

8-23-2021

'Access necessitates being seen': Queer Visibility and Intersectional Embodiment within the Health Information Practices of Queer Community Leaders

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Publication Info

Postprint version. Published in *Journal of Information Science*, 2021.

Travis L. Wagner, Vanessa Kitzie, 'Access necessitates being seen': Queer visibility and intersectional embodiment within the health information practices of queer community leaders. *Journal of Information Science*. pp. 1-15. Copyright © 2021 (The Authors). DOI: 10.1177/01655515211040658

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“Access Necessitates Being Seen”: Queer Visibility and Intersectional Embodiment within the Health Information Practices of Queer Community Leaders

Journal:	<i>Journal of Information Science</i>
Manuscript ID	JIS-21-0174
Manuscript Type:	Research Paper
Keywords:	embodied information practices, queer visibility, health information, intersectionality
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Abstract

Navigating healthcare infrastructures is particularly challenging for individuals identifying as queer, with significant barriers emerging around stigma and practitioner ignorance. Further intersecting, historically marginalized identities such as one's race, age, or ability exacerbate such engagement with healthcare, particularly the access to and use of reliable and appropriate health information. We explore the salience of one's queer identity relative to other embodied identities when navigating health information and care for themselves and their communities. Thirty semi-structured interviews with queer community leaders from South Carolina inform our discussion of the role one's queer visibility plays relational to the visibility of other identities. We find that leaders and their communities navigate these intersectional visibilities through unique and iterative approaches to health information seeking, sharing, and use predicated upon anti-queer, racist, ableist, and misogynistic sentiments. Findings can inform queer-inclusive, intersectionally-informed interventions by health and information professionals such as non-profit advocacy organizations and medical librarians.

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Introduction

This paper starts with a reflective question: Should healthcare and information professionals make information and resources on HIV/AIDs preventative care most visible to Black, queer communities, who are disproportionately affected (*HIV and African American Gay and Bisexual Men*, 2020)? A “yes” response evokes what is well-established in public health, communication, and information science literature: HIV-related health disparities exist among Black, queer communities, and informational and advocacy-based interventions can combat these disparities. However, centering the experiences of the communities in question reframes these assumptions. Historically, social and healthcare institutions have framed queer bodies as deviant due, in part, to their becoming medicalized objects. In turn, medicalization reinforces the persistence of queer bodies as being infected or capable of infecting others, reifying this problematic deviancy. The relationship between medicine and people of color (specifically Black communities) is one of exploitation and systematic violence, which marks Blackness as abnormal and inhuman, thus legitimizing it as a body on which to experiment (Somerville, 1994). From this perspective, the hyper-visibility of information and resources on HIV/AIDs preventative care within Black, queer communities marks their bodies as sites of medical testing and advancement.

Informed by interviews with 30 queer community leaders in South Carolina (SC), this paper examines how queer visibility mediates communities' engagements with health information. Within a health context, information can empower queer communities to define their own health needs, meanings, and values, rather than having these needs imposed on them by others (Gahagan & Colpitts, 2017). We center visibility within a community's various, intersecting identities, as the ways queer communities engage with health information and what information is made visible to them are not monolithic. Race, among other factors, might

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3 precede queerness in a community's relationships to health information (Crenshaw, 1990). We
4 use queer as an umbrella term that describes the complex and continually expanding
5 understandings of gender and sexuality within and outside of binarized modes of thinking (Eng
6 et al., 2005). Research questions guiding this paper are:

- 7 • How does visibility mediate the health information practices of queer communities?
- 8 • How does intersectionality complicate queer visibility?

9 Findings illustrate how participants engage in and reject the notion of collective queer
10 visibility when creating, seeking, using, and sharing health information. Implications suggest that
11 health and information professionals must acknowledge how systemic and structural oppressions
12 shape community health information practices. Finally, we consider whether information and
13 health professionals should use taxonomies of visibility (if at all) to orient resources, services,
14 and information towards an increasingly amorphous group collectively called queer.
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18 Literature Review

19 Queer Visibilities

20 Visibility represents one's ability to be recognized and exert control over how others perceive
21 and represent them (Brighenti, 2007; Lollar, 2015; Lewis & Simpson, 2012). The notion of
22 visibility within the queer politic suggests inherent positivity. Indeed, the "increas[ed] cultural
23 representation of homosexual concerns as well as the recent queering of sex-gender identity
24 undoubtedly has had important positive effects" such as civil protection, the legitimization of
25 queer scholarship, and general moments of queer empowerment (Hennessy, 2002, p. 111).
26 However, Hennessy marks such discursive and cultural acknowledgment of queer identity as
27 false liberation within late capitalism. Put differently, the welcoming of queer individuals into
28 any system, whether it be businesses or healthcare, occurs because queer persons became market
29 consumers. They are visible as a "consumer subject but not social subject" (p. 112).
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32 Such increased queer visibility occurs with perverse irony for various communities
33 within the larger queer umbrella. For individuals living today with HIV/AIDS, their visibility in
34 historical memory and current access to care fail to address the underlying stigma existing
35 around the act of gay sex and those identifying as gay (Beltran et al., 2020). Similarly, the
36 increased offering of transgender medicine and access to transition-related care ignores the
37 realities that such provisions exist alongside a desire to mark these bodies as deviant (Poteat et
38 al., 2013), surveil them, and bring them within normative notions of Western gender binaries
39 (Beauchamp, 2009). Both examples illustrate that the queer subject whose visibility seems new,
40 or part of a "phenomenon," actually suggests increased subjugation and surveillance within
41 normative discourse (Foucault, 1978/1990).
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44 Who gets to be queer and visible depends on other lived experiences that precede and
45 inform queerness. Duggan (2002) calls this phenomenon a "new homonormativity" wherein
46 select queer individuals find value and social acceptance despite their queer identities by
47 attending to and often overtly embracing other privileged identities. For instance, cisgender, gay,
48 white men of relative means experience privilege because their gay identity is either secondary
49 or overlooked. These homonormative queers engage in assimilationist queer politics to the
50 detriment of pro-queer efforts for radical inclusion vis-à-vis groups like Log Cabin Republicans
51 (p. 177). Spade (2011) argues that while many institutions have moved toward positive inclusion
52 for transgender persons, these moves come rarely attend to how such systems remain racist,
53 classist, and ableist.
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3 Further, these efforts often elide that transphobia is far more pervasive from both legal
4 and political standpoints than homophobia. Spade suggests that transgender individuals face
5 "subjection" rather than oppression, resulting in a person being a queer subject whose limited
6 visibility does not protect discrimination in other ways, such as being transgender (2011, p. 25).
7 This type of queer visibility signifies queer identities as allowed, not embraced, and supports the
8 assimilation of certain white queers into neoliberal, pro-American spaces that reinstate racism,
9 xenophobia, sexism, ableism, and other non-inclusive ideologies (Puar, 2005).

10
11 Queer communities of color have long explored how other identities of oppression and
12 subjection exist alongside queerness. Audre Lorde (1984) spent her career making clear that her
13 intersecting identities of woman and "Black, lesbian, warrior, poet" influenced the visibility she
14 possessed within society and informed how she did her "work" advocating for others like her (p.
15 41-42). Lorde highlights the need for people to be constantly aware of how their identities
16 become in/visible within social discourses and contends that pushes for radical inclusion must
17 consider that marginalized identities experience visibility when other intersecting identities are
18 not regulated or suppressed, e.g., queerness as visible when it intersects with whiteness, being
19 cisgender, and experiencing class privilege.

20
21 This condition of visibility may render queerness as hypervisible, wherein certain forms
22 of queerness – predominately those assimilationist in nature – are tokenized and demanded to
23 represent an entire group (Settles et al., 2019). Queer individuals face expectations to
24 universalize their non-queer identities, such as race or ability to assimilate to the white or ableist
25 logics of mainstream queerness (Clare, 2015; Snorton, 2017). This hypervisible tokenization
26 often produces negative physical, psychological, and emotional effects in the populations above
27 (Jackson et al., 1995; LaSala et al., 2008).

30 31 **Embodied Health Information Practices**

32 It is well-established that queer communities experience health disparities compared to
33 heterosexual and cisgender peers. Informational inequities partly produce these disparities. As an
34 example, the site for this study, SC, has what is called a "no promo homo" law, which forbids
35 public school health educators from discussing queer identities and issues "except in the context
36 of instruction concerning sexually transmitted diseases" (SC Stat. § 59-32-30(5)). This law
37 results in a landscape where queer sexual health information constitutes either invisible or hyper-
38 visible sites of surveillance and pathologization and can lead queer individuals like teens to make
39 risky health decisions.

40
41 We envision information as a process, i.e., the act of becoming informed or learning new
42 information; as knowledge, i.e., one's ability to recollect and show understanding of information;
43 and as thing, i.e., physical and digital resources such as data and documents (Buckland, 1991).
44 How one engages with information, as evidenced by their seeking, use, and sharing, represents
45 their information practices. Information practices provide a theoretical frame from which to
46 envision seeking, use, and sharing as socioculturally shaped (Savolainen, 2008).

47
48 There is a particular everydayness to one's information practices contingent on proximity
49 to power, loosely coded as "culture" within scholarship on information practices (Courtright,
50 2007). Power defines what information experts prescribe to be "good," and whose information
51 practices are "normal" (Frohmann, 1992; Olsson, 2007; Julien, 2016). Information practices have
52 been applied as a theoretical frame to critique deficit narratives framing those with oppressed
53 identity intersections as lacking information that can only be provided to them by expert
54 intermediaries like librarians. These intermediaries have training in assessing the "goodness" of
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3 information, often using dominant cultural frames of value, such as information that has been
4 peer-reviewed or undergone a formal publishing process (Lingel & boyd, 2013).

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6 Our deployment of information practices frames queer communities as already aware of
7 how normative values of information exclude and marginalize their identities; these queer
8 communities seek, use, and share information despite this exclusion and marginalization (Gibson
9 & Martin, 2019). Further, these practices become "embodied" contingent on one's work, lived
10 experience, and intersectional identities (Olsson & Lloyd, 2017). Elmore (2017) illustrates how
11 Muslim women immigrants within the UK experience particular challenges in learning English.
12 They find themselves having to alter their location, clothing, and visibility relative to who else
13 occupies the classroom with them. Their resultant information practices exemplify a uniquely
14 embodied navigation of place, resulting in a focus on gaining and losing informational
15 opportunities contingent on social capital tied to Islam's cultural practices (p. 208). For these
16 women, cultural assimilation performance results in their access to information, with their
17 seemingly passive negation of Islamic culture proving quite agentic.

18
19 Keilty's (2016) work on embodied "pleasurable browsing" when engaging with online
20 pornography suggests that one's desire for an authoritative or preferable piece of information can
21 become complicated by their phenomenological orientation and attraction (p. 67). For Keilty, the
22 failure to immediately choose a piece of pornography is not one of failure to use the content, but
23 instead a choice to engage with many options. Such embodied desires also inform one's gender
24 identity in so much as this identity and associated expressions can be themselves be embodied
25 information. For instance, trans and gender-nonconforming people may purposefully choose to
26 express or hide these identities as a piece of information about themselves as a potentially
27 protective action or as a means to obtain information in resolutely transphobic spaces (Huttunen
28 et al., 2020).

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31 Embodied information practices offer a new venue within queer theory to understand
32 how one orients themselves to their world and their lived experience. These orientations produce
33 understandings of bodies as valuable and authoritative sites of information. As a result, seeking,
34 using, and sharing health information becomes a queerly embodied undertaking. This paper
35 advances the connection between embodied information practices and queerness operating
36 within a critical context – health. Further, this paper envisions intersectional identities as critical
37 points of embodied information by positioning queer visibility as a critical mediator of health
38 information practices among communities.
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41 **Methods**

42 This paper reports on a larger research project consisting, in part, of semi-structured interviews
43 with 30 queer community leaders in SC about their and their communities' health information
44 practices. SC served as a critical geographical context due to the unique health disparities
45 experienced by queer populations, including heightened economic instability, unemployment,
46 and lack of health insurance (Mallory & Sears, 2019). Community served as our observation unit
47 due to the importance of community involvement in queer health information practices (Veinot
48 et al., 2013). We assumed that leaders possess a snapshot of their communities' larger problems,
49 practices, and experiences while acknowledging that they are not community spokespeople
50 (Macdonald et al., 2013). We recruited adults and teens, ages 13-17, to acknowledge the
51 presence of dynamic youth queer leaders (Weiser, 2018; Worthen, 2014). Since some youth
52 wished to participate without outing themselves to a parent or guardian, we obtained an IRB
53 waiver of informed consent. Instead, we collected youth assent (see also Steinke et al., 2017).
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3 We used purposive sampling to identify visible queer organizations and affinity groups
4 with an express interest in supporting queer persons. We asked these organizations and groups to
5 self-nominate leaders to participate and recruited additional participants through snowball and
6 theoretical sampling. The latter strategy was to gather alternative perspectives and gaps in
7 demographic representation guided by prior work, highlighting important intersectional identities
8 for queer communities in the American South regarding health outcomes (e.g., Harless et al.,
9 2020). Participants identified across the spectrum of queer identities. The majority of participants
10 (60%) were white, and the remaining 40% were Black and/or biracial. Participants identified
11 across various classes and educational ranges, and many disclosed various disabilities – physical,
12 intellectual, cognitive, and sensory.
13

14
15 Interview topics focused on the health questions and concerns of leaders' communities
16 and how leaders and community members address them. Interviews ended with a drawing
17 exercise, which asked participants to put their communities on a piece of paper and draw around
18 them the people, places, and things shaping how they engaged with health information (see
19 Greyson et al., 2017). Critical focus on intersectional representation occurred through data
20 collection as we asked participants to identify salient identities, geographic settings, and lived
21 experiences that shaped their communities' health information practices.
22

23 This paper focuses on interview transcript analysis, using the drawing exercise as an
24 elicitation device. We analyzed transcripts using a qualitative coding approach similar but not
25 identical to grounded theory. Open coding line-by-line allowed us to derive inductively process
26 and in vivo codes, which we then categorized and refined using axial and focused coding
27 (Charmaz, 2014). We matched larger coding categories to existing theoretical and conceptual
28 frameworks (Saldaña, 2009). We paid particular attention to significant themes informed by the
29 intersection of social identities, locations, and experiences identified by participants. We used
30 member-checking and peer-debriefing to strengthen the finding's trustworthiness.
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33 **Findings & Discussion**

34 Three key constructs emerged from data analysis: visibility, invisibility, and hypervisibility. We
35 discuss each construct below, informed by participant narratives. We also acknowledge the
36 messiness and contested nature concerning the terms individual and community regarding queer
37 populations. Our referencing of the use of community follows the deployed idea of a collective
38 community as offered by participants. Further, this interoperating use of individual and
39 community echoes the complex relations latent within groupings constructed and contested at the
40 site of both sexuality and gender (Callis, 2014). We refer to participants using their chosen
41 pseudonyms and salient identities used to describe themselves.
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44 **Queerness as Visible Identity**

45 As argued above, hetero-cisnormativity within late capitalism renders queerness, at best, only
46 partially visible as a consumer identity (Berlant & Warner, 1998). For participants with other
47 privileged identity intersections, queerness operated as a consumer identity that designated what
48 health information and issues were important to the community and what health practices were
49 considered safe or responsible within this community context. In other instances, participants for
50 whom queerness could be a “normal” part of one's lived experience exerted control over how
51 their health was perceived and represented by marking their health questions and concerns as
52 non-queer.
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4 One way that leaders achieved such normative visibility was through the adoption of
5 certain health narratives. For instance, the visibility of HIV/AIDS narratives informed narratives
6 of participants who identified as white, cisgender, gay men. Such narratives echoed the
7 increasingly consumerist politics of HIV/AIDS advocacy and prevention, marking it as an almost
8 monolithic and uncontested concern through reinforcing queer bodily value as biopolitical
9 (Comaroff, 2007; Youde, 2009). Tony Solano (white, cisgender gay male in college) describes
10 how he and other community leaders orient their members toward HIV/AIDS and STDs: "we
11 would bring everybody together and would make a quick campfire about HIV and other STDs ...
12 [to address] how to prevent them, stay healthy, how to recognize them, and most importantly, to
13 be open with your sexual partner." He expresses personal frustrations when younger members of
14 his community resist this orientation: "young individuals...are not doing that [getting tested] as
15 much. It's more a free for all."

16
17 Because Tony Solano is a leader in his community, he plays a vital role in determining
18 what health issues are of importance among community members and how they should approach
19 them. Not centered in Tony Solano's discussion of this role is his visibility as a normative queer
20 person – a gay, cisgender, white man whose public perception is relatively accepted. While he
21 can be open with his queer identity, expecting others to do the same overlooks crucial
22 intersections of social difference that might not afford others the same visibility. The young
23 people Tony Solano frames as incapable of controlling their health may instead prioritize and
24 seek different health information.
25

26
27 Other participants sought mainstream visibility by subsuming their queer identities under
28 other privileged ones to frame the health issues their communities faced as "normal." Take
29 Charles (white, cisgender, gay man in 50s-60s), who identifies as an "ordinary guy who does
30 ordinary things." He centers his community's health questions and concerns around exercise and
31 diet, expressing frustration with other community members that eat food full of "salt and sugar"
32 at potlucks.

33
34 Both Charles and Tony Solano engage in embodied information practices that render
35 their queer identities as visible and normalized. For Tony Solano, this means that he seeks out
36 and prioritizes HIV/AIDS research and presumes a potential universality to that need, one which
37 he presumes to be a shared and equally embodied information need across all queer-identifying
38 persons. Alternatively, Charles' queerness is so normalized that it often exists as a reality of his
39 identity, which is normal and arguably irrelevant to other queer-centric concerns. Crucially, for
40 both of these participants, their queerness remains a visible identity because neither experience
41 an attempt to deliberately leverage it in relationship to other salient identities, making it visible,
42 as opposed to invisible.
43

44 **Queerness as Invisible Identity**

45
46 Other participants belonged to communities where their queer and/or intersectional identities
47 were at odds with normative discourses, rendering their queerness invisible. This invisibility
48 operated in two interrelated ways – first, as invisible through oppressive erasure, and second, as
49 agentic, allowing communities to prioritize healthcare needs pertinent to other intersecting
50 identities.
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52
53 Annalisa (a white, cisgender, queer college-aged woman) addresses difficulties locating a
54 community of queer persons who are survivors of intimate partner violence (IPV) due to these
55 identities being erased. Noting the cisheteronormative presumption around IPV, Annalisa states:
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3 I'm a domestic violence survivor. And once that ended, I wanted to try to get a face to LGBT people who
4 are facing this issue because most people don't. And especially in the South it's man-woman, man-woman.
5 So, if you actually try to get any legal help, it really doesn't work. So, I volunteered with-- this more of a
6 worldwide organization to break the silence against domestic violence, trying to get more of a face for the
7 LGBT community there. With my own business, I donate to [ORGANIZATION] and any other domestic
8 violence organization that I can find around. There's not a lot of groups in [CITY] that I found for people.
9 So still kind of searching for that.

10
11 Annalisa's identities as queer and a survivor are rendered invisible by heteronormative and
12 cisnormative rhetoric. Such invisibility echoes Kai Cheng Thom's (2019) concern that for queer
13 individuals, movements around justice for sexual harassment often ignore femme individuals
14 who are not straight, white, cisgender women. However, Annalisa recognizes and embodies her
15 invisible queerness to become an information resource for other queer people facing IPV.
16 Specifically, she challenges the representational issues of IPV by informing others that queer,
17 femme presenting persons can be IPV survivors. Speaking on behalf of others like her, she notes
18 that validating her queer identity at the intersection of IPV survivor requires extended queer
19 labor that challenges recalcitrant heteronormative framings of IPV as occurring between specific
20 types of queer persons.
21

22 One's queerness could also be made invisible due to more dominant queer identities
23 within a space. Tony (black, transgender, heterosexual man in his 30s to 50s) illustrates this form
24 of invisibility when recounting his engagement with queer spaces, specifically a lesbian bar; a
25 space he used to engage in comfortably before coming out as a trans man:
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28 At least from my perspective, identifying as a trans male, it was more so the fact that I was no longer in a
29 community, right? So, I would still frequent the same bars, the same places, and then it kind of became,
30 "Why is that guy at a lesbian bar?" It's like, "Oh, you don't know who that is?" And then introduction to my
31 new community of being trans. And then it was like, "Oh." But I still wasn't kind of-- well, I got booted. I
32 got the boot from that community.
33

34 Tony's narrative illustrates how he became subject to particular animosity among bar patrons
35 because others read him as a man entering into a space meant for women only. What is invisible
36 here is Tony's trans identity. While others rightly read him as a man, the presumption among bar
37 patrons is he possesses no inherent queerness. Since Tony's masculinity is made visible, it occurs
38 at the expense of his sexuality being made invisible. This invisibility complicates and contests
39 clear lines of sexual orientation as one's sex-assigned-at-birth has historically informed them.
40 Specifically, Tony identifies with a sexuality attracted to the women he meets in lesbian bars.
41 This identification runs into an iteratively new moment of queer phenomenological
42 disorientation, as Tony is a body read by bar patrons as potentially unwelcome, or what Salamon
43 (2018) calls a body that is both a "danger" and in "danger" as it unsettles cisnormative
44 assumptions around gender and sexuality (p. 83). This paranoia among bar patrons does not
45 suggest that they are trans-exclusionary or necessarily transphobic; instead, due to their historical
46 relationship with violence enacted by cisgender men, Tony's body is one warranting questioning.
47

48 Tony's experiences with having his gender identity as a trans man attracted to women
49 regulated how he provides information to others in his role as a queer community leader. Tony
50 aims to include people with contested identities by asking questions about why and how they
51 should be allowed into queer spaces to engage in health information work:
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55 If there's something you-- if there's a reason a community doesn't want you in, I want to know, one, why
56 were you in the community to begin with? Do you still have that passion, that drives, that resource, that
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3 whatever? That everyone thought you were cool, and realized, wait, you're not. Do you still have that part?
4 Do you want to stay part of the community? Do you still want to help? Do you still want people to come to
5 you to get whatever they need? If you're as done with the community as community is with you, then cool.
6 It's a win-win. Bye. But if you still have that push, that drive, I'm not going to just dismiss you.
7

8 Like Annalisa, Tony's once invisible queerness now impacts how his health information work,
9 particularly how he determines who he lets into his community. When making these
10 assessments, he avoids presumptions of universal negativity, as evidenced by his litany of
11 questions around outsider involvement. Instead, Tony prioritizes outsiders' intention and passion
12 for helping a queer community over their seeming a threat based on perception alone. Though
13 Tony does not outright say this, we can imagine that he, too, sought a willingness to dialogue and
14 understand why he "got booted" from a lesbian space after coming out as a trans man.
15

16 While participants like Annalisa and Tony agentically embraced their queer invisibility
17 when others forcefully erased these identities, other participants actively lowered their queer
18 identities' salience to allow for other identities to emerge. Chloe (black, cisgender, bisexual
19 woman in her 20s-30s) describes how her community's queerness takes a secondary role to their
20 BlacknessBlackness when it comes to using medical professionals as a health resource:
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22
23 In terms of being in the black community, what I have found is that there is, from my perception, a fear of
24 doctors. And that's a discussion that has—that's a discussion that is constantly happening. It's something
25 that I even talk about with my colleagues who identify as Black. That naturally because of historical things,
26 black people do not like going to the doctor. Which then presents another interesting aspect when I talk to
27 Black or POC that identify as LGBT that don't want to necessarily seek out resources from doctors just for
28 fear of stigma or fear of how they'll be treated.
29

30 Chloe and her community's identity as black inform their practice of health information
31 avoidance as such avoidance responds to "historical" practices by medical practitioners that
32 marked black bodies as subject to exploitation (Somerville, 2000). This observation is not to say
33 that Chloe's queerness is outright invisible, but it makes more sense to prioritize needs based on
34 racial identity for her and her community. While this move does not produce queer invisibility
35 outright, it agentically aims to deprioritize it through increased visibility of a different shared
36 identity. Chloe notes that she and her community members are not ignorant or indifferent to their
37 queer identities, only that they have experienced healthcare discrimination primarily contingent
38 on race, suggesting, if anything, that health systems produce queer invisibility for herself and
39 others.
40

41 Participants may also assign other privileged identities more salience to tactically bring
42 visibility to their health questions and concerns. Allison (white, transgender, heterosexual white
43 woman in her 50s-60s) notes how her transness subjects her to health care professionals who
44 offer up specific metrics for her transition process, such as how well she aligns with a
45 male/female binary (Vipond, 2015). These professionals work to fit her transness into
46 transnormative discourses, wherein Allison's identity must match a visible and popular notion of
47 how transitioning should look. Allison embodies her privileged identities at the intersection of
48 age, specifically related to her trans experiences, to push back against these normative discourses
49 when discussing her assessment of medical professionals as trustworthy:
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53 I know what I think makes me trustworthy. But when you go to judge somebody else, if they're
54 trustworthy, that's an extremely individual basis. As I look at your face, do I see anything in your looks that
55 are telling me you're evil or that I'm evil to you? How do you sound? What's your reflection? When you
56 start quoting me stuff, do I think you're giving me BS, or do I think you're giving me knowledge? And
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3 there's a lot of people that know the terms and the keywords, but they do not understand the underlying
4 structure or information. And so when you ask questions, you need to dig beyond the surface to see what
5 they're saying...Because a lot of people can't answer those questions if they're not really involved. Like I
6 say, they've learned the keywords.
7

8 This quote from Allison speaks not only to how she navigates her visibility as a trans woman but
9 also clarifies that she has embodied her queer visibility as an information practice. She
10 understands that others see her as a source of embodied information because she has identified as
11 trans for a long time (openly or otherwise), but equally attends to avoiding sharing about this
12 identity when it might prove detrimental to her community of potentially queer students. In an
13 adjacent manner, she uses a history of mistrust and potential threat around her visibility to
14 question cautiously medical professionals tasked with advising her transition. Her whiteness also
15 affords her the ability to contest medical professionals. Unlike Chloe or Pat (whom we will
16 discuss shortly), Allison can prioritize her concerns as related to her queer identity while
17 simultaneously avoiding concerns that her race might result in her being tokenized, exploited, or
18 ignored.
19

20
21 In some instances, participants choose to render their queer identities invisible as part of a
22 risk/benefit analysis related to identity disclosure. Sarah (white, cisgender, pansexual woman in
23 high school) notes that she "knows a lot of considerably popular people who tell the people they
24 are straight because most of the popular people are very against any type of gay thing or
25 anything like that. So, they have to keep it a secret." For Sarah and her community of other queer
26 high schoolers, the potential social stigma of not aligning with heteronormativity outweighs any
27 benefits of being out. This account complicates the seemingly universal understanding of queer
28 visibility as honesty and safety as seen by other queer leaders with privileged identity
29 intersections like Tony Solano. Keeping their queer identities a secret, Sarah and her community
30 are not being dishonest or unsafe, but instead deciding on their terms that such visibility would
31 bring about more harm than it would benefit.
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34 **Queerness as Hypervisible Identity**

35 Like queer invisibility, hypervisibility operates simultaneously within both frames of oppression
36 and as a point of agentic choice. Both frames reflect societal pressures that mark marginalized
37 persons as different and in need of correction.
38

39 Participant narratives denote how queerness intersects with other historically exploitable
40 identities to produce bodies that are hypervisible sites of exacerbated oppression. Pat (black,
41 transfeminine, gender nonconforming person, of college-age) illustrates such oppression when
42 noting how her community must trade economic and embodied informational exploitation to
43 access health resources:
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46 Our health information and data is profitable, point blank, period. But health information is profitable in a
47 particular kind of way that I think it's really important to be cognizant of, and people devise really interesting
48 ways to get health information from you. I think one of the—a really subtle way that I don't think people
49 really realize that they're providing health information is those DNA tests that people have been—that have
50 gained popularity, especially among African-Americans who don't really have access to genealogical
51 information...also I mentioned during our interview, I talked about pharmaceutical companies and how
52 pharmaceutical companies are also really big into getting you to sign up for clinical trials or just trying to sell
53 you drugs.
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3 Like Chloe, Pat expresses a well-justified hesitation concerning established medical institutions,
4 which she observes have a significant interest in gaining capital – monetary, medical, discursive,
5 etcetera – from the bodies of persons of color. She notes how queer bodies of color become
6 hypervisible sites of the communities' collective paranoia around HIV/AIDs and STDs,
7 suggesting that the aforementioned pharmaceutical companies prey upon her and her community
8 as sites to profit upon for drug treatments. Specifically, Pat notes how the prevalence of health
9 care professionals, often uninvited, in trans of color spaces, illustrating the mainstream desire to
10 see trans bodies of color as sexually promiscuous.

11
12 Pat further explains how her community must play into this hypervisibility as themselves
13 as “carriers” to gain access to health information and services:
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16 So, accessing proper healthcare-- a lot of us also-- some of us are able to access healthcare if we're positive.
17 So, if we are positive, we can go to places like the immunology center and we're able to get on like
18 treatment regimens, and other federally funded programs are able to get us dental care and healthcare.
19 Things like that. There are some people who are referred to as bug chasers, who try to become positive in
20 order to access those things as well.

21
22 Through this account, Pat demonstrates how some of her community members attempt to test
23 positive through bug chasing to access health information and resources. Such bug chasing
24 represents an agentic attempt among community members to be healthy, even if the practice
25 exists outside traditional notions of efficacious health behaviors. While bug chasing may not be a
26 desirable practice, Pat notes its legitimacy among community members who perceive it as one of
27 the few outlets for access available to them.

28
29 Pat's narrative echoes Chloe's around how bodies of color, particularly black bodies, are
30 sites of historical exploitation among the medical sciences. Pat's narrative evokes ideas similar to
31 Somerville's argument that queer black bodies often exist as sites of the sexually perverse, which
32 works to "naturalize and legitimize a cultural myth" that they are to blame for sexual
33 transgression, in this case, HIV/AIDs (p. 37). Her community's desire to become hypervisible is
34 a double-edged sword, one that gives them health care with the caveat that they play into a
35 historical trope of being paraphilic. Pat's narrative reminds us that the choice to avoid visibility
36 can be a strategic act. For her and her community, marginality is not necessarily negative. Her
37 choice and the choice of the individuals she works with to avoid visibility works to avoid
38 tokenization and exploitation within racist and anti-queer medical spaces whose research relies
39 on models driven by profits instead of ethics.

40
41 Queer communities also wielded hypervisibility to engage in direct, embodied
42 informational activism. Kim Williams (white, cisgender, pansexual woman, in her 30s to 50s)
43 exemplifies this activism when discussing how her organization exists for queer people who
44 have hit their breaking point:
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46
47 I'll walk you to the hospital. I'll sit with you until they take you back. I will do whatever it takes to get it
48 done. But I think everybody's trying to reach out more. I don't really know. The people that I deal with,
49 would [local LGBTQ+ organization] help them? No. Okay? They are in trouble. I always say, "Mocha
50 [Kim's organizational co-founder] and Kim get the broken." Okay. And then we kind of tape them up and
51 duct-tape them and get them back to where they can go.

52
53 Kim Williams exists on the periphery of queer activism within SC and stands out as visible in
54 her willingness to help when others will not. Both Kim and her co-organizer Mocha mark this
55 latter work as diverging from other queer activist organizations, which avoid hypervisibility to
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3 align with respectability politics. Consider the comparison of her organization with another that
4 she feels operates under the radar:
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6 We just have to educate more, and I need to make it more visual. I know the [ORGANIZATION], that we
7 are not of the same blood. They like that stealth shit. I don't like that stealth. I think that does us a
8 disservice. We need to be out and proud. Maybe not as loud as we used to be. However, we do need to
9 stand up and defend.
10

11 As Kim Williams notes, such hypervisibility has caused her organization some trouble, including
12 being kicked out of the library where we interviewed her and her co-founder for this project.
13 During this interview, Kim Williams suggested that part of what makes her organization have to
14 be hypervisible relates to economic mobility. Speaking to us as researchers, she suggested that
15 we were able to engage in queer-related research due to our grant funding; similarly, many of the
16 queer organizations she was rightly critical of could afford to be patient and "stealthy" due to
17 their consistent funding streams. Kim Williams contests such stealth by asserting that were her
18 organization to have such funding, they would invest their resources into becoming visibly
19 inclusive:
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23 I want a big kitchen with a huge table like this for [crosstalk] And we can put everybody and all the food on
24 the table. That's what we want. We want a home. We want a rainbow home. We want to get grants and
25 funding, and we want to get something like Harriet [notable SC community leader] has, because it's so
26 beautiful.
27

28 Because her community lacks similar resources, Kim Williams envisions her activism via queer
29 hypervisibility as fundamentally necessary. The queer people she is trying to reach are often at
30 their most dire, whether facing economic hardship or thoughts of suicide; she notes that patience
31 is not an option. Even if it comes with marked disdain directed at her and her organization from
32 others, her hypervisibility proves justifiable if it promises support to those whose needs are
33 invisible in other communities engaging in queer assimilation.
34

35 Both Pat and Kim Williams' navigations of queer hypervisibility are at odds with
36 systemic rhetoric concerning queer exclusion and inclusion. Kim Williams becomes hypervisible
37 to push back against ideas of homonormative assimilation that excludes marginal intersectional
38 identities such as class and mental health (Duggan, 2002). Pat questions hypervisible practices
39 by community members. She views these practices as relevant in accessing healthcare, but as
40 falling short of uprooting systemically racist practices producing these disparities in the first
41 place (Spade, 2011).
42
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44 **Implications**

45 Though each type of queer visibility as produced within various intersectional identities proves
46 iteratively different, some notable findings emerge that invite considerations worth further
47 exploration in future research. While our implications are primarily for the health care profession
48 and how they perceive of queer communities monolithically, the extensions of these discussions
49 certainly impact the work and identity salience of queer community leaders as well. First, queer
50 visibility informs embodied information practices and proximity to health information. This
51 theoretical linkage has been under been underexplored in the literature and is critical to
52 understand as it provides new ways to understand the unique, individual-level ways that queer
53 visibility manifests.
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Second, queer visibility is temporally contextual. How one embodies their queerness as an information practice changes over time and is relative to the saliences other identities afford a person. Such a consideration is hardly new, yet it does provide further affirmation of how temporality requires one to extend their utilization of intersectionality as a theoretical framework. As Jasbir Puar (2005) rightly observes, "intersectionality demands the knowing, naming, and thus stabilizing of identity across space and time, generating narratives of progress that deny the fictive and performative of identification" (p. 128). Future research can incorporate temporality into considerations of intersectionality by understanding the desires of particular groups to achieve assimilation occurs through universalizing queer experiences at the risk of overlooking particular systems of oppression privileging some queer members of LGBTQIA+ communities.

Finally, findings denote that intersectional systemic oppressions mask politics of assimilation and essentialism. Perhaps unsurprisingly, the seductive nature of queer assimilation leads to troubling confluences among queer communities of a universalized queer experience. These confluences can lead to the negation of how other systemic inequalities like racism perpetuate in healthcare systems. Alternatively, queerness can also become a misguided move for embodied essentialism, such as by assuming that younger members of a queer community do not take care of their health due to their age. These findings contribute to prior research by offering important links between theoretical issues within queer community making and the use of health-related infrastructures both individually and collectively.

Findings also have practice-based implications for health professionals and queer community leaders. The first is to recognize and leverage queer silence as informative to professional praxis. As findings and prior research demonstrate, visibility is not necessarily always desired by queer communities. Further, forms of invisibility and hypervisibility may prove agentic in advancing shared goals. Consider Allison, who directly confronts silences within her personal health information seeking practices by embodying a critical lens of authority within medical professionals. Knowing that she faces severe repercussions on a personal level if she is to out herself to her students means she also questions the presumed neutrality and intent of medical professionals who might find themselves bound by similar institutional silences. In turn, health professionals can take this increased inquisitive nature as an attempt to signal a desire for sharing in queer knowledge even if such sharing must happen discretely on their part. Alternatively, the reality that a person may not share their queer identity does not mean that they might not benefit from receiving health information relevant to queer communities. As Allison, Sarah, and to a certain extent, Pat's examples show us, there are queer youth who desire knowledge and health-related information even if they are not openly discussing such desires. When possible, health care professionals could provide queer-oriented healthcare resources within and in proximity to school settings to attend to such deliberate silences.

Further, community leaders and healthcare professionals should recognize that silence does not necessarily reflect ignorance. For instance, we challenge presumptions like Tony Solano's that younger queer folks do not care about their health because they do not speak about HIV/AIDs prevention issues. Presuming silence as an act of ignorance belittles the actualities of many queer youths. Their silence is likely in response to social spaces in which their outness is detrimental or disallowed. Here, queer community leaders might explore policy changes in which schools shift practices to support queer students in verbally expressing concerns around their health information needs. Further, such a reorientation would afford space to consider why

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3 a group, such as the queer communities of color, choose not to seek out explicitly queer health
4 information. Here, such a choice is not one of being ignorant silence but instead choosing to
5 direct one's voice to a more silent community-based need.
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7 Finally, community leaders and healthcare professionals must recognize how queer
8 hypervisibility often produces necessary and agentic embodied information practices. For Pat,
9 the embodied information practices of simultaneously questioning healthcare's hypersurveillance
10 of her body as a queer body of color and her engagement within bug chasing provide an
11 intersecting and literalized use of the body to gain information. She notes that she and her
12 community avoid many healthcare spaces because of costs associated with this work, thus
13 producing information avoidance within a situation wherein health information presumes
14 necessary medical, institutional authority. Despite its dangers and presumed negativity, bug
15 chasing provides a way to access healthcare cheaply and for Pat's community, effectively causing
16 it to be a physically driven means of information access. In turn, healthcare professionals
17 working within HIV/AIDs prevention could better serve communities of color seeking basic
18 healthcare and see preventative services as fulfilling those needs by allowing the use of
19 preventative care with or without testing positive for a given STI/D. Such a reconsideration of
20 resource access allows for queer-focused healthcare to remain intersectional by noting that
21 sexual activities and HIV/AIDs are hardly the only concern of queer communities and remain
22 even less so when placed with other embodied identities.
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26 **Limitations**

27 While our shared positions as queer researchers potentially aided in the recruitment of queer
28 diversity, or presences as white academics potentially hindered interest in participation across
29 diverse identities. Similarly, while our recruitment efforts aimed to include non-academic spaces
30 such as queer affinity groups and LGBTQIA+ community centers, our reliance on snowball
31 sampling meant that many participants had previous ties to our academic institution or previous
32 involvement with our institution. Beyond this, our questions and focus of research prioritized
33 health information practices related to the participants' potential queer identities. While we aimed
34 to be as intersectional as possible in our focus, this particular identity emphasized that many of
35 the points raised around topics such as race and class grew from participant concerns. In turn,
36 future questioning can be more deliberate to allow participants to emphasize how other
37 potentially salient identities factor into their health information practices. Finally, while our
38 questions framed health practices broadly, many participants sought clarification about whether
39 or not mental health issues fell under our lines of inquiry. Such moments of clarification on the
40 part of our participants suggest that while we value the importance of including mental health
41 issues in our analysis, we ought to be more deliberate in future research to evoke mental health
42 concerns in our discussions directly.
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47 **Conclusion**

48 Though a small, geographically specific representation of queer community health practices, our
49 research shows that one's queer identity produces both barriers and unique points of access
50 regarding how queer communities engage with information. However, when it comes to one's
51 relationship with medical institutions, queerness is often a relative identity that makes one's use
52 of and production of health information practices contextually embodied. When it comes to
53 healthcare and the systems producing a thing called health information, discourses of health and
54 those practicing those discourses often choose to see queerness as a priority of embodiment in
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3 some. In contrast, it is a secondary and irrelevant point of identity in others. These embodiments
4 produce unique orientations towards and against health information across one's lived
5 experience, wherein things like race, age, and class produce tiered visibilities of one's queerness.
6 As we have shown, each version of one's queerness and its visibility relative to other lived
7 identities produced unique embodied information practices that marked one's need to be seen or
8 not seen as highly nuanced and anything but universal. Our paper ultimately illuminates that
9 when we discuss queer visibility and its relationship to healthcare, we must also discuss other
10 identities and embodiments that always exist alongside queerness, whether it be race, ability, or
11 class. As such, our participants make clear that no work done to increase the visibility of concern
12 for queer health can exist without also attending to how healthcare has produced multiple points
13 of marginality across other systems of oppression. Ultimately, our work shows that when it
14 comes to prioritizing the healthcare needs of queer persons across intersectional identities, that is
15 hardly enough to focus on the most visible and vocal or the most invisible and quiet. Within each
16 instance of visibility, there exists a purposeful and potential silence. In the moments of
17 invisibility, there too exists a voice full of agentic and focused amplification.
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