DR. CHARLES THOMAS YINGLING (Orcid ID : 0000-0002-7530-3669)

Received Date : 27-Jan-2016
Revised Date : 21-Dec-2016
Accepted Date : 22-Dec-2016
Article type : Discursive Paper

Building Nurses' Capacity to Address Health Inequities: Incorporating LGBT Health Content in a Family Nurse Practitioner Program

Charles Yingling, DNP, RN
Clinical Assistant Professor
University of Illinois at Chicago College of Nursing
845 South Damen Avenue (M/C 802)
Room 912
Chicago, IL 60612
United States of America
cyingl1@uic.edu
+1 312 413 8850

Karen Cotler, DNP, RN
Clinical Instructor
University of Illinois at Chicago College of Nursing
845 South Damen Avenue (M/C 802)
Room
Chicago, IL 60612
United States of America
kcotler@uic.edu

Tonda Hughes, PhD, RN
Professor
University of Illinois at Chicago College of Nursing
845 South Damen Avenue (M/C 802)
Room 1160
Chicago, IL 60612
United States of America
thughes@uic.edu
+1 312 996 5106

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/jocn.13707

ABSTRACT

Aims and objectives
In this discursive paper we describe our experience in incorporating lesbian, gay, bisexual and transgender (LGBT) health content into the family nurse practitioner curriculum at a Midwestern college of nursing in the United States.

Background
Globally, LGBT people face disparities in the domains of physical health, behavioral risks, mental health, and victimization. There remains a paucity of nursing research on most aspects of LGBT health and access to care. To date, nursing leadership and curricular bodies have not provided clear guidance on the role of nurse educators in preparing nursing students to provide care to LGBT people.

Design
Discursive paper describing the development of an LGBT health learning module for inclusion in a family nurse practitioner program.

Methods
We summarize health disparities experienced by LGBT people, describe the process of module development, and outline the learning content included in the module. We also discuss challenges faced in incorporating LGBT content into nursing curricula.

Conclusions
Despite the lack of formal direction from the nursing sector, nursing faculty should prepare nursing students to provide culturally sensitive and competent care to LGBT people. Our experience incorporating LGBT-specific content into the family nurse practitioner program has proven to be positive for both students and faculty.

Relevance to clinical practice
Given their large numbers and presence across systems of care, nurses are uniquely positioned to address barriers to care faced by LGBT people. Modules such as the one described here can be used by nurse faculty to guide the inclusion of LGBT-specific content in family nurse practitioner or other nursing courses—as well as to guide the development of nursing competencies in the care of LGBT people.

Keywords: Cultural Issues, Curriculum Planning, Nurse-Patient Relationship, Primary Care, Sexual Health, Sexuality

What does this paper contribute to the wider global clinical community?

- Given that nurses make up a significant proportion of the global healthcare workforce they are uniquely positioned to address health disparities faced by LGBT people.
- Information about successful integration of LGBT-specific content into the nursing curriculum may encourage nurse educators to use existing resources to develop curricular content aimed at building student competency in the care of LGBT people.
- This information may also be useful to practicing nurses in that it may increase their understanding of sexual-orientation and gender-identity-related health disparities.

INTRODUCTION

Sexual minority people (lesbian, gay, bisexual, and transgender [LGBT]) are becoming a more visible part of the populations of many countries, particularly those in the Western world (Roth 2014). Nevertheless, demographic data for sexual minority population remains difficult to capture. Variability in quantifying the proportion of the global population that is LGBT may stem from diverse societal attitudes towards these populations. For example, nations that are more affluent or secular are more likely to accept homosexuality, whereas nations that are predominantly Muslim or lower income are less likely to support acceptance of homosexuality (Pew Research Center 2013). In societies that do not accept sexual minorities, methodological barriers (e.g. under-reporting) preclude accurate quantification of the LGBT population (Pew Research Center 2013).

Data from nine national surveys conducted in five countries (Australia, Canada, Norway, United Kingdom, United States) estimate that 1.7% to 5.6% of the populations of these countries identify as lesbian, gay or bisexual (Gates 2011). Data regarding the proportion of the world's population that is transgender is much less precise due to underreporting and a lack of any systematic data collection system. Globally, the most recent study to quantify the transgender population of a nation came from the United States (U.S.) suggests that 0.6% of adults in the US identify as transgender (Flores, Herman, Gates & Brown, 2016). We performed an exhaustive search for population demographics of LGBT people outside the Western world and identified no reports. Illustrative of this underreporting is former Iranian president Mahmoud Ahmadinejad's statement, "In Iran we don't have homosexuals…" ("Iran President in NY Campus Row," 2007).

Sexual minorities face widespread discrimination and exclusion in all parts of the world (Hughes, Wilsnack & Kantor 2016). In 2015, the United Nations acknowledged that societal discrimination against LGBT people is a direct threat to health and well-being (United Nations 2015). In the U.S. a movement is now underway to improve the clinical care of sexual minorities. Although some LGBT people receive excellent and supportive care from health care providers, many continue

to experience discrimination, marginalization, and sometimes outright harm within the U.S. healthcare system (Carabez et al. 2015).

There is a paucity of research and literature on LGBT healthcare issues (Institute of Medicine 2011), and even less about nursing care for LGBT people (Bosse et al. 2015, Institute of Medicine 2011, Carabez et al. 2015). Consequently, nurses often lack even basic knowledge about the care of LGBT patients (Obedin-Maliver et al. 2011, Carabez et al. 2015). The success of strategies and initiatives to improve care for LGBT people depends in large part on the improved education of health professionals. Educating healthcare professionals can contribute to general improvement of

care for LGBT people as well as the climate for LGBT providers, faculty, staff and students.

As emphasized in a landmark report published in the U.S. "contemporary health disparities based on sexual orientation and gender identity are rooted in and reflect the historical stigmatization of LGBT people" (Institute of Medicine 2011). Working to address these health disparities is keeping with a core value of the nursing profession—the provision of person-centered care.

In this discursive paper we highlight some of the major health disparities based on sexual orientation or gender identity and then describe our experience in developing and implementing LGBT health content into a family nurse practitioner (FNP) program. In the U.S. family nurse practitioners are advanced practice nurses who are licensed to provide independent, full-scope primary care services for individuals and families in the context of the communities in which patients live and work (Population-Focused Competencies Task Force 2013).

BACKGROUND

Sexual-Minority Related Health Disparities

LGBT people face stigmatization as well as financial, structural, personal and cultural barriers as they attempt to access culturally competent, sensitive health care services (Institute of Medicine 2011). These barriers, and anxiety about them, often prevent LGBT individuals from receiving screening and preventive services, or cause delays in receiving care (McNair et al. 2011).

Given widespread stigmatization of sexual minorities, LGBT people are vulnerable to minority stress (Meyer 1995; Meyer 2003). Minority stress theory proposes three stress processes which underlie the health disparities faced in the LGBT community: internalized stigma, expectations of rejection and discrimination (perceived stigma), and actual prejudice events (Meyer 1995; Meyer 2003). Examples of situations that bring about these stress processes include denial of or shame regarding one's sexual orientation or gender identity (internalized stigma/homophobia); fear of losing housing or employment if one 'comes out' to family or co-workers (expectations of rejection and discrimination); or physical assault motivated by anti-gay bias (actual prejudice events).

To manage stress associated with being a member of a marginalized minority group, LGBT people often engage in unhealthy coping behaviors to manage the symptoms of minority stress (DiPlacido & Herek 1998; Mereish et al. 2014). These behaviors, coupled with barriers in access to culturally competent care, help to explain the disproportionately higher rates of many stress-related health conditions among LGBT people (Meyer 2003). Below we highlight four domains of health disparities: physical health, behavioral health, mental health, and victimization.

Sexual-orientation-related physical health disparities include higher rates of breast and cervical cancer risk factors among lesbian women (Institute of Medicine 2011, Brown et al. 2015), higher risk of anal-rectal cancers in gay men and men who have sex with men (MSM; Garbuglia et al. 2015), higher rates of sexually transmitted diseases (STDs) in gay and bisexual men (Centers for

Disease Control 2015b), higher rates of HIV in transgender people (Centers for Disease Control 2015a), obesity in lesbian women, inadequate reproductive health care for lesbian women, as well as the risk of chronic disease associated with alcohol and substance abuse (Fredriksen-Goldsen et al. 2013, Hughes, 2011; Hughes & Eliason, 2002; Hughes et al. 2015). Exacerbating these disparities are LGBT people's reluctance to disclose sexual or gender identity which, in turn, limits providers understanding of relevant health concerns or risk factors.

Examples of behavioral risks are higher rates of tobacco use, hazardous drinking, drug use and unprotected sex (Johnson et al. 2013, Matthews et al. 2013, Matthews et al. 2014, Talley & Littlefield 2014, Wilsnack et al. 2008). Risky sexual behavior among sexual minorities is attributable in part to societal marginalization of these behaviors (Halkitis & Parsons 2003). Laws that criminalize same-sex intimacy can contribute to behavioral risks by isolating sexual minorities and limiting opportunities for healthy social interchange and dating (Beyrer 2014, Hughes et al. 2015). Higher rates of alcohol and other drug use/misuse, including prescription and recreational drugs, among sexual minorities has been attributed to ameliorative coping in response to marginalization and stigma (Cochran et al. 2007, Hughes 2005, Mereish et al. 2014).

Sexual-orientation-related mental health disparities include an excess burden of depression, anxiety, and suicidal ideation among sexual minorities (Bostwick et al. 2014; Hughes, Szalacha & McNair, 2010; Haas et al. 2010, Russell et al. 2011, Johnson et al. 2013,). These disparities are particularly evident in young LGBT people who are 5-6 times as likely as heterosexual youth to attempt suicide (Russell et al. 2011).

Elevated rates of lifetime victimization among LGBT people also increase risk of negative mental health outcomes (Drabble et al. 2013, Hughes, 2005, Hughes, McCabe et al. 2010, Hughes et al. 2014). Bullying, harassment and hate crimes, sexual assault, intimate partner violence, imprisonment and capital punishment are all forms of violence against LGBT people that stem from societal prejudice and heterosexism (Reitman et al. 2013; United Nations 2015). LGBT youth are at

substantially greater risk of being bullied and harassed than their non-LGBT counterparts (Reitman et al. 2013). In some societies sexual assault ("corrective rape") is sometimes used to punish or "correct" LGBT identity (U.S. State Department 2010; Mueller & Hughes 2016). Intimate partner violence is underreported globally (Gracia 2014). But, in same-sex relationships, reporting of violence and referral for services are even lower due to societal stigma against such relationships (Heise et al. 2002). In societies that criminalize same-sex intimacy or gender nonconformity, imprisonment or capital punishment are further examples of victimization faced by LGBT people (Kollman & Waites 2009, Roth 2014).

Exacerbating the disparities described above are the socioeconomic concerns of LGBT people. Formal barriers to relationship recognition coupled with policies that permit housing and employment discrimination further marginalize LGBT people and their families. Absent legal relationship recognition (which has only recently been an option) and protections against discrimination in the housing and job markets, same-sex couples report greater housing and food insecurity (Gates 2014).

Nursing Care of LGBT People

The World Health Organization (WHO) identifies lack of research and understanding of LGBT health, coupled with provider attitudes towards these populations, as significant barriers to resolving sexual-minority-related health disparities (World Health Organization 2013). Although information about the care of LGBT people is generally sparse, nursing lags behind most health professions in research and education regarding sexual minority health. For example, between the years 2005-2009, only 0.16% of published articles in the top 10 nursing journals worldwide focused on LGBT health (Eliason et al. 2010). Aside from the paucity of research about LGBT people

themselves, there is very little research on the care of the families formed by LGBT people, including their children (Shields et al. 2012).

Both practicing nurses and nursing students report inadequate training in the care of LGBT people (Carabez et al., 2015, Rondahl 2009, Walsh & Hendrickson 2015). Further, from practicing nurses' prejudice against caring for lesbian and gay patients (Rondahl et al. 2004) to homophobic attitudes of nursing students and faculty (Boch 2012), too many nurses demonstrate attitudinal barriers to caring for LGBT people.

Lack of Guidance for Developing LGBT Competencies to Guide Nursing Practice

One of the first calls for the inclusion of foundational content on LGBT health in health professional education came in 2001 in a companion document to the Healthy People 2010 U.S. national health goals (Gay and Lesbian Medical Association 2001). Since that time, the American Association of Medical Colleges (AAMC) has issued clear curricular guidance for medical schools to promote the development of students' knowledge, attitudes and skills and to improve care for LGBT people (Hollenbach et al. 2014). Nursing curricular bodies in the U.S. and elsewhere have yet to develop similar recommendations.

In the U.S., nurse educators utilize curriculum guidelines promulgated by the American Association of Colleges of Nursing (American Association of Colleges of Nursing [AACN] 1996, 2006, 2008, 2011) or the National League for Nursing (National League for Nursing [NLN] 2010). These curricular guidelines assert that nurses at all levels must demonstrate competency in the delivery of culturally sensitive care to diverse populations. However, none specifically identify LGBT people as a population for which nurses must develop such competencies. Given global (World Health Organization 2013) and national (U.S. Department of Health and Human Services 2010, Institute of Medicine 2011) calls for healthcare professionals to redress the health disparities faced by LGBT

people, nurse educators need guidance in preparing nursing students for practice with LGBT clients and patients.

In addition to the lack of formal direction from nursing societies and accrediting bodies, other challenges to nurse educators who wish to include LGBT-specific content are time constraints in an already complex curriculum (Chinn 2013), and faculty's perceptions that they are inadequately prepared to teach this content (Eliason et al. 2010, Lim et al. 2015).

Effects of Education

The positive impact of LGBT-specific content in healthcare provider education is well documented in medicine (Ard & Makadon, 2012). Medical students exposed to this content early in their programs and those who report contact with LGBT people demonstrate greater skill in collecting sexual histories and addressing sexual orientation with patients (Sanchez et al. 2006). In pre-licensure medical education, the effects of educational LGBT-specific content in lectures, guest speakers and role-play demonstrated a positive impact on the attitudes of medical students toward LGBT patients (Kelley et al. 2008). Even inclusion of a small amount of seminar content in medical education affected a positive change in resident physicians' attitudes towards the care of LGBT people (McGarry et al. 2002).

All health professionals are responsible for the care of LGBT people. With a presence across systems of care, nurses, in particular, are uniquely positioned to address sexual-orientation-related health disparities. Changing nursing educational models and curriculum to better prepare students to care for LGBT people is consistent with the values of the nursing profession and ethical nursing practice (American Nurses Association 2015).

METHODS

Integrating LGBT content into an FNP Program

This discursive paper describes our experience developing and implementing an LGBT health module in an FNP program that enrolls students at five campuses. These campuses are part of a large public university in a Midwestern US state. This curricular improvement project does not meet the definition of human subjects research under the U.S. Department of Health and Human Services (U.S. Department of Health and Human Services 2016). It is, therefore, not subject to Institutional Review Board (IRB) oversight. Although part of an urban public university, the four regional campuses serve students from rural and smaller metropolitan areas throughout the state. Our program uses a "flipped classroom," meaning that students' initial contact with course content is at home and time spent in the classroom focuses on discussion and application of content.

In 2010, we modified our FNP program curriculum to include content specific to the primary care of LGBT people. We made this curricular change to better prepare our FNP graduates for practice with LGBT patients. We integrated this content into the final health management course in the program, and placed it in the section of the course that covers gender-specific health topics (i.e. men's health and women's health).

Our approach to designing the FNP module included reviewing the literature to identify the major health issues and concerns of LGBT people, interviewing clinicians who care for LGBT people, and reviewing resources such as the Gay and Lesbian Medical Association (GLMA) recommendations for the care of LGBT patients (Gay and Lesbian Medical Association 2006). Subsequent updates have incorporated content from Joint Commission's Field Guide for the care of LGBT people (Joint Commission 2011). The outcome is a week-long web-based self-study module entitled, "Primary Care of Sexual Minority People." Brennan and colleagues (Brennan et al. 2012) recommend that nursing curricula related to LGBT health include content on lifespan development, health promotion,

disease prevention and access to care, as well as legal and policy issues. Consequently, the LGBT module includes the following sections: minority stress, cultural humility, sexual and gender minority vocabulary, primary care of lesbian women, primary care of gay men and men who have sex with men (MSM), primary care of bisexual people, primary care of transgender and gender non-conforming people, and special considerations in the care of adolescents and young adults. Embedded in the learning module are assigned readings, videos, self-assessment activities, and case-based learning activities. We used the minority stress framework (Meyer, 1995) as the underpinning of module content. Because the learning module is intended to be practical rather than theoretical, the module begins with a video from a nurse theorist Peggy Chinn, explaining how minority stress affects patient care (Vanderbilt School of Nursing 2010).

Cultural humility is an approach to culturally sensitive care originally proposed by Tervalon and Murray-Garcia (1998) in the context of care for people from racial/ethnic minority backgrounds. Rather than advocating cultural competence—which suggests specific endpoints—cultural humility embraces self-evaluation, self-critique and awareness of when a provider is imposing his/her views and values on a patient or community (Tervalon & Murray-Garcia 1998). We use this framework to orient students to the reality that they cannot fully understand the lived experiences of LGBT people and that the role of the healthcare provider is to be open, nonjudgmental and inquisitive in learning about patient's experiences and how those experiences influence health.

Evidence suggests that implicit bias in healthcare is one of the reasons that minority populations, including LGBT people, have poorer health outcomes (Zestcott, Blair & Stone 2016). Unconscious or implicit bias is bias in judgment that occurs as a result from subtle cognitive processes, and is influenced by societal or cultural beliefs (Zestcott, Blair & Stone 2016). First-hand knowledge of, or friendship with, a person who identifies as LGBT reduces bias and homophobic thoughts or actions (Rondahl et al. 2004; Rondahl 2009). While many students may have LGBT friends or family, others do not. To increase knowledge of the day-to-day lives of LGBT people,

students view videos of personal stories from LGBT people describing their experiences of being sexual minorities (e.g., It Gets Better Project, 2009).

Our informal discussions with LGBT-focused providers in the community demonstrated a need for a common lexicon that nurses can use to describe and communicate with LGBT people. Drawing on information from key informants and published resources (Gay and Lesbian Medical Association 2006, Gay and Lesbian Alliance Against Defamation 2014), we built a vocabulary list (see Table 1) for students. This list also includes commonly-used, but inappropriate, terminology to describe sexual minority people (e.g., homosexual, avowed homosexual, homosexual lifestyle, sexual *preference*).

When addressing primary care of lesbian women, we emphasize issues that lesbian women face due to healthcare providers' lack of knowledge or sensitivity. We use a case-based scenario that portrays a successful middle-aged woman in a stable same-sex marriage. We also emphasize that breast and cervical cancer screening recommendations apply to all female-born people, regardless of sexual orientation. The scenario reinforces the fact that many lesbian women have had male partners (Diamant et al. 1999, Everett 2013, Talley et al. 2015). Additionally, we incorporate information about the challenges in health-care decision-making that same-sex couples face when they do not have the benefit of legal recognition of their relationship.

The section of the learning module focusing on gay men/MSM uses a case of a graduate student who experiences housing instability after disclosing his sexual orientation to family members. FNP students also consider specific screening and health promotion services that may benefit gay men/MSM in general. These services include mental and behavioral health screenings for substance use and body dysmorphia, risk-appropriate sexually transmitted infection (STI) screenings and vaccination against human papilloma virus (HPV) and hepatitis A, as well as pre-exposure prophylaxis (PrEP) for the prevention of HIV.

The bisexual health section begins by introducing students to the definition of bisexuality as the capacity for romantic, emotional and physical attraction to more than one gender (Miller et al. 2007). In addition, students are helped to understand that sexual orientation is not a binary construct, but rather that it exists on a continuum with exclusive heterosexuality and exclusive homosexuality on either end (Kinsey et al. 1948). This portion of the module helps students gain nonbiased understanding that many patients have had, or will have, sexual partners of a gender different than that of their current partner. Students are introduced to a tool to guide sexual history taking (Centers for Disease Control 2005) and resources for learning about the health concerns of bisexual people, a group that is more invisible than lesbian, gay and transgender people and not fully accepted in either heterosexual or sexual minority communities (Bostwick, Hughes & Everett 2015; Miller et al. 2007).

The transgender health section of the module uses a case of a transgender woman who is seeking routine health care. Students must consider the implications of hormone replacement therapy and the need to consider prostate health in a woman who still has a prostate gland. Additionally, this portion of the module includes effective interviewing strategies and how to provide a welcoming practice for transgender people such as including gender identity on intake forms and providing gender-neutral restrooms.

The adolescent section of the module provides information to help students to develop an understanding of heteronormativity (i.e. presuming heterosexuality is the norm) and gender conformity/nonconformity. Given that adolescence is generally the developmental period during which young people begin to express their sexual and gender identities, nurse practitioners must be careful to interview young people in such a way as to communicate openness to a range of sexual orientations and gender expressions.

After self-paced study of the LGBT health module, students convene for an in-class meeting during which they discuss content and complete an in-person case study of a male-to-female transgender woman with the presenting complaint of a lump in her breast. LGBT health content is included on examinations for this portion of the course to help evaluate the student's level of understanding.

DISCUSSION

Since incorporating LGBT health content in the FNP course, student evaluations have been strongly favorable. They consistently report that material included in the module is relevant to their clinical practice in primary care and that the content is an appropriate part of the course. Although, as noted above, this curricular improvement project does not meet the definition of human subjects research (U.S. Department of Health and Human Services 2016) we obtained student permission to reproduce the following exemplar feedback regarding the learning content:

> *I think [this content] is far more important than many of us realize...Having been an [emergency room (ER)] nurse for many years I have cared for many LGBT patients but have found that there is a great prejudice in regards to these patients...I want to share an experience from a hospital I had worked at. A young gay man was brutally raped and sought care in our ER. The patient was treated very un-empathetically by both the EMS personnel and ER staff and he overheard derogatory conversations about him while in the ER. The next day he committed suicide leaving an explicit note in which he expressed his feelings of worthlessness and supported these feelings by detailing his treatment and discussions he had overheard by the healthcare team he had sought help from...I think that learning modules like this are the first step in combating the general ignorance of the healthcare community and the healthcare inequities that the LGBT communities face.*

Our experience with implementation of the LGBT health module in the FNP program demonstrates that nurse educators can successfully integrate this content into the graduate nursing curriculum. Below, we discuss factors that can facilitate or hinder successful incorporation of LGBT health content in nursing curricula.

In most nursing programs, curriculum revisions require an iterative process that involves many stakeholders. For major curriculum revisions in our institution course objectives and competences are proposed by faculty teaching the course, reviewed by the curriculum committee,

voted on by the faculty at large and then sent to the state board of education for final approval. Adding the LGBT health module did not require this process as it was the FNP faculty member's conclusion that this content supported the already-approved course that included a focus on gender and sexual health.

Lack of faculty expertise related to LGBT health and faculty perceptions of limited classroom time are commonly reported faculty-mediated barriers to implementation of LGBT content in nursing education (Eliason et al. 2010, Chinn 2013, Lim et al. 2015). FNP faculty initially expressed concerns about the additional content load for students. By integrating LGBT content into the course unit that included special topics related to men's and women's health (e.g. cancer screening, cultural humility, age-specific health promotion), we were able to alleviate these concerns by avoiding duplication of content.

The online learning module was developed mostly by the course coordinator, a faculty member with clinical expertise in LGBT healthcare. The course includes five discussion sections, each led by a different FNP faculty member. Some of the discussion leaders expressed concern about their ability to address student questions related to LGBT health. We managed these concerns by asking faculty to complete the learning module themselves prior to the class meeting and offered opportunities for faculty to speak one-on-one with the module author. Additionally, we shared clinician-focused continuing education resources with faculty who asked for additional information about the care of LGBT people (Gay and Lesbian Medical Association 2012).

Unanticipated were concerns of a few faculty members about the nature of homosexuality. Specifically, several faculty members expressed concerns that the learning module presumed same-sex identity to inherent ("they are born that way"). Studies investigating the genetic basis of same-sex orientation, underway at the time, fueled questions about the etiology of homosexuality, whether it could be treated, and whether content addressing the effects of stigma and discrimination against sexual minority people was relevant. We addressed this concern by reviewing

the state of the science on same-sex attraction that provides ample support of the position that this is a normal variation of human sexuality (American Psychological Association & National Association of School Psychologists, 2015).

Students are the ultimate consumers of the LGBT health learning content in our program. Because this content added to, rather than replaced, other content, we were initially concerned that students might perceive this content as adding to an already heavy course workload. To the contrary, students' response to the LGBT module has been consistently positive. Students report that they enjoy the embedded video content and short activities. They also appreciate and enjoy case-based presentation of the content. Their feedback affirmed our expectation that presenting concepts such as cultural humility, minority stress and health disparities through clinical cases would make topics more relevant and engaging. The minimal negative critique of the content by students was that time spent on LGBT health might better be spent on advanced management of disease processes. Specifically, students have expressed anxiety about not having adequate classroom preparation regarding health conditions that they encounter in their clinical practices.

It is interesting that faculty member's concerns that students from rural areas would have more difficulty with the LGBT course content because they are less likely than urban students to have had experience with LGBT patients. This concern has not proven to be the case. On the contrary, students from all campuses have reported similar knowledge gaps related to the care of LGBT people.

CONCLUSION

There is a global need for nurses to redress inequities faced by LGBT people, particularly in regard to healthcare. To meet this need, upcoming generations of nurses must have the knowledge and skills needed to provide culturally sensitive and appropriate care to LGBT people and their families.

Professional nursing organizations need to develop guidelines for curricular content and competencies related to care of sexual minority patients and clients. This guidance should support the evolving definition of sexual minority which now includes lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual (LGBTQIA) people. Until this is accomplished, individual educators are encouraged to include sexual-minority-specific content in their courses. We hope that our example of a faculty-driven curriculum modification will serve as a guide for others who wish to make their course content more inclusive.

RELEVANCE TO CLINICAL PRACTICE

Given that nurses make up the vast majority of the primary health care workforce they are well poised to address many of the factors that contribute to poorer health outcomes among sexual minority people. Unfortunately, the nursing profession has yet to provide a strong voice or support of this segment of the population or guidelines to assist nursing faculty and students in providing culturally competent and sensitive care to sexual minorities. We provide one example of how LGBT-specific content can be incorporated into the nursing curriculum.

References

American Association of Colleges of Nursing (1996). *The essentials of master's education for advanced practice nursing*. American Association of Colleges of Nursing, Washington, DC.

American Association of Colleges of Nursing (2006). *The essentials of doctoral education for advanced nursing practice*. American Association of Colleges of Nursing, Washington, DC.

American Association of Colleges of Nursing (2008). *The essentials of baccalaureate education for professional nursing practice*. American Association of Colleges of Nursing, Washington, DC.

American Association of Colleges of Nursing (2011). *The essentials of master's education in nursing*. American Association of Colleges of Nursing, Washington, DC.

American Nurses Association (2015). Code of ethics for nurses with interpretive statements. Available at: http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html (accessed 15 November 2015).

American Psychological Association & National Association of School Psychologists (2015). *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. Retrieved from http://www.apa.org/about/policy/orientation-diversity.aspx

Ard KL & Makadon HJ (2012). Improving the health care of lesbian, gay, bisexual and transgender (LGBT) people: Understanding and eliminating health disparities. Retrieved from http://www.lgbthealtheducation.org/wp-content/uploads/Improving-the-Health-of-LGBT-People.pdf

Beyrer C (2014). Pushback: The current wave of anti-homosexuality laws and impacts on health. *PLoS Medicine* **11**, e1001658.

Boch S (2012). *Knowledge, attitudes, behaviors of nursing faculty and students' about lesbian, gay, bisexual and transgender people.* Unpublished thesis. The Ohio State University, Columbus, OH. Available at: http://hdl.handle.net/1811/51928 (accessed 10 November 2015).

Bosse JD, Nesteby A, & Randall CE (2015). Integrating sexual minority health issues into a health assessment class. Journal of Professional Nursing, **31**, 498-507.

Bostwick WB, Boyd CJ, Hughes TL, West BT & McCabe SE (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *American Journal of Orthopsychiatry* **84**, 35-45.

Bostwick WB, Hughes TL, & Everett B (2015). Health behavior, status and outcomes among a community sample of lesbian and bisexual women. *LGBT Health*, **2**, 121-126.

Brennan AMW, Barnsteiner J, de Leon Siantz ML, Cotter VT & Everett J (2012). Lesbian, gay, bisexual, transgendered, or intersexed content for nursing curricula. *Journal of Professional Nursing* **28,** 96-104.

Brown R, McNair R, Szalacha L, Livingston PM & Hughes T (2015). Cancer risk factors, diagnosis and sexual identity in the Australian Longitudinal Study of Women's Health. *Women's Health Issues* **25**, 509-516.

Carabez R, Pellegrini M, Mankovitz A, Eliason M, Ciano M & Scott M (2015). "Never in all my years…": Nurses' education about LGBT health. *Journal of Professional Nursing* **31**, 323-329.

Centers for Disease Control (2005). A guide to taking a sexual history. Available at: http://stacks.cdc.gov/view/cdc/12303 (accessed 15 November 2015).

Centers for Disease Control (2015a). HIV among transgender people. Available at: http://www.cdc.gov/hiv/group/gender/transgender/index.html (accessed 15 November 2015).

Centers for Disease Control (2015b). Sexually transmitted diseases. Available at: http://www.cdc.gov/msmhealth/std.htm (accessed 15 November 2015).

Chinn PL (2013). Commentary: Lesbian, gay, bisexual, and transgender health: Disparities we can change. *Nurse Educator* **38**, 94-95.

Cochran SD, Mays VM, Alegria M, Ortega AN & Takeuchi D. (2007). Mental health and substance use disorders among Latino and Asian American Lesbian, Gay, and Bisexual adults. *Journal of Consulting and Clinical Psychology* **75**, 785-794.

Diamant AL, Schuster MA, McGuigan K & Lever J (1999). Lesbians' sexual history with men: Implications for taking a sexual history. *Archives of Internal Medicine* **159**, 2730-2736.

DiPlacido J & Herek GM (1998). Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals. In *Psychological perspectives on lesbian and gay issues*. (Greene B & Herek GM, eds). Sage, New York, NY, pp. 138-159.

Drabble L, Trocki K, Hughes TL, Korcha R, & Lown A (2013). Sexual orientation differences in relationships between victimization and hazardous drinking among women in the National Alcohol Survey. *Psychology of Addictive Behaviors **27***, 639-648

Eliason MJ, Dibble S & Dejoseph J (2010). Nursing's silence on lesbian, gay, bisexual, and transgender issues: The need for emancipatory efforts. *Advances in Nursing Science* **33**, 206-218.

Everett BG (2013). Sexual orientation disparities in sexually transmitted infections: Examining the intersection between sexual identity and sexual behavior. *Archives of Sexual Behavior* **42**, 225-236.

Flores A, Herman J, Gates G & Brown T (2016). How many adults identify as transgender in the United States?. Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf

Fredriksen-Goldsen KI, Kim HJ, Barkan SE, Muraco A & Hoy-Ellis CP (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health* **103**, 1802-1809.

Garbuglia AR, Gentile M, Del Nonno F, Lorenzini P, Lapa D, Lupi F, Pinnetti C, Baiocchini A, Libertone R, Cicalini S, Capobianchi MR & Ammassari A (2015). An anal cancer screening program for MSM in Italy: Prevalence of multiple HPV types and vaccine-targeted infections. *Journal of Clinical Virology* **72**, 49-54.

Gates GJ (2014). LGBT Americans report lower well-being. Available at: http://www.gallup.com/poll/175418/lgbt-americans-report-lower.aspx (accessed 15 November 2015).

Gates GJ (2011). *How many people are lesbian, gay, bisexual and transgender?* Williams Institute, Los Angeles, CA.

Gay and Lesbian Alliance Against Defamation (2014). GLAAD media reference guide. 9th edn. Available at: http://www.glaad.org/reference (accessed 15 November 2015).

Gay and Lesbian Medical Association and LGBT health experts (2001). Healthy People 2010 companion document for lesbian, gay, bisexual, and transgender (LGBT) health. Available at: http://www.glma.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf (accessed 15 November 2015).

Gay and Lesbian Medical Association (2006). *Guidelines for care of lesbian, gay, bisexual, and transgender patients*. Gay and Lesbian Medical Association, San Francisco.

Gay and Lesbian Medical Association (2012). Top ten issues to discuss with your healthcare provider. Available at: http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=947&grandparentID=534&parentID=938&nodeID=1 (accessed 11 November 2015).

Gracia E (2014). Intimate partner violence against women and victim-blaming attitudes among europeans. *Bulletin of the World Health Organization* **92**, 380-381.

Haas AP, Eliason M, Mays VM, Mathy RM, Cochran SD, D'Augelli AR, Silverman MM, Fisher PW, Hughes TL, Rosario M, Russell ST, Malley E, Reed J, Litts DA, Haller E, Sell RL, Remafedi G, Bradford J, Beautrais AL, Brown GK, Diamond GM, Friedman MS, Garofalo R, Turner MS, Hollibaugh A & Clayton PJ (2010). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality* **58**, 10-51.

Halkitis PN & Parsons JT (2003). Intentional unsafe sex (barebacking) among HIV-positive gay men who seek sexual partners on the internet. *AIDS Care* **15,** 367-378.

Heise L, Garcia-Moreno C, Krug E, Dahlberg L, Mercy J, Zwi A & Lozano R (2002). Intimate partner violence. In *World Report on Violence and Health.* World Health Organization, Geneva, pp. 89-121.

Hollenbach A, Eckstrand K & Dreger A (2014). Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD. Association of American Medical Colleges, Washington, DC.

Hughes TL (2005). Alcohol use and alcohol-related problems among lesbians and gay men. *Annual Review of Nursing Research **23,*** 283-325.

Hughes TL (2011). Alcohol use and alcohol-related problems among sexual minority women. *Alcoholism Treatment Quarterly*, **29**, 403-435.

Hughes TL & Eliason M (2002). Substance use and abuse in lesbian, gay, bisexual, and transgender populations. *The Journal of Primary Prevention **22***, 263-298.

Hughes TL, Wilsnack SC & Kantor L (2015). The influence of gender and sexual orientation on alcohol use and alcohol-related problems: Toward a global perspective. *Alcohol Research: Current Reviews* **38**, e1-e12.

Hughes TL, Johnson TP, Steffen AD, Wilsnack SC & Everett B (2014). Lifetime victimization, hazardous drinking, and depression among heterosexual and sexual minority women. *LGBT Health* **1**, 192-203.

Hughes T, McCabe SE, Wilsnack SC, West BT & Boyd CJ (2010). Victimization and substance use disorders in a national sample of heterosexual and sexual minority women and men. *Addiction* **105**, 2130-2140.

Hughes TL, Szalacha LA & McNair RP (2010). Substance use and mental health disparities: Comparisons across sexual identity groups in a national sample of young Australian women. *Social Science & Medicine* ***71***, 824-831.

Institute of Medicine (2011). *The health of lesbian, gay, bisexual, and transgender (LGBT) people: Building a foundation for better understanding*. National Academies Press, Washington, DC.

It Gets Better Project (2009). It gets better-FDNY. Available at: http://www.itgetsbetter.org/video/entry/10693 (accessed 23 November 2016).

Iran president in NY campus row (2007, September 25), *BBC News.* Retrieved from http://news.bbc.co.uk/2/hi/middle_east/7010962.stm

Johnson TP, Hughes TL, Cho YI, Wilsnack SC, Aranda F & Szalacha LA (2013). Hazardous drinking, depression, and anxiety among sexual-minority women: Self-medication or impaired functioning? *Journal of Studies on Alcohol and Drugs* **74**, 565-575.

Joint Commission (2011). *Advancing effective communication, cultural competence, and patient-and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: A field guide*. Joint Commission, Oakbrook Terrace, IL.

Kelley L, Chou CL, Dibble SL & Robertson PA (2008). A critical intervention in lesbian, gay, bisexual, and transgender health: Knowledge and attitude outcomes among second-year medical students. *Teaching and Learning in Medicine* **20**, 248-253.

Kinsey AC, Pomeroy WB & Martin CE (1948). Sexual behavior in the human male. Saunders, Oxford UK.

Kollman K & Waites M (2009). The global politics of lesbian, gay, bisexual and transgender human rights: An introduction. *Contemporary Politics* **15**, 1-17.

Lim F, Johnson M & Eliason M (2015). A national survey of faculty knowledge, experience, and readiness for teaching lesbian, gay, bisexual, and transgender health in baccalaureate nursing programs. *Nursing Education Perspectives* **36**, 144-152.

Matthews AK, Cho YI, Hughes T, Wilsnack SC, Johnson T & Martin K (2013). The relationships of sexual identity, hazardous drinking, and drinking expectancies with risky sexual behaviors in a community sample of lesbian and bisexual women. *Journal of the American Psychiatric Nurses Association* **19**, 259-270.

Matthews AK, Riley BB, Everett B, Hughes TL, Aranda F & Johnson T (2014). A longitudinal study of the correlates of persistent smoking among sexual minority women. *Nicotine & Tobacco Research* **16**, 1199-1206.

McGarry KA, Clarke JG, Cyr MG & Landau C (2002). Evaluating a lesbian and gay health care curriculum. *Teaching and Learning in Medicine* **14**, 244-248.

McNair RP, Szalacha LA & Hughes TL (2011). Health status, health services use, and satisfaction according to sexual identity of young Australian women. *Women's Health Issues*, **21**, 40-47.

Mereish EH, O'Cleirigh C & Bradford JB (2014). Interrelationships between LGBT-based victimization, suicide, and substance use problems in a diverse sample of sexual and gender minorities. *Psychology, Health & Medicine* **19**, 1-13.

Meyer IH (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin* **129**, 674-697.

Meyer IH (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior* **36**, 38-56.

Miller M, André A, Ebin J & Bessonova L (2007). *Bisexual health: An introduction and model practices for HIV/STI prevention programming*. National Gay and Lesbian Task Force Policy Institute, Washington, DC.

National League for Nursing. (2010). Outcomes and competencies for graduates of practical/vocational, diploma, associate degree, baccalaureate, master's, practice doctorate, and research doctorate programs in nursing. Available at: http://www.nln.org/professional-development-programs/competencies-for-nursing-education/nln-competencies-for-graduates-of-nursing-programs (accessed 7 November 2015).

Obedin-Maliver J, Goldsmith ES, Stewart L, White W, Tran E, Brenman S, Wells M, Fetterman DM, Garcia G & Lunn MR (2011). Lesbian, gay, bisexual, and transgender–related content in undergraduate medical education. *JAMA* **306**, 971-977.

Pew Research Center (2013). A global divide on homosexuality. Retrieved from http://www.pewglobal.org/2013/06/04/the-global-divide-on-homosexuality/

Population-Focused Competencies Task Force (2013). *Population-focused nurse practitioner competencies*. National Organization of Nurse Practitioner Faculties, Washington, DC.

Reitman DS, Austin B, Belkind U, Chaffee T, Hoffman ND, Moore E, Morris R, Olson J & Ryan C (2013). Recommendations for promoting the health and well-being of lesbian, gay, bisexual, and transgender adolescents: A position paper of the Society for Adolescent Health and Medicine. *Journal of Adolescent Health* **52**, 506-510.

Rondahl G (2009). Students' inadequate knowledge about lesbian, gay, bisexual and transgender persons. *International Journal of Nursing Education Scholarship* **6**, Article 11.

Rondahl G, Innala S & Carlsson M (2004). Nurses' attitudes towards lesbians and gay men. *Journal of Advanced Nursing* **47**, 386-392.

Roth K (2014). *LGBT: Moving towards equality*. In *Outlook on the global agenda*. World Economic Forum. (pp. 64–67). Retrieved from http://reports.weforum.org/outlook-global-agenda-2015/global-leadership-and-governance/the-road-to-equality/

Russell ST, Ryan C, Toomey RB, Diaz RM & Sanchez J (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *The Journal of School Health* **81**, 223-230.

Sanchez NF, Rabatin J, Sanchez JP, Hubbard S & Kalet A (2006). Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. *Family Medicine* **38**, 21-27.

Shields L, Zappia T, Blackwood D, Watkins R, Wardrop J & Chapman R (2012). Lesbian, gay, bisexual, and transgender parents seeking health care for their children: A systematic review of the literature. *Worldviews on Evidence-Based Nursing* **9**, 200-209.

Talley AE & Littlefield AK (2014). Pathways between concealable stigmatized identities and substance misuse. *Social & Personality Psychology Compass* **8**, 569-582.

Talley AE, Aranda F, Hughes TL, Everett B & Johnson TP (2015). Longitudinal associations among discordant sexual orientation dimensions and hazardous drinking in a cohort of sexual minority women. *Journal of Health and Social Behavior* **56**, 225-245.

Tervalon M & Murray-Garcia J (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved* **9**, 117-125.

U.S. Department of Health and Human Services (2010). *Healthy People 2020*. U.S. Department of Health and Human Services, Washington, DC.

U.S. Department of Health and Human Services (2016). *Human subjects regulations decision charts.* Retrieved from http://www.hhs.gov/ohrp/regulations-and-policy/decision-charts/index.html

U.S. State Department (2010). 2009 human rights report: Zimbabwe. Available at: http://www.state.gov/j/drl/rls/hrrpt/2009/af/135984.htm (accessed 9 November 2015).

United Nations (2015). Ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people. Available at: http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/september/20150929_LGBTI (accessed 10 November 2015).

Vanderbilt School of Nursing (2010). Peggy Chinn interview. Available at: https://www.youtube.com/watch?v=Pv_mEwT3OkI (accessed 23 November 2016).

Veale JF (2008). Prevalence of transsexualism among New Zealand passport holders, *Australasian Psychiatry*, **42**, 887–889.

Walsh D & Hendrickson SG (2015). Focusing on the "T" in LGBT: An online survey of related content in Texas nursing programs. *Journal of Nursing Education* **54**, 347-351.

Wilsnack SC, Hughes TL, Johnson TP, Bostwick WB, Szalacha LA, Benson P, Aranda F & Kinnison KE (2008). Drinking and drinking-related problems among heterosexual and sexual minority women. *Journal of Studies on Alcohol and Drugs*, **69**, 129-139.

World Health Organization. (2013). *Improving the health care of lesbian, gay, bisexual and transgender people* (EB133/6). World Health Organization, Geneva, Switzerland.

Zestcott C, Blair I & Stone J (2016). Examining the presence, consequences, and reduction of implicit bias in health care: A narrative review. *Group Processes & Intergroup Relations, 19*(4), 528-542.

TABLE 1

Terminology for Women	
Lesbian	Many women that are attracted to other women identify themselves as lesbians (used as either a noun or adjective "I am a lesbian" or "I am a lesbian woman"). Many women may also use the term, "gay" to describe themselves. Because a woman identifies as a lesbian, one should not assume that she does not/has not had male sexual partners. While some lesbian women have histories of exclusively female sexual partners substantial numbers of lesbian women report having had male sexual partners (Talley et al., 2015). Some lesbian women object to the use of the term, lesbian, as a noun as identifying a lesbian detracts from other identities such mother, nurse, veteran, or African-American.
Terminology for Men	
Gay	The predominant term to describe gay men is "gay." Unlike the term lesbian, it is typically used as an adjective.
Men Who Have Sex with Men (MSM)	Not all men who are sexually active with other men identify as gay. So, when describing behavior rather than identity, MSM is the more appropriate term.
Terminology for Transgender People	
Transgender	The word transgender is an adjective that applies to people that feel that their assigned sex (i.e. biological sex) does not match their true gender identity. Some transgender people may feel that their true sex is different from the sex into which they were born. Other transgender people may identify as neither male nor female.
Male-to-female	A person that was born as a biological male but identifies as female. Some

(MTF) Transgender	people may identify themselves as a *trans woman*.
Female-to-male (FTM) Transgender:	A person that was born as a biological female but identifies as a male. Some people may identify themselves as a *trans man*.
Intersex	Intersex is a predominantly clinical term which describes the biological state of having discordance in sexual organs (e.g. having both a penis and ovaries). Previously, this condition was called hermaphroditism. Biology aside, some individuals identify as intersex as a statement that they do not identify as either exclusively male or female.
Transsexual (uncommon)	A term that some transgender people may use to identify as a person that has undergone or is undergoing medical or surgical therapies to transition their gender identity. Clinicians should be cautious in using this word as it connotes an endpoint and a misunderstanding of the experience of transgender people. Transgender people do not "become" transsexual after surgeries. It is an older term that some people still use to describe themselves, but it is not a term that the clinician should use without first hearing the patient use it.
Inappropriate Terminology	
Transvestite/Cross-Dresser	A person that identifies as the sex she or he was assigned at birth but enjoys dressing as the opposite sex. This is a term that describes a behavior and not an identity. It is not an appropriate term for a clinician to use.
Sexual Preference	This term is inaccurate as it implies that sexual orientation is a choice. A more accurate and relevant term is sexual orientation.
Homosexual	While not inherently offensive, the term is considered to be outdated and 'clinical'. In addition, the term has been used by some to vilify members of the LGBT community.
Gay/Alternative Lifestyle	All people make lifestyle choices. For example, some people are fitness enthusiasts while others opt for a sedentary lifestyle. Sexual orientation is not a "lifestyle". Further, LGBT people do not view their lives as alternative to anything.
Lover	Some LGBT people may identify their spouse or partner as their "lover". However, identifying a spouse or significant other as a "lover" may be seen as diminishing the role that person plays in other aspects of an LGBT person's life.
Companion (as a term to describe an LGBT person's spouse or significant other)	This term is euphemistic and does not validate the relationship that an individual may have with his or her spouse or significant other.
Slang terms	As with any minority community, some LGBT people sometimes reclaim derogatory or slang terms that others have used to describe them (e.g., queer, dyke). It is not appropriate for a nurse to use these terms to describe a patient or community unless explicitly requested by the patient.