique, yet
interrelated experiences of homo-bi-transphobia and hetero-cis-normativity. Information
behavior and practices literature examining LGBTQIA+ populations illustrates this argument.
Findings denote that these populations engage in specific practices like satisficing to locate
media representations that are “good enough” amidst a dearth of LGBTQIA+ related information
(Floegel and Costello, 2019). Practices may exhibit resilience by protecting and defending
individuals and communities against perceived and experienced adverse outcomes (redacted).
Further, LGBTQIA+ populations may establish new information value systems, such as relying
on embodied cognition and sensory information to make sense of their transgender identity
(Huttunen et al., 2019). These populations also perform acts of resistance, such as authoring
slash fanfiction that departs from the traditional, hetero-cis-normativity embedded in media
narratives (Floegel, 2020).

Aside from this small, but vital body of work, there is a lack of understanding of how
discursive power shapes LGBTQIA+ health information practices or how it may seep into
LGBTQIA+ community dynamics. How LGBTQIA+ individuals resist discursive power within
health informational contexts also remains unexplored. This understanding is critical for
stakeholders such as medical professionals and health librarians to address stressors and barriers
produced by discursive power that negatively impact LGBTQIA+ health information practices. Identifying ways that LGBTQIA+ populations already resist this power can inform these strategies.

**Methods**

We completed 30 semi-structured individual interviews with SC LGBTQIA+ community leaders from January – August 2019. We selected SC as a geographical context because LGBTQIA+ residents experience more severe health challenges and stressors compared to national averages as addressed in the above Literature Review. Community served as our unit of observation, given the observed importance of community involvement in LGBTQIA+ health information practices (Veinot et al., 2013). We assumed that leaders are vital stakeholders within their communities and can provide a bird’s-eye view of their everyday practices.

We recruited community leaders by contacting visible SC LGBTQIA+ communities and affinity groups via email and asking them to nominate leaders to participate. We defined a leader as someone who “actively engages with others to accomplish change” (Komives et al., 2013, p. 22). Under this definition, leaders could be positional – they have a title and defined responsibilities for decision-making and action – or transformational – they have a desire to empower others to enact social change. Transformational leaders do not necessarily have titles (Komives et al., 2013; Renn, 2007). Existing constructs in fields like sociology and geography informed community criteria (Hillary, 1995). We included youth ages 13-17 in our sample due to dynamic youth LGBTQIA+ leaders (Weiser, 2018; Worthen, 2014). Since some youth wished to participate without outing themselves to a parent or guardian, we obtained an IRB waiver of informed consent and instead collected youth assent (see also Steinke, Root-Bowman, Estabrook, Levine, & Kantor, 2017). Additional snowball sampling occurred at the end of each interview when we asked leaders to recommend other participants. Since data collection and analysis were iterative, we used theoretical sampling to identify perspectives that could flesh out or potentially contradict new findings.

Interviews occurred face-to-face at a location of the participant’s choosing. Topics centered on the community’s health questions and concerns and how they addressed them. Following the interview, participants engaged in information world mapping (IWM). We focus on the participants’ information world maps for this paper. IWM is a participatory arts-based elicitation technique (Greyson et al., 2017). Informed by theorizations of information grounds, horizons, ecologies, and worlds, IWM captures participants’ conceptual geographies inclusive of elements such as place/space, social context, people, and technologies. The method is most indebted to Sonnenwald’s (1999) information horizon concept, which describes what information sources are available to people based on context and situation. This concept is well-suited for spatial metaphors as it describes what is phenomenologically in-reach within the lifeworld (Savolainen, 2007).

IWM empowers socially marginalized participants to define and depict their information worlds and elicits in-depth information about participants’ everyday information practices in context (Greyson et al., 2017). IWM is a relatively nascent method and has been applied within health information contexts to elicit the information practices of young parents (Greyson, 2017), individuals relocating to urban spaces (Lingel, 2015), and family caregivers’ health information work (Dalmer, 2017, 2019). There does, however, exist some precedent for the use of IWM at the intersection of health information practices and LGBTQIA+ populations, as evidenced by Freund et al.’s (2016) use of the method with LGBTQ youth. While creators of this technique
initially viewed it as supplementary to interviews, their recent work demonstrates that situational analysis of maps contributes insights beyond the analysis of interview transcripts alone (Greyson et al., 2019).

For this exercise, we gave participants a handout adapted from Greyson et al. (2017) and verbally reviewed the handout. The handout asked participants to put their communities on a piece of paper and draw the people, places, and things influencing how their communities create, seek, share, and use health information. It also offered specific prompts for participants to consider including on their maps. We gave participants blank pieces of white paper and various drawing tools, including pens, colored pencils, and markers (scented and unscented), to make the drawings. It was common for participants to express some degree of hesitancy before drawing by making comments such as “oh no,” or “I’m not an artist.” Over time, we learned to modify our interview protocol accordingly, forewarning participants of a drawing exercise and stressing that there was no right or wrong way to make the drawing. We also used humor to ramp down participant insecurities. For instance, the lead author often joked that her idea of high art was cartoons. We found offering scented markers also assuaged these insecurities as several participants commented on these markers offering a sense of nostalgia. In other cases, we observed participants who appeared more at ease when drawing than when being verbally interviewed, which confirms the usefulness of IWM as an elicitation technique that can triangulate other data collection methods like interviews.

As participants drew their maps, the researcher or researchers present would busy themselves capturing field notes. This capture served a dual purpose: to collect important contextual details characterizing the interview and make participants feel that the researchers were not observing them as they drew. Participants then discussed their maps with the interviewer, explaining their choices and intentions behind their map’s respective design.

We first analyzed interview transcripts using open qualitative coding (redacted), granting us a crucial context for understanding the maps. We then performed situational analysis on 28 maps, guided by Greyson, O’Brien, and Shankar (2019) and Clarke (2005). Due to temporal and physical constraints, two of our participants did not engage in IWM. While the situational analysis method often deploys analysis of situational, social world, and personal, given the community-oriented nature of the study, we focused exclusively on the situational while understanding that some elements of the social and personal inevitably emerge. For each map, we wrote three memos:

1. Locating memos overviewing the map’s context
2. Big picture memos describing the map and our initial impressions
3. Specification memos discussing various map elements, such as composition, presence/absence, and work of the image

While memos specifically focused on the maps, we incorporated quotes from interview transcripts when participants described the maps to provide additional context. Following memoing, we then identified keywords and phrases from memos to create a “messy situational map.” We organized these data into an “ordered situational map” using Clarke's (2005) deductive categories. For images of these maps, see (redacted).

Results

Demographic Information
The 28 participants who engaged in IWM chose pseudonyms and provided self-reported individual demographics and the self-reported demographics of their communities. We also provided participants with a prescreening questionnaire, which asked them their race/ethnicity, educational status, and location. We focused on these three social locations due to prior work on Southern LGBTQIA+ communities identifying them as salient to informing their LGBTQIA+ identities (Harless et al., 2020). We do not report demographic data following quantitative, categorical norms because they fail to account for the complexities of LGBTQIA+ lives (Ruberg and Ruelos, 2020). Instead, each participant discussed in-depth receives their specific demographic identifiers provided by them during their interview. For additional demographic information, see (redacted).

How Discursive Power Shapes LGBTQIA+ Health Information Practices

Data analysis identified six ways that discursive power shapes the health information practices of LGBTQIA+ communities:

1. Producing absence
2. Providing unwanted information
3. Commoditizing LGBTQIA+ communities
4. Condensing LGBTQIA+ people into monoliths
5. Establishing the community’s normative role in information practices
6. Applying assimilationist and metronormative discourses to information sources

These discourses operate outside of SC LGBTQIA+ communities in other social and cultural contexts (themes 1-3), within communities (themes 4-5), and both within and outside communities (theme 6). We illustrate these findings using participant information world maps, supplementing them with participant descriptions from semi-structured interview transcripts. We have obscured parts of some maps to protect participant privacy.

Producing Absence. This theme describes instances where participants identified an absence of health information, resources, and information practices. Tessie – an older white, cisgender lesbian – illustrates this theme by dividing her map (Figure 1) in the middle. The right side depicts her community’s health energies – physical, emotional, spiritual, mental – and the information sources and practices they engage in to support these energies – community, word of mouth, the faith community, and technology. The left side consists of white space signifying what Tessie calls “the vacuum, where it’s not happening.”

[Insert Figure 1]

Tessie attributes this vacuum to surrounding social and regional discourses that are “20 years behind” those of progressive urban locales. She describes these discourses as “bigotry,” which while “everywhere, [here] you get to get away with it more.” Such bigotry produces an environment where a limited number of medical professionals affirm LGBTQIA+ identities and issues: “…we know one doctor here who works with trans people. That's heartbreaking." To avoid bigotry, Tessie's community members remain closeted: “I think I know more people now that are in the closet or remain in the closet.” As a result, they are less likely to disclose their LGBTQIA+ identities to medical professionals, “limit[ing] their knowledge of what’s really happening in your life.”
While Tessie directly depicts and names absence on her map, other participants discovered absence while drawing. Kyle – a white college-aged transmasculine, genderqueer, non-binary, ace person, who also potentially identifies as a lesbian – provides another example in their map (Figure 2). The bottom left-hand corner shows a stick figure sitting behind a desk. The figure “is a person at a health desk at a doctor’s office or something.” A word bubble comes out of the figure's mouth reading: "Hi! What are your name & pronouns so I can put them in our system?" However, Kyle's depiction of this affirmative healthcare space is imaginary. He adds, "I should have drawn somebody actually using those names and pronouns later because that's usually not what happens. That's the missing link in the system right now.”

[Insert Figure 2]

Medical institutions, such as clinics, doctor’s offices, hospitals, and urgent care centers, were only included on 11 participant maps – less than half of all participants. By noting this absence, we are not suggesting that SC LGBTQIA+ communities should utilize medical institutions. Instead, this absence suggests these communities lack access to critical infrastructure for health information and resources available to other populations.

Providing Unwanted Information. Discursive power also manifests on maps as unwanted information. Pink Lily Flower – an agender, queer person of color of African, Middle Eastern, Native, and European descent in their 20s to 30s – lists some of the institutions, sources, and channels “butting into our business” on one page of their map (Figure 3) in red. The unwanted information provided by these sources is hetero-cis-normative at best, homo-bi-transphobic at worst. They provide an example of homo-bi-transphobia intersecting at the “church” and “protest” (i.e., protests against LGBTQIA+ people) categories: “One church who was at Charlotte AIDS walk a couple years ago … were whispering into gay people's ears, ‘This is your punishment.’” Pink Lily Flower also includes news – “some of the news is slanted and construed in ways that aren't correct” – and social media – “a lot of protests are either on Instagram or Facebook for some reason” – as an institution and information source, respectively, for unwanted information.

[Insert Figure 3]

Charlie Burt – a white, middle-aged, cisgender, lesbian – illustrates this theme further by highlighting political ideology as unwanted information by her community (Figure 4). She visually depicts this ideology via “stupid red hats,” evoking the red "Make America Great Again” hats worn by Donald Trump and his followers. These hats symbolize their decidedly anti-LGBTQIA+ political ideology (New York Times Editorial Staff, 2020). Additional examples of unwanted information identified in participant maps include practitioners who provide conversion therapy, medical professionals who lack LGBTQIA+ community competency, local and national organizations that deny LGBTQIA+ identities and issues, and people who are unsupportive of them.

[Insert Figure 4]
Commoditizing LGBTQIA+ Communities. Participants describe how institutions, specifically research and medicine, generate material gain from SC LGBTQIA+ communities. On her map (Figure 5), Pat – a college-age, black, transfeminine, gender-nonconforming person of Afro-Caribbean descent – draws a dollar sign signifying how her community’s health data are “profitable.” She describes two ways that research and medical institutions “devise really interesting ways to get health information from you.” These are: “DNA tests … that have gained in popularity, especially among African-Americans who don’t really have access to genealogical information,” and “free clinical trials.”

[Insert Figure 5]

Tony – a middle-aged, black, transgender man – shows a one-sided provision of community health data and information to medical professionals and researchers on his map (Figure 6). At the top of the page, beginning on the left-hand side, are four transgender symbols (⚧) representing Tony and community members. There is a bidirectional arrow from this symbol to a box reading "WWW" for the World Wide Web. From the WWW box to the image's right, there is another bidirectional arrow between the box and a stethoscope, representing "online doctors." Tony explains that his community uses telemedicine to circumvent travel-related costs and lack of affirming experiences embedded within physical healthcare: “you don't have to leave you don't have to worry about the receptionist that's a jerk.” Tony also includes another unidirectional arrow pointing from three trans symbols to the stethoscope.

[Insert Figure 6]

As Tony explains: “with some online doctors, they actually send information both ways [bidirectional arrow]. But they're getting information from the community. I don't think there's a lot of doctors that sending the information back over [unidirectional arrow].” These doctors might not provide information back to Tony's community because they use community data for material benefit. As Tony later states: “What happened so many times is, ‘Oh, we can get this grant if we can find some trans people.' But what are you doing for us?” Notably, both Tony and Pat's communities are queer, trans, and black. Maps depicting communities with more dominant LGBTQIA+ identities and who are white do not note similar exploitation. This finding demonstrates how intersecting experiences of social difference – here, gender, sexuality, and race – influence how discursive power operates among specific SC LGBTQIA+ communities (Crenshaw, 1991).

Condensing LGBTQIA+ People into Monoliths. This theme illustrates discourses that conflate some community members' experiences with those of all LGBTQIA+ individuals. In some cases, participants explicitly reject this conflation on their maps. On her map, Vada – a college-age, white, cisgender, lesbian – symbolizes a group of people accessing information via a laptop using Google (Figure 7). The closer the person is to the computer, the more access they experience. One “cishet” (cisgender and heterosexual) person is closer than the other LGBTQIA+ people to the computer. However, Vada’s map indicates that not all LGBTQIA+ people in her community experience access equally. Bodies that are “white cis LGBT” (Vada’s self-described identity) have more access than “POC trans” (a transgender person of color), for example.
Chloe — a black, bisexual, cisgender woman in her 20s to 30s — also rejects a universal or essential LGBTQIA+ identity in her map (Figure 8). Chloe displays her and her community’s intersecting identities by putting the word "BLACK" next to a stick figure of the same shade. She also illustrates "word of mouth" occurring between two brown stick figures. These drawing choices denote how collective experiences of being black and LGBTQIA+ inform her community's health information world. Chloe and Vada’s maps illustrate the need for both a collective LGBTQIA+ identity in opposition to cisgender and heterosexual privileges and distinctions to LGBTQIA+ identities, such as one’s race in informing how they engage with health information.

Other participants place themselves on the map as implicit stand-ins for their community. In his map (Figure 9), Charles – an older, white, cisgender, gay man – depicts a quadrant of Earth displaying two places of significance to him – Alaska, where he lived, and his local LGBTQIA+ center. Using arrows, he illustrates how his community gives and receives information “sideways” and “back and forth.” A combination of geographical and spatial contexts unique to Charles informs this process. Further, the side profile depicts Charles, literalizing him as the community figurehead. Charles’ map does not indicate egoism but instead denotes the difficulty of articulating a community's collective practices he can only imagine and never honestly know (Ross, 2012). The consequences of such community imaginaries become realized as discursive power when SC LGBTQIA+ community leadership coalesces around a constellation of privileged, intersecting identities, such as white, cisgender, and male.

Establishing the Community’s Normative Role in Information Practices. This theme denotes instances where what a community collectively defines as normative information practices harm individual members. Tony exemplifies this finding in the bottom right quadrant of his map (Figure 6). The circle labeled “reception of info” symbolizes how Tony’s community engages in information sharing practices like word of mouth to ensure that members receive needed information. Although Tony would like all who need health information centered on transgender identities to be welcome in this circle (signified by the peace sign labeled “all are welcome” with an arrow pointing at the circle), he discusses community gatekeepers (red transgender symbols and line with perpendicular crosses symbolizing a barrier) who keep those deemed "outsiders" at bay. Tony further indicates being at odds with this gatekeeping practice by separating himself from the circle, as symbolized by the purple transgender symbol. He sees himself as the "Lone Ranger," who asks outsiders their intentions (indicated by the purple question mark), letting them into the community if they desire trans-specific health information.

Charles’ map (Figure 9) provides another example of a normative community practice: “getting information sideways," symbolized by the blue arrow going into this ear (arrow located below the ear). Charles elaborates on this practice, stating that his community will disclose individual members' personal health information (e.g., sexual health status) if they feel others...
should know. To prevent "having all your business on the street," community members will search for health information on "Google, if [they're] smart."

Applying Assimilationist and Metronormative Discourses to Information Sources. Several participants expressed the interrelationship between their communities and broader US LGBTQIA+ cultural discourses within their maps. A critical discourse is assimilationist or the idea that LGBTQIA+ people should adopt heterosexual and cisgender norms, such as getting married or adopting a gender binary, to be entirely accepted. Such assimilation functions as an "inescapable sphere" whose discursive power threatens "everyday struggles of resistance" among LGBTQIA+ communities (Muñoz, 1999, pp. 11–12).

Assimilationist discourses emerged on participant maps as valuing national-level LGBTQIA+ organizations whose political leveraging may disenfranchise those whose identities experience intersectional marginalization. The lower righthand corner of Ben’s – a black, cisgender, gay, male teenager (Ben uses both he/him and she/her pronouns) – map (Figure 10) depicts organizations like GLAAD and the Human Rights Campaign as critical sources for health information among her community. Ben symbolizes these organizations using logos, hinting at their visibility and legibility across various contexts, including outside LGBTQIA+ communities.

[Insert Figure 10]

Such visibility has advantages. For instance, Ben and her community can easily locate resources produced by these organizations. However, they also adopt assimilationist discourses harmful to those who are not cisgender, gay, white men (Duggan, 2002), such as Ben and other black community members. Puar (2006) overviews the Human Rights Campaign’s troubling history of upholding white, middle-class American values at the expense of normalizing anti-LGBTQIA+ sentiment directed at communities of color and non-white immigrants. While it is not Ben's responsibility to be aware of or address these critiques in her map, they highlight how the information his community consults may be pro-LGBTQIA+ without intersectional accountability.

Adopting assimilationist discourses by participants or their communities could lead to a metronormativity of information sources. Metronormativity is a theoretical construct describing LGBTQIA+ experiences' binarization into urban/rural and good/bad. It assumes that a person cannot live a meaningful life as LGBTQIA+ outside of a metropolitan area (Halberstam, 2005). Participants implicitly and explicitly mapped metronormativity discourses onto information sources by privileging those that were more cosmopolitan in scope over those more localized.

Tony Solano – a college-age, white, cisgender, gay man – depicts a list of information resources organized by scope – ranging from national to interpersonal (Figure 11). To the left of the list are two blue squiggly lines depicting a river, which symbolizes information flowing “mostly downstream” from national health institutions to Tony Solano’s organization (blurred to protect his privacy) to his community members and, finally, to interpersonal interactions between individual community members and medical professionals. Tony Solano expresses concern with community members who engage in health information practices that do not include input from their organization, which sources information from national health institutions. Tony illustrates this concern when discussing how community members might address a health question about
the effectiveness of PrEP (pre-exposure prophylaxis) versus how his organization would address it:

PrEP. Is it effective? [The community wants] to hear from people who were actually on the medication. Are they using it? Have they had side effects? How is it affecting them and their day-to-day life? Is that something that I want to openly put out to all my group members and followers or is it something that we want to say, "Hey, let's give a little bit more time to see what's going to happen with this."

[Insert Figure 11]

Tony Solano's map contrasts Pat's (Figure 5), which depicts how pharmaceutical companies “exploit” her community by offering “free clinical trials” in exchange for health information and resources. When compared to Tony Solano’s map and description, the very clinical trials that exploit Pat’s community members are those likely to influence what information Tony Solano and his organization disseminate to their community, such as the results of clinical trials by national pharmaceutical industries about the effects of health interventions like PrEP. Participants like Pat view national health institutions as having increased wariness compared to those like Tony Solano, who see them as having the community's best interest at heart. The variance of experience and perspective likely has to do with the privileged identity intersections of people like Tony Solano and his community leadership, centered on white, cis male identities. Paralleling the arguments made by Vada in her map (Figure 7), such individuals are subject to discrimination and other hardships not experienced by non-LGBTQIA+ people. However, this discrimination varies based on intersecting experiences of social differences in ways that render national-level information sources most relevant and safe for those with privilege.

How Participants Resist Discursive Power
Participants resist discursive power in and through their maps using two central tactics: 1) (re)appropriating discourses and 2) imagining new information worlds.

(Re)appropriating Discourses. This theme describes instances where participants or the community (re)appropriate discourses to reveal their underlying instability (Butler, 1988; Foucault, 1981). Kyle’s map (Figure 2) illustrates this theme. The top middle of the image consists of a written list of resources Kyle's community finds to address their health questions and concerns, as indicated by the green checkmark. Two of these resources have the trademark symbol appended to them: “[NAME] (The Gay Sex Ed Person™)” (name removed and blurred to protect participant privacy) and “The Gay Doctor™.” Kyle's use of the trademark symbol appears to be a tongue-in-cheek tactic that highlights LGBTQIA+ people's tokenization in educational and healthcare spaces. His use of the word “the” furthers this idea, as it insinuates that there is only one person who provides LGBTQIA+ sex education and healthcare. The trademark symbol also echoes the above discussion of how national LGBTQIA+ organizations may produce valuable information by local communities, even at the potential expense of assimilation to a discourse of knowledge as regulatable. Finally, the trademark symbol may signify the increasing corporatization of LGBTQIA+ identities and issues (Hennessy, 2002).
This example constitutes a (re)appropriation because Kyle highlights the futility of tokenization and corporatization discourses as applied to the LGBTQIA+ community – why, for example, can’t all sex educators and doctors focus on LGBTQIA+ issues? – simply by including them on the map. The middle right of Kyle's image provides another example of (re)appropriation. It contains a box around the writing: "New! Research done by bigots says biological essentialism is real!" This drawing is crossed out in red, representing information Kyle’s community does not want. Here, the square drawn around the text can represent a research journal or perhaps a news article reporting on this research. This drawing represents a creative take-down of biological essentialism, a discourse highly regarded and unquestioned particularly within the hard sciences that envisions a person’s biology, sexuality, and gender identity as inextricably linked (Laqueur, 1992). By portraying the written information as a publication, Kyle shows that this sort of information would be unquestioned in many other contexts. The only reason the drawing involves a second look is his choice of the word "bigots" and a red pencil to cross out the image.

Participants also engaged in (re)appropriation by using stick figures to depict gender as an expression and performance (Butler, 1988). Traditionally, these figures, especially on bathroom doors, "call on or reference an entire social system" of binarized gender logics (Enke, 2016, p. 217). However, participants evoked stick figures to highlight a gender binary's instability, using its presumed rigidity to either undermine gender or reorient normative values placed upon specific gendered identities with LGBTQIA+ communities. Sarah – a white, cisgender, pansexual, female teenager – uses stick figures on her map (Figure 12) to symbolize community members sitting in a circle. Without context, one may interpret this image as one with cisnormative depictions of gender. However, as Sarah describes her image, she notes that some figures represent “boys who wear skirts.” By not indicating either in her drawing or description, which skirt-wearers are "boys," Sarah demonstrates the instability of gender as a category as the viewer cannot discern members' gender identities based on their hairstyles or clothes.

[Insert Figure 12]

Like Sarah, other participants express gender in alternative ways despite the limits of clothing and hairstyles force stick figures into a perceived gender binary. For instance, Tony (Figure 6) uses the transgender symbol as a stick figure replacement. Participants sometimes use "obvious" gender signifiers to highlight identities of importance to the community. Pat, whose community consists of transfeminine and queer femme people of color, engages in this practice by including stick figures wearing skirts (Figure 5). Skirts, which signal an expression traditionally associated with feminine and femme identities, visually signals that her community centers members with these identities.

*Imagining New Information Worlds.* Some participants used IWM not to depict what was occurring within their communities, but instead, what they and their communities wish would occur. Jordan – a college-age, black, cisgender, gay man –provides an evocative example in his map (Figure 13). During the interview, he discussed his frustrations with being a gay man at an HBCU (Historically Black College/University) that openly denies its LGBTQIA+ students' existence. His map depicts a bird's eye view re-creation of his college campus, visibly inclusive of LGBTQIA+ students. His drawing includes "dorms for students who have been kicked out of their homes for being out," a library and archive staffed with people promoting LGBTQIA+
history and culture, and a rainbow archway marking his campus as a site of visible LGBTQIA+ pride. Therefore, Jordan's map exists in an imagined future to resist a current reality that does not acknowledge him and his LGBTQIA+ community. Jordan’s drawing represents one of two that include a library. It is notable, then, that the library functions in Jordan’s drawing as a potential emancipatory space for his community.

[Insert Figure 13]

Pink Lily Flower’s description of their map (Figure 3) provides an example of a community that has collectively worked to achieve this re-envisioning or imagining. As previously discussed, they indicated in red several institutions that provided unwanted, often derogatory information to their community. One of these institutions was a church. This finding takes on new meaning when considering that Pink Lily Flower identifies as a spiritual leader and is an ordained reverend, and they lead a spiritual community. However, Pink Lily Flower clarifies that their community does not exist within traditional discursive framings of churches:

To be a church that radically welcomes Muslims, to be a church that radically welcomes divine feminines, who people call witches, to be a church that is headed by a gay person, and to be a church that refuses to use the word church at all, and to be something, a collective, that suggest we can love Jesus, but we don't need your religion to love him.

This quote illustrates how Pink Lily Flower and their community have created a spiritual space separate from religion and churches since these institutions reify discriminatory discursive power dynamics. This space evokes elements of spirituality that empower the community.

Discussion

Findings align with research on LGBTQIA+ health and health information practices. Communities are subject to discursive power, namely homo-bi-transphobia, from outside institutions that traditionally provide critical health information infrastructure and support. This finding supports public health research identifying barriers of care experienced by LGBTQIA+ populations (Lerner and Robles, 2017; Romanelli and Hudson, 2017). This discursive power produces an absence of affirming health information and resources that SC LGBTQIA+ individuals can locate outside their communities. In turn, this finding reaffirms the importance of community for LGBTQIA+ individuals in health contexts (Veinot et al., 2013).

Findings also demonstrate how individual communities and members experience varied informational outcomes based on their intersecting experiences of social difference. Black communities with gender identities and sexualities marginalized within the broader LGBTQIA+ umbrella, for example, experienced the commodification and withholding of their health data by medical and research institutions and pharmaceutical companies. This observation reflects a documented history of racist exploitation of black bodies by these institutions (Somerville, 1994). Further, this finding highlights the importance of employing an intersectional analytical lens to understand the healthcare experiences of LGBTQIA+ populations (Romanelli and Hudson, 2017), with implications for extending intersectional analysis into an information practices framework (Adkins and Moulaison Sandy, 2020).

SC LGBTQIA+ communities are not immune to discursive power seeping into collective dynamics and producing instabilities and shortcomings for specific individuals. We found that
influential members, such as leaders and gatekeepers, adopted an LGBTQIA+ community’s imagined construct and normative expectations therein. In this way, our findings reflect Anderson’s (1991) concept of imagined communities, which positions nations and, in this case, LGBTQIA+ communities as socially constructed. Such expectations shape community criteria for belonging in an information world, acceptable health information practices, and valuable information sources. These findings also echo small world (Chatman, 1999) and normative behavior theories (Burnett et al., 2001), which describe how communities engage with information to support or reclaim meaning within their lived realities. Our work adds to these concepts and theories by combining them. Specifically, findings denote how leaders’ may perceive information practices and sources as collective. However, they reflect the perspectives of those in power within the community, such as leaders, who often hold privileged identity intersections. We should also note that our analysis does not intend to critique the participants or their maps. We do not question that participants’ information world maps work for some if not many, of their community members.

We found that participants engaged in acts of resistance during IWM, specifically by (re)appropriating dominant discourses and imagining new information worlds that support LGBTQIA+ communities. These acts align with Foucault’s concepts of reversed discourses (Foucault, 1981) and techniques of the self (Foucault in Habermas, 1994). Instances where participants created new information worlds for their communities also aligns with Floegel’s (2020) world-queering construct. While world-queering operates within slash fanfiction, its underlying signification as a practice where LGBTQIA+ people create information worlds free of hetero-cisnormativity and homo-bi-transphobia, suggests its salience within other contexts, such as health.

How participants envisioned their role as leaders appeared to shape this form of resistance. Before creating his map, Jordan described himself as having straight passing privilege (i.e., he is presumed by others not to possess the essentialist looks and mannerisms of a gay person). This privilege allows him to infiltrate anti-LGBTQIA+ spaces on this campus to express his community’s concerns in ways not available to those with differing LGBTQIA+ visibilities. Jordan’s ability to navigate varying forms of LGBTQIA+ visibilities contributes to him being a leader, as he can interact with others on campus to accomplish change. Jordan’s map can be interpreted as a product of this leadership as it manifests his ability to occupy anti-LGBTQIA+ spaces and enact the change he envisions. Such resistance may not be viewed as attainable or even imagined by members of Jordan’s community who cannot infiltrate these spaces in the first place.

Further, there are potential differences between how participants engage in resistance based on whether they are in a positional (i.e., having a formal title and defined responsibilities) or transformational role (i.e., works to achieve change), which may be further mediated by intersectional identities. Pat, who operates in a transformational role, observed that she is not considered a leader by “legitimating institutions.” Instead, she exists outside of a “leadership class” of LGBTQIA+ leaders who are supported by “the bulk share of the financial and material resources that are available and also [recognized] by other established leaders in the community.” As a result, how Pat – a black, transfeminine, gender-nonconforming person of Afro-Caribbean descent – imagines resistance would likely differ from someone in the established leadership class, most likely an older, while gay or perhaps lesbian cisgender person. How power differentials affect resistance and imagination – both between different types of
leaders and leaders and non-leaders – is an area for our future work. Currently, we are engaging non-LGBTQIA+ leaders in IWM and plan to analyze these differentials further.

Findings confirm the usefulness of participatory visual methods like IWM in capturing “the arrangements of everyday context” in shaping how individuals and communities engage with information (Hicks and Lloyd, 2018, p. 229). Specifically, we found that maps elicited additional insight into themes centering on sociocultural barriers to health information, community dynamics, intersectionality, and resistance not found within interview transcripts. Situational analysis (Clarke, 2005) illuminated the discursive power underlying these themes. Like Greyson et al. (2019), we found it valuable first to analyze interview transcripts to have an underlying context for interpreting the maps.

**Implications for Research, Practice, and Advocacy**

This work extends the salience of an information practices approach to understanding the contextual dynamics shaping how LGBTQIA+ communities create, seek, share, and use health information—understanding how discursive power informs these dynamics is critical for three key reasons. First, this understanding refutes potential deficit framing that can essentialize LGBTQIA+ people as inherently health information illiterate or lacking this information (Perrin et al., 2020). Second, understanding that power depends on resistance provides researchers with ways of understanding how LGBTQIA+ communities can express agency beyond responding to power, such as engaging in protective and defensive information practices (redacted). Finally, highlighting how power also exists within communities, particularly marginalized ones, highlights the unique, intersectional experiences of LGBTQIA+ people (Crenshaw, 1991) rather than condensing them into a collective “Other” category. Future health information practices research can adopt this theoretical framework and apply it to other marginalized communities to gain a more contextual, critical, and informed perspective of their health-related information engagements.

Findings also have implications for practice. IWM can function as a pedagogical tool used by information service providers like public and health librarians to engage with their local LGBTQIA+ communities, informing health-related, affirmative services, spaces, and collections. Such initiatives would further extend libraries’ work providing health-related support (Bertot et al., 2015; Horrigan, 2015). IWM can also provide a vital way for LGBTQIA+ community leaders to understand how discursive power functions within their communities—teaching IWM would involve researchers adapting data collection and analysis methods for practical use, then offering training sessions for practitioners, who could then train local leaders as a type of community engagement. Further, our findings reaffirm the work of Greyson et al. (2019) and Dalmer (2017) by suggesting that IWM data is not merely secondary to other elicitation methods, but generative data to be taken seriously in isolation.

When working with LGBTQIA+ communities, participants can be informed by participants’ resistance tactics, specifically questioning whose identities exist in the margins concerning healthcare and health information issues. Practitioners can attend to these tactics by incorporating multiple LGBTQIA+ community members’ perspectives into engagement initiatives like IWM training, not just the perspectives of those most visible. One way practitioners can leverage LGBTQIA+ community health knowledges is to follow the community health workers’ framework. Community health workers serve as intermediaries between health professionals and communities subjected to historical traumas within medical institutions (American Public Health Association, 2016). We envision opportunities for
LGBTQIA+ community members to receive community health worker training, then work alongside information professionals to serve their communities, ideally with a stipend for their time and effort. In this role, LGBTQIA+ community health workers could co-create with information professionals workshops, resources, and documents for community members to address their health questions and concerns and health care professionals working with LGBTQIA+ patients.

**Limitations**

Limitations of this work relate to what and how data collection and analysis represent LGBTQIA+ communities. While generalizability is not a goal of qualitative research, there are essential community experiences and perspectives we missed from hidden communities like sex workers or those distrusting of researchers. Further, our methods implicitly assume that leaders can map their communities' health information practices. In reality, we understand that leaders are not spokespeople for their communities and that any representation of these practices would be limited. Our positionalities and their attendant privileges, namely our whiteness and elite status as academics, produced blind spots within our data analysis. Ways that we will address these limitations in future work is by conducting focus groups with SC LGBTQIA+ community members and critically analyzing how our positionalities shaped our data collection and analysis through reflexive journals.

**Conclusion**

A desire to be healthy and engage with information and resources for well-being is hardly unique. Informed by IWM with 28 SC LGBTQIA+ community leaders, findings show that for LGBTQIA+ persons, these engagements are not equitable due to powerful discursive, societal, and community dynamics. Further, discursive power negates the information practices of people with less dominant LGBTQIA+ identities and marginalized intersectional identities across locations like race and class. Despite the constraints this power produces, participants engage in acts of resistance through (re)appropriating discourses and imagining new information worlds. Medical and information professionals can learn from these community leaders through their descriptions of how discursive power works within their communities and resistance tactics. What they learn can inform community engagement efforts for LGBTQIA+ health promotion. Whether attending to intersectional healthcare needs or making a world where healthcare is not traumatizing, LGBTQIA+ communities can and do push beyond power. It is time that the health information they strive to obtain does the same.

**Acknowledgements:**

This research was funded by the Institute for Museum of Library Services (IMLS) and part of a larger project entitled, Examining Public Library Service to LGBTQ Communities for Health-related Information. The funding period for the project is from 09/01/18 to 08/31/22. The PI on this project is Vanessa L. Kitzie. For more information, the project website can be accessed via the following link: http://bit.ly/hiplgbtq.

Special thanks to Valerie Lookingbill for her help on this project. We would like to express gratitude for the community leaders who participated in this project. Your insights and candor
have elevated our thinking, which we hope does justice in representing your personal and community-based experiences, as well as your knowledge, resilience, and resistance.

References

Note: Some references removed for blind review


31–38.

Floyd, J. (2019), “SC did not expand Medicaid under Obamacare, but cost and enrollment are growing anyway”, The Post and Courier.


Muñoz, J.E. (1999), *Disidentifications: Queers of Color and the Performance of Politics*, University of Minnesota Press, Minneapolis, MN.


Weiser, S.M. (2018), The Art of Resistance: An Arts Based Understanding of Activism, University of South Carolina, available at:
Tessie's Information World Map

278x214mm (300 x 300 DPI)
Kyle's Information World Map

278x215mm (300 x 300 DPI)
Community EA, Outreach, Pride Programs, Events, Health Deps., Online, protest, new, motions, LGBTQ People, Marginalized people, Mental Health, Religious Organizations, Conferences, Workshops

Pink Lilyflower's Information World Map

214x280mm (300 x 300 DPI)
Charlie Burt's Information World Map

278x215mm (300 x 300 DPI)
Pat's Information World Map

279x214mm (300 x 300 DPI)
Tony's Information World Map

279x214mm (150 x 150 DPI)
Vada's Information World Map

278x215mm (300 x 300 DPI)
Chloe's Information World Map

278x215mm (300 x 300 DPI)
Charles' Information World Map

277x215mm (300 x 300 DPI)
Ben's Information World Map

278x215mm (300 x 300 DPI)
Tony Solano's Information World Map

215x279mm (300 x 300 DPI)
Sarah's Information World Map

278x215mm (300 x 300 DPI)
Jordan's Information World Map

278x215mm (300 x 300 DPI)