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

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

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

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

**Literature Review**

**Queer Visibilities**

Visibility represents one’s ability to be recognized and exert control over how others perceive and represent them (Brighenti, 2007; Lollar, 2015; Lewis & Simpson, 2012). The notion of visibility within the queer politic suggests inherent positivity. Indeed, the "increased cultural representation of homosexual concerns as well as the recent queering of sex-gender identity undoubtedly has had important positive effects" such as civil protection, the legitimization of queer scholarship, and general moments of queer empowerment (Hennessy, 2002, p. 111).

However, Hennessy marks such discursive and cultural acknowledgment of queer identity as false liberation within late capitalism. Put differently, the welcoming of queer individuals into any system, whether it be businesses or healthcare, occurs because queer persons became market consumers. They are visible as a "consumer subject but not social subject" (p. 112).

Such increased queer visibility occurs with perverse irony for various communities within the larger queer umbrella. For individuals living today with HIV/AIDS, their visibility in historical memory and current access to care fail to address the underlying stigma existing around the act of gay sex and those identifying as gay (Beltran et al., 2020). Similarly, the increased offering of transgender medicine and access to transition-related care ignores the realities that such provisions exist alongside a desire to mark these bodies as deviant (Poteat et al., 2013), surveil them, and bring them within normative notions of Western gender binaries (Beauchamp, 2009). Both examples illustrate that the queer subject whose visibility seems new, or part of a "phenomenon," actually suggests increased subjugation and surveillance within normative discourse (Foucault, 1978/1990).

Who gets to be queer and visible depends on other lived experiences that precede and inform queerness. Duggan (2002) calls this phenomenon a "new homonormativity" wherein select queer individuals find value and social acceptance despite their queer identities by attending to and often overtly embracing other privileged identities. For instance, cisgender, gay, white men of relative means experience privilege because their gay identity is either secondary or overlooked. These homonormative queers engage in assimilationist queer politics to the detriment of pro-queer efforts for radical inclusion vis-à-vis groups like Log Cabin Republicans (p. 177). Spade (2011) argues that while many institutions have moved toward positive inclusion for transgender persons, these moves come rarely attend to how such systems remain racist, classist, and ableist.
Further, these efforts often elide that transphobia is far more pervasive from both legal and political standpoints than homophobia. Spade suggests that transgender individuals face "subjection" rather than oppression, resulting in a person being a queer subject whose limited visibility does not protect discrimination in other ways, such as being transgender (2011, p. 25). This type of queer visibility signifies queer identities as allowed, not embraced, and supports the assimilation of certain white queers into neoliberal, pro-American spaces that reinstate racism, xenophobia, sexism, ableism, and other non-inclusive ideologies (Puar, 2005).

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

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

**Embodied Health Information Practices**

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

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

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

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

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

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

**Methods**

This paper reports on a larger research project consisting, in part, of semi-structured interviews with 30 queer community leaders in SC about their and their communities' health information practices. SC served as a critical geographical context due to the unique health disparities experienced by queer populations, including heightened economic instability, unemployment, and lack of health insurance (Mallory & Sears, 2019). Community served as our observation unit due to the importance of community involvement in queer health information practices (Veinot et al., 2013). We assumed that leaders possess a snapshot of their communities' larger problems, practices, and experiences while acknowledging that they are not community spokespeople (Macdonald et al., 2013). We recruited adults and teens, ages 13-17, to acknowledge the presence of dynamic youth queer 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. Instead, we collected youth assent (see also Steinke et al., 2017).
We used purposive sampling to identify visible queer organizations and affinity groups with an express interest in supporting queer persons. We asked these organizations and groups to self-nominate leaders to participate and recruited additional participants through snowball and theoretical sampling. The latter strategy was to gather alternative perspectives and gaps in demographic representation guided by prior work, highlighting important intersectional identities for queer communities in the American South regarding health outcomes (e.g., Harless et al., 2020). Participants identified across the spectrum of queer identities. The majority of participants (60%) were white, and the remaining 40% were Black and/or biracial. Participants identified across various classes and educational ranges, and many disclosed various disabilities – physical, intellectual, cognitive, and sensory.

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

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

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

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

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

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

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

Queerness as Invisible Identity
Other participants belonged to communities where their queer and/or intersectional identities were at odds with normative discourses, rendering their queerness invisible. This invisibility operated in two interrelated ways – first, as invisible through oppressive erasure, and second, as agentic, allowing communities to prioritize healthcare needs pertinent to other intersecting identities.

Annalisa (a white, cisgender, queer college-aged woman) addresses difficulties locating a community of queer persons who are survivors of intimate partner violence (IPV) due to these identities being erased. Noting the cishetoronormative presumption around IPV, Annalisa states:
I'm a domestic violence survivor. And once that ended, I wanted to try to get a face to LGBT people who are facing this issue because most people don't. And especially in the South it's man-woman, man-woman. So, if you actually try to get any legal help, it really doesn't work. So, I volunteered with-- this more of a worldwide organization to break the silence against domestic violence, trying to get more of a face for the LGBT community there. With my own business, I donate to [ORGANIZATION] and any other domestic violence organization that I can find around. There's not a lot of groups in [CITY] that I found for people. So still kind of searching for that.

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

One's queerness could also be made invisible due to more dominant queer identities within a space. Tony (black, transgender, heterosexual man in his 30s to 50s) illustrates this form of invisibility when recounting his engagement with queer spaces, specifically a lesbian bar; a space he used to engage in comfortably before coming out as a trans man:

At least from my perspective, identifying as a trans male, it was more so the fact that I was no longer in a community, right? So, I would still frequent the same bars, the same places, and then it kind of became, "Why is that guy at a lesbian bar?" It's like, "Oh, you don't know who that is?" And then introduction to my new community of being trans. And then it was like, "Oh." But I still wasn't kind of-- well, I got booted. I got the boot from that community.

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

Tony’s experiences with having his gender identity as a trans man attracted to women regulated how he provides information to others in his role as a queer community leader. Tony aims to include people with contested identities by asking questions about why and how they should be allowed into queer spaces to engage in health information work:

If there's something you-- if there's a reason a community doesn't want you in, I want to know, one, why were you in the community to begin with? Do you still have that passion, that drives, that resource, that
whatever? That everyone thought you were cool, and realized, wait, you're not. Do you still have that part? Do you want to stay part of the community? Do you still want to help? Do you still want people to come to you to get whatever they need? If you're as done with the community as community is with you, then cool. It's a win-win. Bye. But if you still have that push, that drive, I'm not going to just dismiss you.

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

While participants like Annalisa and Tony agentically embraced their queer invisibility when others forcefully erased these identities, other participants actively lowered their queer identities' salience to allow for other identities to emerge. Chloe (black, cisgender, bisexual woman in her 20s-30s) describes how her community's queerness takes a secondary role to their Blackness when it comes to using medical professionals as a health resource:

In terms of being in the black community, what I have found is that there is, from my perception, a fear of doctors. And that’s a discussion that has—that’s a discussion that is constantly happening. It’s something that I even talk about with my colleagues who identify as Black. That naturally because of historical things, black people do not like going to the doctor. Which then presents another interesting aspect when I talk to Black or POC that identify as LGBT that don’t want to necessarily seek out resources from doctors just for fear of stigma or fear of how they’ll be treated.

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

Participants may also assign other privileged identities more salience to tactically bring visibility to their health questions and concerns. Allison (white, transgender, heterosexual white woman in her 50s-60s) notes how her transness subjects her to health care professionals who offer up specific metrics for her transition process, such as how well she aligns with a male/female binary (Vipond, 2015). These professionals work to fit her transness into transnormative discourses, wherein Allison’s identity must match a visible and popular notion of how transitioning should look. Allison embodies her privileged identities at the intersection of age, specifically related to her trans experiences, to push back against these normative discourses when discussing her assessment of medical professionals as trustworthy:

I know what I think makes me trustworthy. But when you go to judge somebody else, if they're trustworthy, that's an extremely individual basis. As I look at your face, do I see anything in your looks that are telling me you're evil or that I'm evil to you? How do you sound? What's your reflection? When you start quoting me stuff, do I think you're giving me BS, or do I think you're giving me knowledge? And
there's a lot of people that know the terms and the keywords, but they do not understand the underlying structure or information. And so when you ask questions, you need to dig beyond the surface to see what they're saying...Because a lot of people can't answer those questions if they're not really involved. Like I say, they've learned the keywords.

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

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

**Queerness as Hypervisible Identity**

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

Participant narratives denote how queerness intersects with other historically exploitable identities to produce bodies that are hypervisible sites of exacerbated oppression. Pat (black, transfeminine, gender nonconforming person, of college-age) illustrates such oppression when noting how her community must trade economic and embodied informational exploitation to access health resources:

> Our health information and data is profitable, point blank, period. But health information is profitable in a particular kind of way that I think it’s really important to be cognizant of, and people devise really interesting ways to get health information from you. I think one of the—a really subtle way that I don’t think people really realize that they’re providing health information is those DNA tests that people have been-that have gained popularity, especially among African-Americans who don’t really have access to genealogical information...also I mentioned during our interview, I talked about pharmaceutical companies and how pharmaceutical companies are also really big into getting you to sign up for clinical trials or just trying to sell you drugs.
Like Chloe, Pat expresses a well-justified hesitation concerning established medical institutions, which she observes have a significant interest in gaining capital – monetary, medical, discursive, etcetera – from the bodies of persons of color. She notes how queer bodies of color become hypervisible sites of the communities’ collective paranoia around HIV/AIDS and STDs, suggesting that the aforementioned pharmaceutical companies pray upon her and her community as sites to profit upon for drug treatments. Specifically, Pat notes how the prevalence of health care professionals, often uninvited, in trans of color spaces, illustrating the mainstream desire to see trans bodies of color as sexually promiscuous.

Pat further explains how her community must play into this hypervisibility as themselves as “carriers” to gain access to health information and services:

So, accessing proper healthcare-- a lot of us also-- some of us are able to access healthcare if we're positive. So, if we are positive, we can go to places like the immunology center and we're able to get on like treatment regimens, and other federally funded programs are able to get us dental care and healthcare. Things like that. There are some people who are referred to as bug chasers, who try to become positive in order to access those things as well.

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

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

Queer communities also wielded hypervisibility to engage in direct, embodied informational activism. Kim Williams (white, cisgender, pansexual woman, in her 30s to 50s) exemplifies this activism when discussing how her organization exists for queer people who have hit their breaking point:

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 done. But I think everybody's trying to reach out more. I don't really know. The people that I deal with, would [local LGBTQ+ organization] help them? No. Okay? They are in trouble. I always say, "Mocha [Kim's organizational co-founder] and Kim get the broken." Okay. And then we kind of tape them up and duct-tape them and get them back to where they can go.

Kim Williams exists on the periphery of queer activism within SC and stands out as visible in her willingness to help when others will not. Both Kim and her co-organizer Mocha mark this latter work as diverging from other queer activist organizations, which avoid hypervisibility to
align with respectability politics. Consider the comparison of her organization with another that she feels operates under the radar:

We just have to educate more, and I need to make it more visual. I know the [ORGANIZATION], that we are not of the same blood. They like that stealth shit. I don't like that stealth. I think that does us a disservice. We need to be out and proud. Maybe not as loud as we used to be. However, we do need to stand up and defend.

As Kim Williams notes, such hypervisibility has caused her organization some trouble, including being kicked out of the library where we interviewed her and her co-founder for this project. During this interview, Kim Williams suggested that part of what makes her organization have to be hypervisible relates to economic mobility. Speaking to us as researchers, she suggested that we were able to engage in queer-related research due to our grant funding; similarly, many of the queer organizations she was rightly critical of could afford to be patient and "stealthy" due to their consistent funding streams. Kim Williams contests such stealth by asserting that were her organization to have such funding, they would invest their resources into becoming visibly inclusive:

I want a big kitchen with a huge table like this for [crosstalk] And we can put everybody and all the food on the table. That's what we want. We want a home. We want a rainbow home. We want to get grants and funding, and we want to get something like Harriet [notable SC community leader] has, because it's so beautiful.

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

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

**Implications**

Though each type of queer visibility as produced within various intersectional identities proves iteratively different, some notable findings emerge that invite considerations worth further exploration in future research. While our implications are primarily for the health care profession and how they perceive of queer communities monolithically, the extensions of these discussions certainly impact the work and identity salience of queer community leaders as well. First, queer visibility informs embodied information practices and proximity to health information. This theoretical linkage has been under been underexplored in the literature and is critical to understand as it provides new ways to understand the unique, individual-level ways that queer visibility manifests.
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 conflations among queer communities of a universalized queer experience. These conflations 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
a group, such as the queer communities of color, choose not to seek out explicitly queer health information. Here, such a choice is not one of being ignorant silence but instead choosing to direct one’s voice to a more silent community-based need.

Finally, community leaders and healthcare professionals must recognize how queer hypervisibility often produces necessary and agentic embodied information practices. For Pat, the embodied information practices of simultaneously questioning healthcare's hypersurveillance of her body as a queer body of color and her engagement within bug chasing provide an intersecting and literalized use of the body to gain information. She notes that she and her community avoid many healthcare spaces because of costs associated with this work, thus producing information avoidance within a situation wherein health information presumes necessary medical, institutional authority. Despite its dangers and presumed negativity, bug chasing provides a way to access healthcare cheaply and for Pat's community, effectively causing it to be a physically driven means of information access. In turn, healthcare professionals working within HIV/AIDS prevention could better serve communities of color seeking basic healthcare and see preventative services as fulfilling those needs by allowing the use of preventative care with or without testing positive for a given STI/D. Such a reconsideration of resource access allows for queer-focused healthcare to remain intersectional by noting that sexual activities and HIV/AIDS are hardly the only concern of queer communities and remain even less so when placed with other embodied identities.

Limitations

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

Conclusion

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

References


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