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Changing language, changes lives: Learning the Lexicon of LGBTQ+ health equity

Kodiak R. S. Soled[1], **Kristen D. Clark**[2], **Molly R. Altman**[3], **Jordon D. Bosse**[4], **Roy A. Thompson**[5], **Allison Squires**[6], **Athena D. F. Sherman**[7]

[1]Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, Boston, Massachusetts, USA

[2]Department of Nursing, University of New Hampshire, Durham, New Hampshire, USA

[3]Department of Child, Family, and Population Health Nursing, University of Washington, Seattle, Washington, USA

[4]School of Nursing, Northeastern University, Boston, Massachusetts, USA

[5]Sinclair School of Nursing, University of Missouri, Colombia, Missouri, USA

[6]Rory Meyers College of Nursing, New York University, New York City, New York, USA

[7]Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, Georgia, USA

1 | INTRODUCTION

Lesbian, gay, bisexual, pansexual, transgender, nonbinary, two-spirit, queer, questioning, and other sexual and gender diverse-identified people (i.e., LGBTQ+[1]) represent a heterogeneous group of communities. These communities have gained significant social acceptance and legal protections in the United States over the last decade, although those hard-fought advancements remain tenuous. Complex multilevel stigma (e.g., individual, interpersonal, and structural) continues to impact how health systems provide person-centered care to LGBTQ+ people, which negatively impacts their health outcomes. In addition, compulsory heterosexuality and cisgenderism, that is, heterosexuality and cisgenderism are assumed and enforced upon people by a heterocisnormative society (Rich, 1980), in nursing perpetuate stigma within the health care setting (Chinn, 2008; Searle, 2019), rendering LGBTQ+ nurses invisible. As we continue our series on learning the language of health equity, this paper seeks to advance our understanding of culturally

Correspondence Kodiak R. S. Soled, Harvard Pilgrim Health Care Inc., Wellesley, MA, USA. kodiak_soled@harvardpilgrim.org.

AUTHOR CONTRIBUTIONS

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CONFLICTS OF INTEREST

The authors declare no conflict of interest.

[1]There are many acronyms (e.g., LGBTQQIP2SAA) used to describe LGBTQ+ communities. When deciding which acronym is most appropriate to use, it is important not to include every letter for the sake of inclusivity. Only utilize letters representing the subgroups explicitly included (e.g., LGBQ+ for a research population of sexually diverse people).

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sensitive and person-centered language to support nurses, midwives, and researchers in advancing health equity among LGBTQ+ communities.

2 | LGBTQ+ COMMUNITIES IN THE UNITED STATES

Nurses, midwives, and researchers should be cognizant of the nuances between sex, gender, and sexuality. Sex, gender, and sexuality are multidimensional concepts that are often conflated, misunderstood, and even politicized. However, everyone has a sex, gender, and sexuality—even you. Sex is based on a cluster of anatomical and physiological traits, that is, external genitalia, secondary sex characteristics, gonads, chromosomes, and hormones. Sex is assigned at birth as female, male, or intersex/differences of sex development. Gender encompasses identity, expression, and social-cultural norms or expectations associated with specific sex traits. Gender identities include, but are not limited to, cisgender, nonbinary, gender fluid, transgender, and two-spirit. Sexuality (also called sexual orientation) encompasses components such as emotional, romantic, and/or sexual attraction, sexual identity, and sexual behavior. Sexual identities include, but are not limited to, bisexual, gay, heterosexual, lesbian, pansexual, same-gender loving, two-spirit, queer, and questioning. Table 1 provides further details regarding these constructs and identities.

Recent estimates suggest that 6.8% of the U.S. adult population identifies as sexually diverse (i.e., the LGBQ+ communities of the LGBTQ+ umbrella; Jones, 2022) and 0.5%–0.7% as gender diverse (i.e., the T communities)—which is more than a 200% increase from estimates a decade earlier (Herman et al., 2022; Jones, 2022). These estimates are theorized to be much lower than actual population levels, however, due to complications with assessment and disclosure deterrents (e.g., stigma and victimization). A growing LGBTQ+ population may be driven by younger generations, as 20.8% of Generation Z (born between 1997 and 2003) identify as LGBTQ+ (Jones, 2022). Increased community size may be further driven by improved methodological approaches to identify LGBTQ+ individuals implemented over the last decade through research and advocacy. A 2011 Institute of Medicine (IOM) report entitled *The Health of Lesbian, Gay, Bisexual, and Transgender People* provided a state of the science on the unique health disparities LGBTQ+ individuals experience (Institute of Medicine, 2011). The IOM report prompted the National Institutes of Health to create the Sexual and Gender Minority Research Office (SGMRO) in 2015 and to formally designate sexual and gender minority[2] (i.e., LGBTQ+) people as a health disparity population in 2016 (Perez-Stable, 2016). Subsequently, funding for LGBTQ+ health research and collection of sexual orientation and gender identity (SOGI) data in nationally representative samples have substantially increased (SGMRO, 2022a, 2022b). So, too, has the availability of SOGI fields in electronic health records (Cahill et al., 2016). Yet, continued efforts are needed to support researchers, policymakers, and clinicians in identifying disparities, establishing policies that promote equity, and providing high-quality, person-centered care to LGBTQ+ people.

[2]Sexual and gender minority (SGM) is the scientific language used to describe LGBTQ+ people by the NIH and in the published literature. We prefer and advocate for the term sexual and gender diverse (SGD), however, to move away from labeling a population as a minority and move toward celebrating the diversity within it.

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3 | THE HISTORY OF LGBTQ+ EXCLUSION AND DISCRIMINATION

LGBTQ+ people have existed globally throughout history, with the first recordings going back 5000 years (Peralta, 2011; Schott, 2016). For centuries, LGBTQ+ people have been persecuted (e.g., sanctioned death penalties, incarceration) under the guise of “anti-sodomy laws” and “public indecency” prohibitions for dressing in a manner that was socially attributed to the opposite sex. Not until the 20th century was being an LGBTQ+ person decriminalized in the United States, and antidiscrimination legislation based on sexuality and gender has yet to be realized in all 50 states. For example, The Equality Act (2021), a bill that would amend the *Civil Rights Act* (1964) to expand antidiscrimination protections to LGBTQ+ people in public spaces, is currently awaiting a vote in the U.S. Senate. As more than 50% of LGBTQ+ adults experience harassment or discrimination in public places (Gruberg et al., 2020), this legal protection is paramount to LGBTQ+ peoples' health and wellbeing. Furthermore, compulsory sterilization requirements were recently outlawed by the European Convention in 2017, but the practice persists globally (Stack, 2017; The Associated Press; 2019). In fact, it remains a punishable crime in 15 countries to cross-dress and in 69 jurisdictions to engage in private, consensual same-sex sexual activity; in 11 of those jurisdictions, the death penalty is legally possible (Afghanistan, Brunei, Mauritania, Pakistan, Qatar, and United Arab Emirates) or actively implemented (Iran, Northern Nigeria, Saudia Arabia, Somalia, and Yemen; Human Dignity Trust, 2022; Sherman et al., 2021a).

The legal protections gained for LGBTQ+ people continue to be under threat. In 2022 alone, over 300 anti-LGBTQ+ bills have been introduced in state legislatures in the United States, with over 70% of the states signing or introducing anti-LGBTQ+ bills into law (Human Rights Campaign, 2022). For example, Florida's “Don't Say Gay” bill banned classroom instruction on SOGI topics (Parental Rights in Education, 2022). Yet, most bills have targeted transgender youth, including banning access to medically necessary and evidence-based care endorsed by major medical associations (American Psychological Association, 2020; Korioth, 2021; Madara, 2021) and fueled by scientific misinformation (Lepore et al., 2022). Similar anti-LGBTQ+ legislation has also been introduced globally, including in the United Kingdom, Poland, Hungary, Singapore, and Afghanistan. In the United States, the National Association of Pediatric Nurse Practitioners and Society for Pediatric Nurses signed an amicus brief in support of providing health care for transgender youth (Brandt & Rutledge, 2021). However, with few exceptions (American Academy of Nursing, 2015; American Nurses Association (ANA), 2018; Sedlak & Boyd, 2016), professional nursing associations have historically been glaringly silent in response to antidiscriminatory LGBTQ+ legislation.

Health care systems have been complicit in this history of exclusion of and discrimination towards the LGBTQ+ community. Since the first Diagnostic and Statistical Manuel of Mental Disorders (DSM) was published in 1952, sexually diverse people have been categorized as having pathological mental disorders, in the same category as paraphilias, such as pedophilia (Drescher, 2015). Pathologization then justified the harmful and unsettling “treatment” options, including conversion therapy (e.g., electroshock), castration, and lobotomies. Gender-diverse people received a pathological diagnosis beginning in 1975, as gender and sexual identities were grouped together before this period (Schwend, 2020).

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Gender diversity still exists in the DSM today. It has a less stigmatizing label of “gender dysphoria,” however, to distinguish the mental disorder from a person's identity and instead focus on the discomfort or distress some gender-diverse individuals experience when their physical body does not reflect their gender identity. Functionally, this term provides a way to receive a diagnosis—a prerequisite to accessing gender-affirming care such as hormone therapy, surgery, or psychotherapy in many countries (Schwend, 2020). Further, despite the removal of “homosexuality” from the DSM in 1973 and efforts to de-pathologize gender diversity, this history has perpetuated stigmatizing attitudes towards LGBTQ+ people that have cost them their lives (e.g., a delayed public health response to the HIV/AIDS epidemic). These mischaracterizations of LGBTQ+ populations persist today, such as in the current framing of the monkeypox epidemic as a sexually transmitted infection (Bragazzi et al., 2022), impacting health, health care access, and safety.

4 | EXCLUSION AND DISCRIMINATION CONTRIBUTE TO LGBTQ+ HEALTH INEQUITIES

LGBTQ+ health inequities are most commonly explained by minority stress—the additional stress (e.g., discrimination, victimization) experienced by LGBTQ+ people related to the marginalization of their sexuality and/or gender (Brooks, 1981; Hendricks & Testa, 2012; Meyer, 2003). Within health care systems, discrimination and mistreatment are common experiences for LGBTQ+ people. LGBTQ+ people are often refused care and experience harsh or abusive language, unwanted physical contact, and physically rough or abusive care (Ayhan et al., 2019; Cicero et al., 2019; Gruberg et al., 2020). These experiences are heightened among both gender-diverse people and LGBTQ+ people from racial and ethnic minoritized groups (Gruberg et al., 2020). Discrimination, victimization, and stigmatization can impede care delivery, engender mistrust, and negatively impact LGBTQ+ individuals' mental and physical health outcomes (Hatzenbuehler, 2009; Ramsey et al., 2022; Soled, Dimant et al., 2022; Tyerman et al., 2021; White Hughto et al., 2015). Even the anticipation of discrimination is dangerous as about 15% of LGBTQ+ and 30% of gender-diverse adults will postpone or avoid medically necessary care out of fear of discrimination (Gruberg et al., 2020; Jaffee et al., 2016; Seelman et al., 2017).

Stigma toward LGBTQ+ people may become evident in the health care setting through microaggressions, implicit bias (Sabin et al., 2015), and expressed discomfort in care for people with identities that differ from their own (Carabez et al., 2016). These attitudes do not stop at LGBTQ+ patients' experiences. The few existing studies of LGBTQ+ nurses highlight work-based stress related to their sexual and/or gender identities (Eliason et al., 2018), including experiences of homophobia, discrimination, and harassment from patients, peers, and supervisors (Eliason et al., 2011). As such, LGBTQ+ nurses may feel the need to hide their identity to avoid such negative consequences (Eliason et al., 2018; Randall & Eliason, 2012). Over time, having to hide one's identity, a component of minority stress, can have a negative impact on mental health (Pachankis et al., 2020). In one study, this stress was associated with problematic substance use among LGB nurses (Avery-Desmarais et al., 2020).

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Microaggressions are subtle forms of discrimination and include microassaults, microinsults, and microinvalidation. For example, verbal communication using insensitive language, even when unintentional, is a microaggression. Microaggressions have negative health consequences such as increasing symptoms of traumatic stress and depression and contributing to low self-esteem (Nadal et al., 2016). Using language that centers heterocisnormativity, that is, the assumption that heterosexual and cisgender people are the norm, is a common microaggression that can perpetuate discrimination in more insidious ways. For example, some insurance companies use language in policies that restrict health care services to a specific gender (e.g., cervical cancer screening restricted to women, excluding transgender men and transmasculine individuals) or restrict assisted reproductive technology to those with an infertility diagnosis—a diagnosis that is impossible for many LGBTQ+ people to receive (Soled, Niles et al., 2022).

Discrimination and the resulting poor health outcomes are particularly heightened for LGBTQ+ people with multiply marginalized identities. Intersectionality theory explains why people with multiply marginalized identities and social positions (e.g., dis/ability, class, race, gender, nativity, sexuality) will experience multiple, overlapping sources of discrimination (e.g., ableism, classism, racism, cisgenderism, ethnocentrism/xenophobia, heterosexism) and adverse health outcomes (Bowleg, 2012; Collins, 2000; Crenshaw, 1989; hooks, 1981; The Combahee River Collective, 1977). For example, intersections between gender and race and the resultant cisgenderism and racism are likely culprits for the exorbitantly disparate poor health outcomes for Black transgender women and femmes, including being 2.73 times more likely to die than other Black transgender people, 2.38 times more likely than Black cisgender men, and 2.43 times more likely than Black cisgender women (Hughes et al., 2022). Intersectional effects are consistently observed among a number of physical and mental health outcomes (Walubita et al., 2022; Zubizarreta et al., 2022). Within the health care system, this compounded discrimination among individuals with intersecting marginalized identities can further impact health negatively through inequities in health care access and receipt of lower quality treatment (Bosworth et al., 2021).

5 | THE LEXICON OF LGBTQ+ HEALTH EQUITY

The legacy of criminalization, pathologization, and stigma carried out through discriminatory language, as well as the historical trauma inflicted, requires intentional repair between systems of power (e.g., health care professionals, researchers) and the LGBTQ+ community. Effective communication is a cornerstone of patient safety, improved outcomes (Disch, 2012), and person-centered care (Kwame & Petrucka, 2021). Moreover, it is nurses' and midwives' ethical obligation to use language that is respectful of identities and promotes the provision of culturally congruent, competent, and safe care (ANA, 2018)—both of which require LGBTQ+ language literacy. Therefore, learning the lexicon of LGBTQ+ health equity can be a starting point for rebuilding trust, facilitating the delivery of high-quality person-centered care, and promoting LGBTQ+ health equity.

Like any new language, learning the lexicon of LGBTQ+ health equity requires intentional and continuous engagement and practice to develop fluency (Squires & Thompson, 2021). Practice can be gained by actively identifying ways one unconsciously or unintentionally

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commits harm to others. This may disrupt one pathway through which implicit biases and stigma are communicated, perpetuate socially constructed power dynamics, and foster further marginalization (Shattell, 2009). Becoming conscious of one's positionality and relationship to systems of power and oppression and gaining fluency in the lexicon of LGBTQ+ health equity, are powerful strategies for mitigating the impacts of systemic discrimination (Altman et al., 2021).

There are several important and broad considerations in understanding and communicating LGBTQ+ identities. First, **identities are fluid**, meaning they can change over time throughout the life course. Identity fluidity means sexual and gender identities should be repeatedly asked and updated in longitudinal surveys (Flentje et al., 2020) and, when relevant and appropriate, in clinical contexts. Secondly, **identities are not singular**, meaning a person can have multiple sexual and gender identities simultaneously. Thirdly, **identities are not defined by anything beyond self-reported identification**. For example, a person's sexual behaviors or attractions do not define their sexual identity (e.g., a person with same-sex behaviors may identify as heterosexual), nor does their gender expression (i.e., the way that an individual communicates their gender through chosen name, pronouns, manner of dressing, or hairstyles) or sex assigned at birth define their gender identity (e.g., a person that uses she/her pronouns and has long hair may identify as nonbinary) Additionally, **identities are adjectives that should qualify a noun** (e.g., “a queer person” or “queer people,” not “queers” or “a queer”). Further examples of outdated and stigmatizing language to avoid can be found in Table 2.

Areas that impact everyone, but particularly LGBTQ+ people, are pronouns and names. Like sexual and gender identities, pronouns should not be assumed based on gender identity, gender expression, sex assigned at birth, or legal name, and a person can have multiple pronouns. If multiple pronouns are indicated (e.g., he/they, ze/she), using any of the included pronouns is appropriate. Using incorrect pronouns to refer to someone is called misgendering and is harmful. Furthermore, an individual's legal name may differ from the name they use. For some gender-diverse people, being referred to by a legal name no longer used is called deadnaming and is also harmful. Avoid misgendering and deadnaming someone in any setting by first introducing yourself with name and pronouns, then requesting the names and pronouns of the individual (“and how may I refer to you?”). When appropriate and relevant to the conversation, subsequently ask for sexual and gender identities, including the option to decline to answer. Prefacing these assessment questions with the reason for asking and what will be done with the information (e.g., “we ask everyone these questions because we want to provide the best care”) may help increase comfort disclosing SOGI data. Name, pronouns, and identities should never be qualified with “preferred” because how one identifies is not a preference. After affirming language fluency and competency have been gained, one can add pronouns to places such as email signatures, video conferencing screen names, presentations, name badges, and door names. This may be a practice that normalizes visibility of LGBTQ+ lives and signals allyship to LGBTQ+ people, although this and other signs of inclusion (e.g., displaying a rainbow flag) may also cause significant harm when performative such as when still employing inappropriate and outdated language in other interactions.

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Humility, decentering oneself in the interaction, and actively resisting defensiveness when a mistake is held accountable are essential when developing language fluency. Communication mistakes and other nonaffirming actions should be addressed promptly through a brief yet sincere apology. When in a safe space, such as a health equity training, it may be helpful to practice the moment a mistake is made by using an affirming statement and apology such as “his vitals are… I'm sorry. Their vitals are…”. This focus on the mistake and corrected restatement is part of a process coined “deep practice,” which facilitates the production of myelin in the brain and supports stronger, faster skill fluency (Coyle, 2009). There should also be accountability and follow-through when a mistake is made or witnessed. Accountability includes identifying the cause, whether system or individual level, such as advocating to update the language used in an organization's electronic medical record system if it does not support best clinical practices. Accountability can also include respectfully correcting the language of a colleague in an interaction with or reference to an LGBTQ+ person. Moreover, the lexicon of LGBTQ+ health equity is continually evolving as we learn and become more precise with our language over time. Thus, anything written today may soon be outdated and necessitates ongoing training and education.

6 | RESEARCH LGBTQ+ HEALTH EQUITY ALLYSHIP

The visibility and inclusion of LGBTQ+ populations in data are paramount for evidence-based clinical guidelines, curriculum standards, policies (e.g., organizational, state, and federal), and resource allocation. As purported by Niles et al. (2022) earlier in this editorial series, data must be disaggregated for the various LGBTQ+ communities to understand the unique inequities and needs of heterogeneous subgroups. Although the collection of SOGI data has become more commonplace, there is still a widespread need to include SOGI questions within population surveys and public health surveillance efforts (Patterson et al., 2017), health data (e.g., electronic medical records and insurance claims; Bosse et al., 2018), and all research (Heck et al., 2017; Pedersen et al., 2022) including within LGBTQ+ research (e.g., collect gender identity in a study of lesbian couples), and research on nurses. Efforts should support knowledge development specifically in under-researched health and wellbeing areas (e.g., Coulter et al., 2014; SGMRO, 2022a), including further elucidation of strengths, resilience, and positive attributes of LGBTQ+ identities (e.g., Riggle & Rostosky, 2014). Unique ethical implications should be considered, however. For example, data must have robust privacy and confidentiality standards, entities collecting data must have non-discrimination policies in place, and personnel collecting data must be trained on the ethical conduct of research with LGBTQ+ populations (Medina & Mahowald, 2022; Moseson et al., 2020b; National Academies of Sciences, Engineering, and Medicine [NASEM], 2022).

As with LGBTQ+ language, data collection best practices may soon be outdated. Current guidance for measuring sex, gender identity, and sexuality includes using language that accurately and precisely identifies LGBTQ+ people, reduces the conflation of sex as a biological variable with gender, improves the quality of data on LGBTQ+ populations, and improves the research experience for LGBTQ+ study participants (NASEM, 2022). There is debate on the utility of allowing multiple or write-in response options to foster inclusion in representation versus forcing a single identity selection to yield sufficient

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statistical power in data analyses and contribute to understanding. The context should guide the appropriate implementation of multiple versus singular identity response options. We have included example language for SOGI data collection in Table 3 using evidence-based recommendations from leading researchers, clinicians, and LGBTQ+ community members (Federal Interagency Working Group on Improving Measurement of SOGI in Federal Surveys, 2016; InterACT, n.d; Puckett et al., 2020; Reisner et al., 2016; Suen et al., 2020).

For those interested in researching LGBTQ+ communities, a compilation of publicly available population data with LGBTQ+ measures is maintained and updated on the SGMRO webpage (SGMRO, 2022b), as well as a multidimensional and intersectional framework to elucidate factors that influence LGBTQ+ health inequities [SGMRO, 2021]. Importantly, research should be conducted with, not on, historically oppressed and minoritized communities such as LGBTQ+ people. Community-based participatory research methods can serve as an important tool to center community members and community-based organizations as leaders and leverage their skills, strengths, and solutions on research teams as co-investigators, advisory board members, and co-authors. The specific subgroup identities under study should also be reflected in community engagement efforts (e.g., a study on trans men should include trans men and transmasculine community members in the research process). Academic institutions and funding agencies play an important role in supporting these research methods to allow investigators to overcome structural challenges in meaningful community engagement such as allowing community members to be co-investigators with equal compensation and power to determine what research questions are prioritized (Aguilar-Gaxiola et al., 2022; Ricks et al., 2022). Researchers also play a role in influencing institutions and agencies to support equitable and community-engaged research practices (Lett et al., 2022; Scott et al., 2020). Support and resources for community-engaged research can be found at the Patient-Centered Outcomes Research Institute (n.d.) and Engage for Equality (n.d.).

7 | CLINICAL LGBTQ+ HEALTH EQUITY ALLYSHIP

Implicit bias embedded within insensitive language may hinder the delivery of person-centered care, particularly for those with multiply marginalized identities, and consequently contribute to adverse health and health care outcomes (Afulani et al., 2021; Altman et al., 2022). Thus, in conjunction with earlier recommendations in this series for working with Latinx and Hispanic populations, practicing culturally respectful communication is an important provision in the delivery of person-centered care (Nava et al., 2022). This is accomplished through centering the person's needs and goals and considering the holistic person instead of focusing on a disease, risk factor, or symptom (Nava et al., 2022). Person-centered and trauma-informed care are necessary and complementary approaches for communities that have experienced marginalization and trauma to promote physical and emotional safety and autonomy, repair distrust, reduce structural heterocisnormativity, and improve health and health care outcomes (McKinnish et al., 2019; McNicholas et al., 2021; Park et al., 2018; Rubashkin et al., 2018).

One opportunity to reduce structural heterocisnormativity is to include an organ or anatomical inventory (Deutsch et al., 2013) and a sexual and reproductive health inventory

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(Ragosta et al., 2021) as opposed to assuming organs and sexual behaviors based on sex assigned at birth and presumptive heterosexuality. By asking or providing a list detailing what organs a person has and has had removed, an organ or anatomical inventory serves three functions: it opens and normalizes a conversation around body parts, allows the assessment of body part names that an individual is comfortable with, and promotes understanding of what preventative screenings or health promotion guidance may be most appropriate to recommend. A sexual and reproductive health inventory collects information pertaining to sexual practices and reproductive goals. A few examples of information to collect include asking if the person is having sex and what body parts interact with that of their sexual partner(s). It is also important to ask about practices used to prevent or promote pregnancy or sexually transmitted infections, depending on the relevancy to the person and their sexual practices. Practicing a clinical assessment with affirming and trauma-informed scripts may be useful in developing fluency in this area (e.g., Hahn et al., 2019; Krempasky et al., 2020; Tillman, n.d.).

Other areas where language should be assessed are included in Table 4. Although the diversity of language options and needs should be familiar, it is best practice to mirror the language someone uses (except for some language that is only acceptable for insiders to use) or ask what terms they would like you to use. We highly recommend further education and training to gain a comprehensive understanding of inclusive language considerations and structural changes that address intersectionality and promote person-centered and trauma-informed care within the clinical context (e.g., Bi et al., 2021; Human Rights Campaign, n.d.; Moseson et al., 2020a; Ragosta et al., 2021; Rioux et al., 2022). It is also critical that LGBTQ+ content be included in all levels of nursing and midwifery curricula and other health professions' training programs, as well as be included as part of ongoing continuing education for practicing professionals (Hughes et al., 2022; Sherman et al., 2021b; some resources include Bi et al., 2020, 2021; Bosse et al., 2015; Eliason & Chinn, 2015; Lavender Health, n.d.).

8 | CONCLUSION

This paper is a primer in learning the lexicon of LGBTQ+ health equity and supports efforts to promote nurses' and midwives' understanding of culturally sensitive and person-centered language. LGBTQ+ people are a growing population with inequitable health outcomes, in part caused by discriminatory, stigmatizing, or outdated language that permeates policies, curricula, research, and clinical practice. Language has immense power to shape our world and lived realities including the power to signal respect, safety, and inclusion—or the opposite. Although the journey of LGBTQ+ language literacy requires humility and continuous engagement, with intentional practice fluency will develop. Moreover, as nurses and midwives, we took an oath to “do no harm.” Thus, each and everyone of us plays a critical role in using language that communicates respect, safety, and inclusion. By doing so, we each take a small step forward in creating an equitable future for all.

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TABLE 1

Sex, gender, and sexual orientation definitions and identities

Construct	Definition	Identities[a]
Sex	A cluster of anatomical and physiological traits that include external genitalia, secondary sex characteristics, gonads, chromosomes, and hormones	Female Male Intersex/differences of sex development
Gender	Identity, expression, and social-cultural norms or expectations that are associated with specific sex traits	Man (cisgender[b] or transgender[c]) Woman (cisgender or transgender) Nonbinary[d] Gender fluid Two-spirit[e]
Sexual orientation	Emotional, romantic, and/or sexual attraction, identity, and behavior	Asexual Bisexual Gay Heterosexual Lesbian Pansexual Same-gender loving Two-spirit Queer Questioning

[a] The gender and sexual identities listed here are neither exhaustive nor mutually exclusive (e.g., someone may identify their gender as both transgender man and nonbinary).

[b] Someone who has a gender that is consistent with societal expectations based on one's assigned sex at birth (e.g., a woman assigned female at birth).

[c] Someone who has a gender identity that is different than societal expectations based on their assigned sex at birth (e.g., a woman assigned male at birth).

[d] Someone (of any assigned sex at birth) whose gender identity is outside of the traditional binary of man/woman.

[e] A term used among Indigenous populations that denotes an individual having both a “male” and “female” spirit and may be used to describe either gender or sexuality.

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TABLE 2

Inappropriate language to describe LGBTQ+ people

Outdated and harmful language	**Current best practice language**[a]
A homosexual (noun); homosexuality	A [gay/queer/etc.] person (adjective) Sexually diverse people
A lesbian (noun), lesbians, lesbianism	A lesbian woman (adjective); lesbian women
Transgenders, transgendered, transvestite, tranny	A transgender person, transgender people
Gender nonconforming[b]	Gender diverse/fluid/expansive, genderqueer, nonbinary
Sex change/sex reassignment surgery	Gender affirming surgery
A real or biological man/woman	A cisgender man/woman
Gay or queer as a putdown, fag, dyke	Gay or queer to describe a person
Sexual preference/lifestyle	Sexual orientation
Preferred name, preferred pronouns	Legal name/chosen name, pronouns
Hermaphrodite	Intersex person or a person with differences in sex development

[a] It is best practice to assess and use the terms identified by an individual to describe themselves and their anatomy.

[b] Some LGBTQ+ people may identify as gender nonconforming and should not be corrected. However, this language emphasizes not conforming to or meeting society's expectations around gender norms. Gender diverse, fluid, or expansive moves away from centering conformity as the status quo, and thus should be used by allies.

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TABLE 3

Recommendations to collect data on sex, gender identity, sexuality, and intersex/differences in sex development (DSD)

Survey questions	Response options
Sex and Gender Identity	
(Optional Q0: What is your gender identity)	[free-text]
Q1: Recognizing these are limited options, which of the following categories best describes your current gender identity (please choose one)?	Man, transgender man, cisgender man Woman, transgender woman, cisgender woman Nonbinary, genderqueer, gender fluid, agender [If the respondent is American Indian or Alaskan Native (AIAN)]: Two-spirit I do not feel that my identity fits into one of these categories [Free text]: What words do you use to describe your gender identity?
Q2. What sex were you assigned at birth, on your original birth certificate?	Male Female Third sex/"X"[a] Prefer not to answer
Q3. Have you ever been diagnosed by a health professional with an intersex condition or a difference in sex development, or were you born with (or developed naturally in puberty) genitals, reproductive organs, or chromosomal patterns that do not fit standard definitions of male or female?	Yes No Don't know Prefer not to answer
Sexuality	
Sexual Identity Which of the following best represents how you think of your sexual identity (please choose one)?	Asexual Bisexual Gay Lesbian Pansexual Queer Same-gender loving Straight/heterosexual [If respondent is AIAN:] Two-Spirit I use a different term [free-text] Don't know Prefer not to answer
Sexual Behavior[b] During [your lifetime, the past 12 months, etc.], who have you had sexual contact with (select all that apply): *Sexual contact includes any touching of intimate body parts of a person upon another (e.g., kissing, anal sex, fingering).*	Cisgender women Transgender women Cisgender men Transgender men Two-spirit person Nobody/no sexual contact Nonbinary Person with another gender [free-text] Don't know Prefer not to answer
Sexual Attraction[c] During [your lifetime, the past 12 months, etc.], who have you been sexually attracted to (select all that apply):	Cisgender women Transgender women Cisgender men Transgender men

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Survey questions	Response options
	Two-spirit person Nobody Nonbinary Person with another gender [free-text] Don't know Prefer not to answer

[a] A third sex option or "X" is becoming increasingly available on birth certificates for people who do not identify with male or female, such as people who are intersex, have differences in sex development, or are nonbinary. This option is currently only available in 16 states and the District of Columbia, but is increasingly becoming adopted (Movement Advancement Project, n.d.).

[b] In clinical settings, sexual behavior should only be asked or discussed when it is pertinent to the care being rendered and should be followed by a series of questions to determine what types of sex occurred and with what body parts to assess health needs accurately. Sexual abstinence and celibacy are also sexual behaviors; sexual contact should never be assumed.

[c] In clinical settings, sexual attraction should only be asked or discussed when it is pertinent to the care being rendered.

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TABLE 4

Constructs that employ heterocisnormative language in the clinical context and possible de-gendered replacements

Construct	Heterocisnormative or gendered language	Possible replacement language
Intake forms or electronic medical record systems		
Parental names	Mom/mother, dad/father	Parents
	Biological parent	Genetic or gestational parent
Physiological processes	Period	Bleeding, menstruation
	Breastfeeding	Nursing/lactating/chestfeeding
	Biologically male/female	Assigned male/female at birth
Names of body parts	Breast	Chest
	Ovaries, uterus	Internal organs
	Vulva, clitoris	External genitals, pelvic area
	Vagina	Genital/frontal opening/front hole
	Labia, lips	Outer folds
	Penis, testicles	Outer parts
	Prostate	Internal gland
Partner/support person's relationship	Wife/husband	Partner (regardless of legal status), spouse, chosen family
Structural environment		
Clinic name	Women's Health Center	The Birth Center
Department name	Maternity ward	Labor and delivery
	Maternal/Women's Health	Perinatal/Family/Reproductive health
Room names	New mother's room	Nursing/Lactation room
	Women's/men's bathroom	Gender neutral bathroom

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