Exploring Intersectionaity Theory and Its Implications for LIS Pedagogy: Insights from LGBTQIA+ Communities Across Age, Gender, Immigrant Status, and Race/Ethnicity

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ABSTRACT

This paper explores how intersecting forms of marginalization shape health information access for diverse LGBTQIA+ populations, focusing on sapphic individuals across generations and LGBTQIA+ people of color. Guided by Collins' matrix of domination, we identify structural, disciplinary, cultural, and interpersonal barriers to health information across multiple identities produced by interlocking power systems of race, gender, sexuality, age, and citizenship. Based on these findings, we provide suggestions for how the LIS curriculum can incorporate intersectionality theory into training future information professionals to work with equity-deserving populations within health contexts.

ALISE RESEARCH TAXONOMY TOPICS

Social justice; Specific populations; Pedagogy; Information needs; Information seeking.

AUTHOR KEYWORDS

Intersectionality; Sapphic individuals across generations; LGBTQIA+ people of color; Health information; LIS education.

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INTRODUCTION

The intersection of race/ethnicity, ability, age, immigration, and LGBTQIA+ status shapes how individuals access health information. Existing LIS studies demonstrated the challenges facing LGBTQIA+ individuals embodying multiple marginalizations in health information access. Sapphic communities, i.e., people of various gender identities, such as cis women, trans femmes, trans mascs, and nonbinary, who experience attraction to women or woman-aligned individuals (Hamou, 2022), encounter heterosexual and gender assumptions in healthcare. Providers often assume lesbians are low STI risk and uninterested in maternity, yet require pregnancy testing for monogamous same-sex couples. Information gatekeeping and negative experiences foster distrust and reluctance to seek healthcare (Polonijo & Hollister, 2011; Ruppel et al., 2017). Generational differences also shape LGBTQIA+ individuals' health information access. While LGBTQIA+ youth face family rejection and cis-heteronormative sex education, older LGBTQIA+ adults are more likely to encounter misconceptions about their sexual orientation and anticipated stigma due to historical discrimination in health settings (Clark et al., 2020; Conyers et al., 2023; Evans et al., 2017; LaVaccare et al., 2018; Steinke et al., 2017). LGBTQIA+ POC often face trade-offs between finding providers who understand their racial background or their LGBTQIA+ identity (Agenor et al., 2022). Exclusion within both racial and LGBTQIA+ communities creates additional barriers to health information among LGBTQIA+ POC (Cantos et al., 2023; Lopez-Leon & Casanova, 2023).

While these studies acknowledge the diversity among LGBTQIA+ individuals, intersectionality provides a theoretical perspective to understand their experiences. This paper uses Collins' matrix of domination to identify the unique challenges to health information among LGBTQIA+ individuals embodying multiple marginalizations, with a focus on sapphic individuals across generations and LGBTQIA+ POC. The findings contribute to LIS pedagogies in health information services by centering the experiences of diverse LGBTQIA+ populations we aim to serve–not just relying on "best practices" or "standards" created by professionals, but informing what inclusive, culturally competent, and intersectionality-informed librarianship for health information should look like in practice. While we focus on specific populations, this paper offers insights about other groups experiencing multiple marginalizations.

THEORETICAL FRAMEWORK

Intersectionality theory

Intersectionality theory is an approach to understanding the complexities of human experiences and how multiple systems of power and oppression interact (Collins & Bilge, 2016). It emphasizes that interlocking systems of power, such as race, gender, sexuality, and age, shape people's context-specific experiences (Collins, 2017; Collins & Bilge, 2016). Intersectionality theory provides a framework to understand how multiple, overlapping systems of power shape the health information access of LGBTQIA+ individuals. Rather than treating barriers to health information as created by one single power system, this study recognizes that race, gender, sexuality, age, and citizenship co-construct the marginalization of participants. With this theoretical lens, the findings do not generalize LGBTQIA+ experiences but instead account for variations shaped by social and historical context.

The matrix of domination

The matrix of domination is a conceptual model that helps us think about how power, oppression, privilege, and resistance are systematically distributed (Costanza-Chock, 2020). This model emphasizes that power is organized in multiple levels (Collins, 2017; López et al., 2018), including:

- The structural domain: public policies that organize and regulate social institutions
- The disciplinary domain: practices of social institutions that create and sustain inequality
- The cultural domain: hegemonic ideas and counter-hegemonic ideas; it is the "glue" connecting all levels of power
- The interpersonal domain: everyday experiences of marginalization in social interactions

Collins (2017) also emphasizes that domination and resistance are intertwined; within every system of oppression, there are also resistant practices. With this framework, we explore barriers to health information of sapphic individuals across generations and LGBTQIA+ POC within structural, disciplinary, cultural, and interpersonal domains created by the interlocking power systems of race, age, gender, sexuality, and citizenship.

METHODOLOGY

This paper draws on several qualitative research projects that examine the health information practices of LGBTQIA+ communities and individuals, including:

- Project 1: Semi-structured interviews with 30 LGBTQIA+ community leaders (January – August 2019, South Carolina)
- Project 2: Virtual focus groups with 34 LGBTQIA+ individuals (August 2020 – March 2021, South Carolina)
- Project 3: Virtual semi-structured interviews with 5 Chinese gay men in the US (November 2024 – June 2025, different states in the US)

Among them, Project 3 explores the impacts of intersectionality on health information access. However, it is necessary to include Projects 1 and 2 to address the limitations of a small, homogenous sample in the project. Therefore, we selected sapphic participants in Projects 1 and 2 to provide a more comprehensive understanding of how sexuality intersects with other power systems. Generational cohorts emerged as a key intersecting identity in the earlier findings of Projects 1 and 2; however, the intersection of age and sapphic identities was not thoroughly investigated from an intersectionality lens (see Kitzie, 2024). Accordingly, this paper highlights two cases: sapphic individuals across generational cohorts and LGBTQIA+ POC. Altogether, the participants from all three projects spotlighted in this paper illustrate the complexity of LGBTQIA+ communities, providing valuable examples of how race/ethnicity, gender, sexuality, age, and citizenship interlock and create barriers to health information access.

Guided by the matrix of domination, we used thematic analysis to identify themes related to health information barriers within the structural, disciplinary, cultural, and interpersonal domains. The coding process combined both inductive and deductive approaches. An existing codebook informed the analysis of Projects 1 and 2. We reorganized the codes with the matrix of domination. We coded data from Project 3 inductively using open coding, then applied axial coding to group the emergent codes deductively into the matrix of domination.

PRELIMINARY FINDINGS

Structural barriers

Participants revealed barriers to health information rooted in exclusionary policy and institutional design. Younger sapphic participants reported that they received abstinence-only sex education that erased queer experiences. Older sapphic adults who formed partnerships before the Marriage Equality Act may lack official marriage certificates, limiting their rights in their partners' healthcare decision-making. Chinese LGBTQIA+ immigrants expressed concerns about unstable immigrant policies and visa-related restrictions. For example, Tony (Man, Gay, Chinese) was on his partner's visa to legally work in the US: "With the Trump administration, I am not sure if he will cancel the H4B," which could be an "unpredictable future." This uncertainty can threaten Chinese LGBTQIA+ immigrants' legal status to stay in the US and limit their employment opportunities, resulting in limited access to health insurance and resources. The cost and complexity of healthcare in the US also hindered Chinese LGBTQIA+ immigrants from seeking health support from health professionals. Kevin (Man, Gay, Chinese) mentioned that he didn't continue therapy beyond his university's free sessions due to the cost of external referrals.

Disciplinary barriers

Institutional gatekeeping restricts participants' access to health information. Trans youth face restrictive laws requiring parental approval for gender-affirming care. Abby Jennings (Transgender woman, Lesbian, White, 18-25) noted that she understood "the legal point" of medical institutions following age-based limits of consent laws; however, she was concerned that families might kick youth out of their homes if they brought up health issues related to their trans identities. Younger LGBTQIA+ individuals face challenges in schools due to the denial of gay-straight alliances and other support spaces. The monolingual health resources limited Chinese LGBTQIA+ immigrants' access to health information. For example, Tony preferred to seek health information from Chinese websites because he found it challenging to understand the language used in information conversations on US websites, such as "short names and programs."

Participants also expressed frustration at the lack of culturally competent providers. Howard (Man, Gay, Chinese) shared his experience of a consulting session with an Indian female therapist for his pressures: “I felt like she had a hard time understanding the situation of Chinese people. I just didn’t feel she could really relate, so I felt like talking to her wouldn’t be helpful.” Howard also expressed his concerns about the US approach to mental healthcare, saying he tried medication but stopped due to side effects and ineffectiveness: “I felt like I was better off not taking it.” Lacking visibility in US society and academic research also contributes to our participants’ limited access to mental health support. As Kevin pointed out, Chinese LGBTQIA+ immigrants were “small in number” and “not very visible” in the US society, resulting in the difficulty of “find[ing] peers with similar backgrounds.” He noted that “the issues faced by this group just aren’t very prominent” in academic research.

Cultural barriers

Adultism may impact younger sapphic individuals’ interaction with health information, as manifested by the consent laws when seeking gender-affirming care. Abby Jennings related her lack of confidence in evaluating health information to being young, which may evidence internalized adultism. Historical events related to LGBTQIA+ communities may shape older sapphic adults’ health information access. Deb (Lesbian, White, 55-64) recalled that during the AIDS crisis, she saw families exclude close friends from their loved ones’ death transition. This experience makes Deb concerned that her community will “have to go back to the closet as they get older,” which may lead to irrelevant health information and limited access to community support.

Cultural differences and racism contributed to the social isolation of Chinese LGBTQIA+ immigrants. Kevin described struggling to connect with his White classmates: “I felt like I had to make significant adjustments…to find common ground with White peers. But then I also felt confused because I didn’t know how much of an adjustment would still feel fine for me.” He reflected on the difficulty of distinguishing marginalization from differences: “I felt like my way of being might not be acknowledged by the mainstream. So I wasn’t sure if I was actually doing something wrong, or was I just different?” Jarret (Man, Gay, Chinese) also mentioned that sometimes he was aware of racism in the US, particularly during the COVID-19 pandemic.

LGBTQIA+ POC were marginalized both in White LGBTQIA+ spaces due to racial exclusion and in racial/ethnic communities where heteronormativity silenced their experiences. For example, when talking about his perceptions of LGBTQIA+ spaces and events in the US, Jarret said, “Being Chinese, being Asian, and also being an immigrant, I feel like…I’m not really part of their community. I feel there’s a kind of boundary there.” Therefore, Jarret hesitated to seek mental health support from White dominant LGBTQIA+ communities. Tony found support in Chinese communities but felt they silenced his gay identity by heteronormative assumptions: “...sometimes they will also like, how about you bring your girlfriend or wife [to gatherings]? And they subconsciously identify you…I don’t know how to answer this question.”

Interpersonal barriers

Family rejection based on sexual orientation was a shared interpersonal barrier for younger sapphic individuals and Chinese LGBTQIA+ immigrants to health information. For example, Ladylot (Lesbian–but doesn't like the term, Black, 18-25) felt that her family was not a good place for getting health information because "sometimes I feel like family here is to tear you down." Jarret also avoided seeking health information from his family because of his gay identity. Additionally, he attributed this avoidance to Chinese family culture – "I think a lot of parents, even if it's not related to the gay identity, sometimes just don't know how to comfort their kids…they just make you even more anxious." Negative experiences with healthcare providers, such as miscommunication and discrimination, created mistrust and led some participants to avoid formal health information. For example, Shannon (Gay, Lesbian, Masculine woman, Black, 35-54) described how experiencing gay bashing impacted her decision to seek health information, "...once you have an experience like the one I described, I never, went back to the doctor for the issue I was going for."

Participants acknowledged the essential support from LGBTQIA+ communities in health contexts but noted challenges in engaging with other members. One issue discussed is the lack of inter-generational information exchange within LGBTQIA+ communities due to different terminologies and perceptions of sapphic visibilities, which is a barrier created by the intersection of LGBTQIA+ status and age. Participants may feel uncomfortable in the White dominant LGBTQIA+ spaces. For example, Vada (Lesbian, White, 18-25) pointed out that White women might feel comfortable and welcomed in some LGBTQIA+ spaces, "but not necessarily all people of color feel as comfortable coming into the group." In addition to challenges, participants demonstrated resilience and agency in fulfilling their health information needs through strategies such as community-building, seeking health information across countries, and identity management.

PRELIMINARY DISCUSSION AND CONCLUSION

Our findings demonstrate how race/ethnicity, age, and citizenship intersect with LGBTQIA+ identities to shape health information access across structural, disciplinary, cultural, and interpersonal domains. Participants' experiences challenge the queer tunnel version by acknowledging the visibility of LGBTQIA+ individuals' identities varied in different scenarios, as well as their priority in health information practices. While equity-deserving communities show resilience, the responsibility to improve their access to health information lies with LIS professionals and educators. However, many MLIS graduates feel unprepared to serve diverse populations due to persistent curricular injustices, such as limited IDEA content (Patin et al., 2021).

Threats (2025) highlights that challenging deficit models in health information services and education through an intersectionality lens requires examining how interlocking power systems marginalize communities. The matrix of domination guides our analysis of barriers and informs recommendations for LIS education to address these challenges. Incorporating critical analysis of policy and institutional infrastructures into LIS curricula helps students understand the structural barriers facing equity-deserving communities. Classes can include case studies to examine how exclusive policies, such as marriage or immigration-based employment and health insurance policies, influence LGBTQIA+ populations' health information access.

The disciplinary barriers require LIS education to prepare students to recognize and challenge institutional gatekeeping in health contexts. Floegel and Jackson (2019) pointed out that academic libraries often uphold Whiteness, inaccessible spaces, homogenous collections, and hegemonic practices. This conclusion may also apply to other information institutions. To challenge institutional gatekeeping, LIS programs should encourage research amplifying equity-deserving groups' voices, provide advocacy training on racial, generational, and LGBTQIA+ justice for students, and prepare students to provide multilingual, age-inclusive, and culturally relevant health information.

As to the cultural barriers, LIS curricula need to embed critical theories that help students understand how dominant discourses shape who is (in)visibility in health information services. Kitzie et al. (2019) and Kitzie, Wagner, et al. (2022) stress the need for LIS curricula to embed social justice principles and critical theories to promote health information justice. Valuing the lived experiences of equity-deserving communities is vital for LIS professionals to dismantle systemic oppression (Floegel & Jackson, 2019). Students should know how to analyze narratives in health contexts and create counter-narratives that reflect the lived experiences of LGBTQIA+ people under intersectional oppression.

Interpersonal barriers underscore the need for cultural competence, empathy, and collaboration in health information services. Cooke et al. (2016) emphasize the importance of cultural competence and critical self-reflection in preparing socially responsible information providers. LIS course design can include workshops and role-play simulations that help students practice inclusive services and encourage self-reflection on how their social positions may impact their interactions with equity-deserving patrons. Moreover, interventions should address the structural sources of discrimination and focus on the strengths of these communities (Threats, 2025). Therefore, LIS courses should encourage students to participate in community-driven projects with LGBTQIA+ organizations to co-create inclusive health information resources.

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