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Exploring Hypervigilance Among Trans+ People Navigating Cisgendered Healthcare

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EXPLORING HYPERVIGILANCE AMONG TRANS+ PEOPLE NAVIGATING CISGENDERED HEALTHCARE

by

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ABSTRACT

This thesis uses the limited research on LGBTQ+ specific hypervigilance and queer battle fatigue to explore the prevalence of hypervigilance and fatigue in trans+ medical experiences, even when emotions aren't centered in their narratives, while also using participants' narratives and minority stress theory to suggest changes to the American medical system. Data was taken from a previous study of in-depth interviews on healthcare experiences of 60 trans+ young adults ages 18-24. Analysis of the data was done in NVivo using line-by-line coding for mentions of emotional responses linked to hypervigilance within interview transcripts. Results show that 67% of participants shared fears about their medical care. The main themes revolved around being outed by medical providers to unsupportive parents, along with avoiding medical help out of fear of being mistreated by the provider and/or staff. Participants also shared frustration with having to educate medical providers and others in positions of power about their care or even having to go so far as to "reenter the closet" to ease through interactions. 58% of participants reported feeling anxiety and fatigue around their healthcare visits. The implications of this thesis are that the scholarship on trans+ hypervigilance applies to experiences when not asked about hypervigilance but also suggests adding 'frustration' to transgender hypervigilance categories. Secondly, queer battle fatigue applies to systems outside of education, in this case, healthcare. Finally, the findings from this study further corroborate that the current medical systems can negatively impact trans+ patients and propose ways to decenter cisnormativity from healthcare.

Keywords: Transgender, Hypervigilance, Fatigue, Minority Stress Theory, Medical Providers.

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LIST OF ABBREVIATIONS

G.N.C.	Gender Non-Conforming
LGBTQ+.	Lesbian, Gay, Bi, Trans, Queer, Plus others
MST	Minority Stress Theory
QBF.	Queer Battle Fatigue

INTRODUCTION

Within the United States, there are an estimated 13 million trans+, and/or LGBQ+ people, which accounts for approximately 4% of the total American population (Williams Institute, 2022). The LGBTQ+ population faces worse health outcomes (Frost, 2015) and employment discrimination (Arana, 2020; Cech & Waidzunas, 2021) than their non- LGBTQ+ peers, but LGBTQ+ individuals are still not a protected class in the United States (Nadal, 2019). The lack of protection status comes with a cost, as many LGBTQ+ people find themselves in a hypervigilant state, characterized by "a chronic and pervasive state of alertness and readiness to respond to potential threats in the environment" (Rostosky et al., 2021, p. 1), often on the lookout for unsafe situations and adjusting their behaviors accordingly.

In research on hypervigilance, LGBTQ+ populations are rarely discussed. The topic of hypervigilance is often framed in the context of chronic health conditions (Krause et al., 2023; Wolf et al., 2018), or veteran populations (Rostosky, 2021). The most significant contribution to knowledge about LGBTQ+ specific hypervigilance is Rostosky, Richardson, McCurry, Riggle's (2021) article "LGBTQ Individuals' Lived Experiences of Hypervigilance*,"* which identified emotional categories encompassing LGBTQ+ hypervigilance such as anxiety, stress, fear, and sadness. This was accomplished through questionnaires based on self-reports from LGBTQ+ Americans.

LGBTQ+ individuals can only live in a state of hypervigilance for so long before it affects their mental health (Meyer, 2003) and physical health (Frost et al., 2015). This chronic state of stress is identified as "queer battle fatigue," or fatigue from just being queer (Wozolek, 2015). However, in current scholarship, queer battle fatigue is still closely tied to education, either discussing battles fought by queer professors and teachers within their institutions (Story,

2020; Calafell, 2017), or queer teachers witnessing and reflecting on bullying and suicide attempts among queer students (Robinson, 2022). Grounding American systems such as religion, politics, sociocultural norms, and healthcare, in the theory of "cisgendering of reality" by scholars Sumerau, Cragun, and Mathers (2016) highlights systematic cisnormativity and cisgendered realities, that transgender, and others under the trans umbrella face by living outside the norm of straight, white and cisgendered. Cisnormativity leads trans+ individuals to be "hypervisible" within American society (Collier & Daniel, 2019). This thesis aims to expand queer battle fatigue to include experiences of trans+ people within the United States' healthcare system by grounding health systems as "cisgendered realities."

Minority stress theory is well established in LGBTQ+ scholarship discussing the negative health outcomes caused by stigma and long-term stress (Johnson et al, 2020; White-Hughto et al, 2015). For the millions of LGBTQ+ Americans living with chronic stress and hypervigilance, both their physical and mental health deteriorate (Frost, 2015; Meyer, 2015). LGBTQ+ people often face discrimination when they seek to improve their declining health due to long-term stress, they encounter discrimination within the cisgendered healthcare system (Campebell, 2022; Johnson et al., 2019; Doan et. al. 2022).

This thesis builds upon Rostosky et al.'s (2021) LGBTQ hypervigilance framework, queer battle fatigue (Wozolek et al., 2015), and minority stress theory (Meyers, 2003) to examine the prevalence of hypervigilance and fatigue within narratives of trans+ people focused on navigating the American healthcare system. This will be done by analyzing a dataset of 60 in-depth interviews with trans+ young adults in Florida. The aim of this analysis is to explore and create more scholarship on trans+ hypervigilance and document participants' experiences to suggest improvements to American healthcare.

Defining Terms

To begin it is important to establish the terms and definitions and how they will function in regard to the following paper. The discussion of gender in this thesis will refer to an individual's social, cultural, and psychological characteristics that pertain to stereotypes, norms, traits, and roles of men and women (Gilbert & Scher, 1999) This should be distinguished from biological sex, often abbreviated as 'sex' defined as "the physiological and biological aspects of a person" (Lev, 2004).

The difference between "sex" and "gender" is necessary to establish because the focus on transgender individuals within this paper will require a sense of precision; a precision needed for the contrast of the majority of individuals that experience congruence between their sex assigned at birth and gender identity, for the purposes of this paper are referred to by the term "cisgender" (Budge et al., 2013).

Transgender is a term used by individuals who identify or present themselves as a gender other than the one assigned to them at birth and/or beyond and between gender binaries (Sumerau et al., 2015). This definition of transgender encompasses everyone under the 'transgender umbrella' including non-binary, gender-questioning, and other "non cis" individuals. Within this paper, the term "trans+" will be utilized specifically to refer to everyone under the transgender umbrella. Additionally, the term "queer" and the initialism LGBTQ+ are used interchangeably throughout the paper to encompass both individuals who identify outside of gender and sexuality norms.

LITERATURE REVIEW

Cisgendered Reality and American Healthcare

The cultural oppression of LGBTQ+ individuals has long been recognized as a distinct problem by civil rights groups such as the Human Rights Campaign and the American Civil Liberties Union (Equality Act, 2019). However, in recent years, the LGBTQ+ community has faced consistent attacks in the form of hurtful and demeaning rhetoric. For example, in Florida, there is Senate Bill No. 1028 is an anti-trans law prohibiting transgender people from participating in sports based on their preferred gender identity, and HB 1557, also known as the "Parental Rights in Education Act" or "Don't Say Gay," bans discussion on gender or sexuality in Florida public schools. This inconsistency in public recognition of trans individuals and lack of concern for their rights and protections can be attributed to the ingrained cisnormativity and cisgendered structures within American culture and society.

Moving away from the broader LGBTQ+, and specifically in to trans+ issues, cisnormativity refers to “a hierarchical system of power that structures legal, administrative, and policing systems and results in the “hypervisibility’ of gender variance” (Collier & Daniel, 2019, p. 2). Put simply, cisnormativity assumes that every individual fits into sexual dimorphism, and the gender binary, that is male or female, and any deviation from this “accepted truth” is met with hegemonic disdain and an absence of understanding or accommodation (Miseo, 2022). This societal othering of those who fall outside the norms of gender expression, leads trans+ individuals feeling “hypervisible” while navigating society. This hypervisibility, by its definition, increases the scrutiny potential threat that transgender and gender-nonconforming individuals face from their bosses (Cech & Waidzunas, 2021), their peers and even family throughout society (Arijs et al., 2023). Coupled with a lack of acceptance within American society, this constant hypervigilance becomes a necessity even in everyday social situations.

However, cisnormative awareness alone is not sufficient in mitigating the perceived effects and impacts of a cisnormative society. This is explored in Sumerau, Cragun, and Mathers' (2015) theory of "cisgendering reality", where they ask open-ended questions to transgender individuals who were current or former members of the Christian denomination of Mormon and the larger Latter-Day Saints. Their research revealed that religious leaders and their followers view trans people as outsiders and reinforce this belief by "socially constructing and maintaining cisnormative interpretations of the world through their ongoing teachings, rituals, and other faith-related activities" (Sumerau et al., 2015, p. 296). These leaders erase and punish transgender individuals and their stories to strengthen cisnormativity, as it aligns with their beliefs and values. The concept of a cisgendered reality within this thesis is twofold. First, Christian ideologies have a considerable influence on American society and its sociocultural norms (Barton, 2012). With approximately 63% of the U.S. population identifying as Christian (Pew Research, 2022), many of which participate in religious activities such as attending services, Sunday schools, and gendered church hobby groups like sewing circles, it is not surprising that American systems of power uphold cisnormativity. Christian religions define what is considered 'American' (Edgell et al., 2006) also known as Christian Nationalism (Whitehead & Perry, 2015) As Christian leaders strive to erase and marginalize transgender individuals, the 'American ideal' remains cisgender, and largely white (Bjork-James, 2019). This creates generation after generation of leaders pushing Christian hegemony or the belief that "Christianity should be the norm and Christians should be in power in the United States" (Todd et al., 2020, p. 2). This hegemony perpetuates erasing and marginalizing those who do not fit the 'American Way' (Davis, 2019).

Secondly, when setting aside the influence of Christianity on American society, it is essential to recognize that Christianity itself is a religious institution. As institutions, religious organizations promote their own values and principles to influence the mainstream context. Thus, the idea of a "cisgendered reality" can also be understood within the context of "cisgendered systems" prevalent in the American healthcare system, as identified by this study and others (see Scott et al., 2021; Toman, 2021). The medical system in America relies on cisnormative language in paperwork that depends on biological classifications and teachings that are disrupted by the existence of transgender people (Kessler and McKenna, 1978; Lampe, 2024). By upholding these established norms, "cisgender systems" fail to create space for many trans+ individuals to freely identify in a way that aligns with their personal views, leading to choices of forced compliance or self-closeting

These factors collectively contribute to the shaming and "othering" of trans+ individuals, placing them at a higher risk of forgoing necessary care and jeopardizing their health. Alternatively, they may choose to endure fatigue and fear as they navigate a potentially harmful healthcare system.

THEORETICAL FRAMEWORK

Queer Battle Fatigue and Hypervigilance

Racialized Battle Fatigue was originally a discussion about fatigue surrounding being not white within the education system by William A. Smith (2006). Since then, it has been expanded to other minority groups, such as the LGBTQ+ population by Boni Wozolek, Ross Varndell, and Taylor Speer, Queer Battle Fatigue (QBF) was developed in part by a transman graduate student and co-author Ross Varndell, who used his experiences to help develop the theory (2015). QBF

was created from and is often used within scholarship by other trans+ academics to help put a theory to their feelings. (See Suarez, 2020; Robinson, 2022).

QBF argues that fatigue sets in within the lives of queer individuals when they are in a constant state of fear regarding the acceptance of their gender expression or sexual orientation within their everyday lives. Exhaustion can occur due to something as "simple" as living in the closet, or when a queer person must alter their mannerisms or "mask" in order to "pass" and fit into cisnormative society. Whether this masking is for safety or to go by "unnoticed" (Suaraz, 2020), this concept is referred to as "ontological fatigue" or fatigue caused by simply "being" (Wozolek et al., 2015).

QBF explains experiences as implicit and explicit aggressions (Wozolek et al., 2015). Implicit aggressions are subtle, such as the microaggressions of assuming a woman has a husband or being stared at in the store, while overt (explicit) harassment includes bathroom violence and homophobic and transphobic laws. These everyday microaggressions can wear away a queer person's energy and confidence, as well as impact their mental and physical health.

Viewing queer experiences through the lens of QBF often leads to identity resilience, with individuals willing to fight against the same structures and norms that harm them, or to paranoia, living in a state of hypervigilance to conform to the norms ingrained in American society. Hypervigilance defined here as "a chronic and pervasive state of alertness and readiness to respond to potential threats in the environment" (Rostosky et al., 2021, p. 1), creates an environment where queer individuals may feel constantly threatened solely because their existence creates "friction with sociocultural norms and values" (Wozolek et al., 2015, p. 2). These sociocultural norms are deeply embedded within our systems in America, further contributing to the inescapable nature of queer people living with fatigue and hypervigilance.

Specifically looking at the limited research on hypervigilance among LGBTQ+ people, it was found that a concerning 68% of queer participants self-reported feeling hypervigilant, and 31% monitored their surroundings even during mundane daily life in a wide range of social settings, such as with family, coworkers, and even strangers on the street or at bars (Riggle et al., 2021; Rostosky, 2021). This can have an even greater effect on trans+ individuals, who aren't able to mask their queerness as easily as some other members of the LGBTQ+. Trans+ individuals need to monitor their surroundings, whether grounded in a real threat or a perceived or implied one, can have a lasting effect on the mental state of trans+ individuals which are identified as proximal stressors under Minority Stress Theory. In this paper, the validity of QBF is being tested within a healthcare context. When considering the cisgendered systems integral to American society, healthcare and education are included in the same thought. What QBF exemplifies within queer life could help many people across different systems better understand their emotions, and this thesis aims to start the expansion of QBF with healthcare.

Minority Stress Theory and Health

Ilan H. Meyer's (2003) Minority Stress Theory will be referenced as guidance to bridge understanding of hypervigilant behavior, its impact on an individual's health, and why efforts should be made to reduce chronic vigilance triggers. Meyer's minority stress model states that both distal and proximal stressors can lead to adverse health outcomes.

Meyer (2003) categorizes stress as distal, or external events, and proximal, or lingering events. Distal stressors are often visible stressors, such as harassment or financial issues. Proximal stressors, on the other hand, stem from expectations and anxieties about distal stressors, as well as internalized beliefs about oneself influenced by sociocultural messaging. Proximal stressors impact an individual's physical and mental health long after the triggering event has

been removed (Lefevor et al., 2019). This proximal, or chronic and persistent stress over time escalates into hypervigilance, and compromises LGB people's health just by having to live in a "hostile and stressful" social environment (Meyer, 2003). This is shown in one study that resulted in 73% of LGBTQ+ participants stating that these proximal stressors, and the hypervigilance they cause, impacted their health and well-being (Rostosky et al., 2021).

As for specifics, studies have linked stressors with negative health outcomes. Health issues from long-term stress range from queer people having a threefold increased likelihood of onset of conditions such as cancer, the flu, and hypertensive disorders (Frost et al., 2015). Physical health is not the only health that is damaged. Specifically, Meyer's (2015) identified a plethora of mental illnesses associated with long-term stress, such as depression, anxiety, substance use disorders, and suicide, among the LGBTQ+ population.

Specifically within the trans+ population, gender non-conforming (GNC, i.e., genderqueer, nonbinary, two-spirit, etc.) individuals have been known to experience more stressors and worse mental health outcomes associated with minority stress than binary, cisgender men and women (Lefevor et al., 2019).

Taking all the scholarship on long term stress and its health effects, on top of the poorer health outcomes that come with being LGBTQ+, and systematic barriers within the American healthcare system that alienate trans+ individuals (Campebell, 2022; Johnson et al., 2019)into account, LGBTQ+ research results often end up representing LGB, but only minorly representing TQ+ people, with only a small number of trans and even smaller number nonbinary, and genderqueer individuals in their populations (Darwin, 2017). Studies also often represent all LGBTQ+ individuals as a monolithic group, which results in trans voices being drowned out by gay and lesbian experiences (Riggle et al., 2011). The current study will use QBF and MST to

ground the different emotions felt to queer hypervigilance. Because the population of this analysis is strictly trans+ individuals, this study should also be able to add a depth of information about specifically trans and genderqueer populations, and the nuances of trans stress, fatigue, and hypervigilance.

Due to the data's nature, the potential findings might also be applied to the medical field with the aim of suggesting meaningful changes to current practices. Changes in healthcare could help shift the current system from a cisnormative one, with a focus on biology, to a system that provides care grounded in representing the person in front of them instead of just treating the symptoms of their body.

METHODOLOGY

Overview

This study's analysis uses a dataset of in-depth interviews from a qualitative study conducted by Dr. Lindsay Taliafarro and Dr. Shannon Carter. Their study explored transgender and nonbinary young adults' healthcare experiences. By utilizing narratives not centered on hypervigilance specifically, I look to examine in what ways descriptions of navigating different American systems reveal the presence of trans+ hypervigilance. Specifically, this analysis explores: Is hypervigilance present? If so, what types of events, words, or actions trigger a fearful or hypervigilant response during healthcare visits? Finally, what do these individuals experiencing these triggers suggest to improve their health care quality and outcomes? By investigating these experiences of trans+ participants, I aim to expand our understanding of hypervigilant behavior and fatigue within the trans+ community.

Sample and Recruitment

Recruitment for the interviews was conducted using personal and professional contacts at LGBTQ+ organizations and health centers around Central Florida, as well as encouraging participants to recommend the study to others they know that would qualify. This recruitment is known as 'snowball sampling.' Through these methods, the final sample size consisted of 60 trans+ young adults within and around Central Florida. Participants ranged in age from 18 to 24, with an average age of 20.8 years old.

Within the sample, 38% of participants identified as GNC, while 61% identified as binary transgender, that is either transmen or transwomen. The majority of the sample identified as white, comprising 73% of participants. The remaining races accounted for 3% black, 17% Hispanic/Latinx, and 7% other. Due to the age range, education, employment, and financial status

of the sample, the majority (90%) of participants were covered under their parent or guardian's insurance plan. All this information can be seen in Appendix A.

Data Collection

Data was collected through individual, one-on-one, in-depth qualitative interviews that lasted between 45 to 90 minutes. Participants were given the option to choose between an in-person or phone interview. All interviews were audio recorded and transcribed verbatim by a professional transcriptionist. The interviews were conducted by a white nonbinary graduate student from the University of Central Florida who is also a member of the LGBTQ+ community.

The interviews were semi-structured, incorporating a combination of casual conversation to elicit personal anecdotes and a more structured series of questions outlined in the interview guide (see Appendix B). The conversational nature allowed participants to emphasize issues or experiences, while the guide ensured that all key topics were covered. Categories within the interview guide included trans identity, experiences with healthcare services and institutions, individual health issues, and personal experiences.

Once introductions were exchanged, the purpose of the study and rights were stated, and if participants verified that they understood and consented to being part of the study, recording began. First, participants were asked basic demographic questions, such as age and education, before moving to opening discussions about gender, sexual identity, pronouns, and what their identity means to them. Further questions focused on healthcare, including experiences within several types of medical institutions (e.g., general, psychological, and reproductive health appointments). Specifically, participants were asked about their interactions with healthcare personnel and disclosing their trans identity. Because of the conversational nature of the

interview, participants were also given the opportunity to express issues that were important to them.

Any clarifying questions, final statements, and a thank you were expressed before asking for any concerns and recommendations. The interviewer's contact information was shared in case participants had any thoughts outside of the interview, along with continuing the snowball sampling before the session ended. For further details on interview structure, refer to Appendix B for the Interview Guide.

Data Analysis

Analysis was done using NVivo Version 14. In keeping with the spirit of the original framework, the analysis focused on the participants' stories and lived experiences. Line by line coding was done where the researcher parceled out if and what emotions were present within each sentence of the transcript (Budge et al., 2013). Coding for each transcript took between 1 to 2 hours. After the initial coding of all 60 transcripts, a second pass was conducted to ensure the emotional nodes accurately reflected the participants' narrative, followed by establishing connections within each emotional node.

The analysis of the interviews was guided by two main references. The first is the emotional categories identified in Rostosky, Richardson, McCurry, and Riggle's (2021) article "LGBTQ Individuals' Lived Experiences of Hypervigilance." These emotional categories were used as preliminary guidelines for analysis highlighting common emotions that correspond with queer hypervigilance, such as anxiety, stress, fear, sadness, and shame.

The second aspect is the initial study's codebook. The codebook was used to guide the analysis of data, specifically looking for the categories reflecting emotions, such as fear, discomfort, and thoughts and attitudes about different health care experiences. Implementing the

codebook ensured to code both the emotions felt that aligned with Rostosky's emotional categories, and allowed additional emotional categories related to hypervigilance from this data set were included since this study specifically focused on trans narratives, rather than relying solely on categories derived from the experiences of cisgender individuals (87.3%).

Reflexivity

I, the author, must make my personal attachment to this research clear, before proceeding with the analysis. As mentioned earlier in this paper, I am an out and proud lesbian. While I do not consider myself trans+, I have been with my wife since long before she transitioned. That being said, while reading through interview accounts of fatigue caused by searching for trans-friendly doctors, I had the realization that I have been the cisgender buffer between these cisnormative systems and my transgender friends even back when the highest degree I had obtained was a high school diploma. This thesis is not my first act of queer activism by far. By being an advocate for trans+ acceptance and health, I had unknowingly made myself blind to the reality that many trans+ individuals do not have access to an active and engaged cisgender buffer such as myself, someone to help overcome the burdens of awkwardness and microaggression in professional settings. That is when I started to ask the questions posited by this thesis.

Outside of the medical system, living just down the road to the Pulse nightclub, which is the second worst mass shooting in US history (Shahid et al., 2021) and the deadliest incident of violence against LGBTQ+ people in the United States (Rotramel, 2020) is an experience unlike residing in any other place. The 2016 massacre created a surge of acceptance with businesses touting rainbow flags, safe place signs, and "#orlandostrong,", which mostly remains to this day. The majority of the queer community still remember this incident, it is the type of stressor that continues to hang over their heads to this day, the fear that something like that might happen

again. Due to its history, Orlando is relatively accommodating, but the greater Central Florida area is by no means friendly or accepting of queer folk, and this general lack of concern permeates into many aspects of everyday life, including the sensibilities of healthcare staff.

I say all of this to inform you that I have not only experienced the best of support while marching in Orlando pride parades, but also onslaughts of planning escape routes for not only myself but also my friends whenever we leave places we have vetted before.

RESULTS

Data analysis revealed negative emotional themes across the participants' narratives. Trans+ participants showed signs of hypervigilance and QBF in a variety of healthcare scenarios. Below is an examination of the prominence of expected themes like fear, anxiety, and hypervigilance among interview participants. After that is an analysis of the effects of fatigue on participants, specifically on the overwhelming factors that lead to prolonged QBF. Finally, these findings discuss a lack of shame among participants, in contrast with the guiding study that found shame to be a common emotion found in the guiding study (Rostosky et al., 2021), as well as the participants' emphasis on frustration.

Fear and Vigilance

Out of the 60 participants interviewed, 40 (67%) participants shared stories of being fearful because of their gender identity moving through cisnormative systems. Most commonly these fears revolve around identity disclosure, or 'being outed,' which is the act of non-consensual trans identity disclosure. Another fear includes being mistreated while moving through medical institutions. These fears around identity disclosure take a toll on trans+ individuals, causing increased vigilance in situations that others would consider banal.

Fear of being outed or mistreated

When looking at being outed, Jules, a 21-year-old transwoman on her parents' insurance emphasizes the power imbalance involved in a medical visit as she shares worries about being outed when asked about staying closeted to medical professionals.

> Well, it's just the fear that some kind of paperwork could reach the hands of my family, which I'm not out to, and they would be confused and ask, "Oh, who's [name]?" And I just dread that. I just dread that scenario of being outed without my permission or anything.

Parker, a 20-year-old transman who went a step further and avoided opening up to his therapist for fear of being outed to his parents, the owners of his insurance at the time.

> It usually meant for me that I couldn't share a lot of my experiences with my mental healthcare doctor, let alone the fact that I'm trans. A lot of times before I went to this mental healthcare provider, I would feel alienated because I was trans and I couldn't tell my healthcare provider that I was trans because they would tell my parents.

These trans+ young adults experienced independence issues, as Jules' story expresses while trying to become the people they want to be in their new adulthood. However, because of insurance-based financial and healthcare fears, many end up staying closeted and suffering mentally like both Meyer (2015) and Lefevor et al. (2019) found.

When not stonewalling for safety like Parker had to, some participants powered through their fears of being outed, only to worry about and fear being denied medical service or mistreatment by medical staff the entire time.

Jasper, a 19-year-old transman, emphasizes this fear of being denied care, as he discusses fearing going to medical appointments even though they aren't gender related, like oral care or, in his case, a general practice provider to get antibiotics.

> I know a lot of the doctors that I'm going to go see for like antibiotics, my gender identity is not going to be an issue, or I would hope it wouldn't be. I would hope they wouldn't be like, "Oh, well you're trans, and so we're not going to give you basic healthcare."

The underlying concern about potentially being denied healthcare due to being trans emphasizes the way gender works its way into healthcare, even when it is not the focus of discussion.

Questions as hypervigilance

In extreme cases, these fears can grow and manifest, resulting in hypervigilant behavior. Commonly expressed within participant narratives is questioning everything related to healthcare and making safety plans.

Feelings of fear and anxiety about being outed, misgendered, and turned away in office can result in trans young adults not getting the healthcare they so desperately need because of these fears of mistreatment and anxiety. The incursion of fear-based questions is one of the main ways participants expressed hypervigilance.

Terran, a 20-year-old transman, explains just that, as he describes his inner monologue reflecting on his avoidance of the medical field which is so strong he spirals into anxiety-ridden questions:

> There's always that fear of what if I go to the hospital and they deny me care, and what if it is my appendix and I die, because they don't want to treat me because I'm trans? And that's a genuine fear, and that's something they can do, which is also scary.... I've been in the ER with my roommate, who's also trans, getting so freaked out. I'm like, "What if they see us and they realize that we're queer and they kick us out? What happens? What do we do then?"

Terran here shows how fear can get morphed into anxiety, paranoia and hypervigilant behavior. which further affects individuals physical and mental health.

Parker, a 20-year-old transman, also expresses this fear-powered assault of questions, worries, and anxiety when he discusses a common theme talked about later, which is trans patients having to be 'smarter' on trans health than professionals.

> I don't know a lot of things about healthcare or anything like that. So it makes me feel not that confident in their treatment of me, because what if something they prescribe me is wrong? What if they misdiagnose me? What if they try to tell me that it's better for my health if I'm off of testosterone?

Parker, Terran, and other participants all point out a worry of provider's personal opinions 'corrupting' their [medical professionals] Hippocratic oath. A fear that can only exist because of the support the cisgendered system offers for hate outside of the societal norm.

Safety planning as hypervigilance

Within participants' stories, pre-planning safety measures include carrying weapons and always having escape plans in place. These plans exist in their minds wherever they go, placing them in a hypervigilant state whenever they go out.

Hayden, an 18-year-old transman, directly shares feelings of alertness and fear of hate-crime-based harm during daily outings in life:

> We have to be careful where we go, how we dress. Having to always be in a group, in most places. Scared that we might get shot and/or we might get like killed out in the middle of nowhere, just because of who we are. To just have to always be on high alert is just something that hurts me, in a way.

Finley, a 21-year-old transman, has even gone as far as finding safety backups for when he is out on the chance his de-escalation goes poorly, all because he has decided to live his life authentically.

> If they're just going to deadname me and not use my correct pronouns, I can just ignore them until I have to see a different face, because inevitably they will go away. But if it becomes a dangerous situations, I also have backup plans where it's like, "Oh, there's a ton of people over there, so if someone tries to hurt me, I can just go over there."

These levels of alertness come at a cost and are a perfect example of how vigilance is not only a thought process or state of mind, but rather additionally has a physiological effect when thinking of 'safety planning' as work that must be done before each and every outing.

Fatigue

Battle fatigue, or "exhaustion by simply being themselves" (Wozolek et al., 2015, pg. 3), is present in 58% of total participants' narratives. The main topics that caused fatigue among the 35 participants include 'masking' their identity, reentering the closet, and/or other safety precautions that rely on them lessening themselves and their identity, in order to get through

situations easier. Along with having to go above and beyond and do invisible, thankless work for adequate or equal care, these burdens can erode the psyche and induce fatigue.

Hiding oneself causing fatigue

Blake, a 21-year-old transmasculine person, discusses the fatigue and depression that comes with being misgendered by both peers and bosses while at work.

> It's a very male-dominated field, so it's hard, because I identify as male but they see me as a woman. So there's a weird sense of like female discrimination despite how masculine I usually present in my dress and my mannerisms. So that's just weird. It's a [laugh] bad time. I usually come home really drained and really just depressed, especially if I have to interact with like my boss or someone higher up than me.

This cacophony of misgendering and lessening himself when interacting with those in positions of power is the perfect combination to cause fatigue. As he said himself, he feels "drained".

The theme of "masking", or putting on a sort of persona, is more apparent from Cameron, a 22-year-old transman who talks at length about the emotional effect of changing his appearance and mannerisms to fit into society.

> I have to mediate my presentation of myself to try to flow through society more smoothly. And it kind of does bring up a little resentment ... At least I'm not being harassed. But then again, it's also like—but I'm also still suffering, and I still have this discomfort that is being caused, and this emotional turmoil that is coming across every time I have to do just a very basic need, basic healthcare, just staying alive and treating myself.

Being forced to mask like that denies one of their sense of self, which eats away at one's energy and happiness, as mentioned by both Cameron and Blake.

Extra labor causing Fatigue:

Commonly, the fatigue discussed within QBF is caused by labor (Story, 2020), whether emotional or otherwise. Multiple participants talk at length about the extra effort and work they have to do for equal care and the emotional effects that it has on them.

Phoenix, a 21-year-old nonbinary person, discusses the unspoken labor that goes into searching for healthcare providers, all to avoid mistreatment.

> I have to find someone who specializes in those things [gender affirmative surgeries] that is also covered by my insurance. Which makes it very hard, because it's hard to find LGBT doctors, and it's hard to find mental health specialists that would specialize in what I need them to, and then also have to have them in my network. It gets very tiring very quickly.

Rory, an 18-year-old nonbinary person, shares the complicated feelings surrounding being some people's - in this case, a medical provider's - first and maybe only trans person, which comes with the added burden of education on various relevant trans topics such as trans specific health needs, an aspect often touched on within QBF (Story, 2020).

> It's such a process to tell people and explain, because a lot of them don't know. It's so time-consuming that if I'm going in for something quick or it's just a nurse that I'm seeing, there's no point in me taking that time and explaining it and putting that effort in if it's going to be so long and such a big process to explain things to them.... I personally don't mind educating people, because I think it's good for people to know all the different identities, and I think it's good for them to be educated. But I feel like the more I do it, the more tired I get of doing it. Because I feel like everyone should be educated and they should know things, but it's also not my specific job for them to know that I exist as a person with a different gender identity than them. It gets tiring.

Rory and Phoenix are not the only ones sharing this sentiment; these quotes are just a small portion of recounts discussing the fatigue that comes with the extra work trans+ people have to do to make it through interactions.

Shameless and frustrated

In Rotosky et al.'s (2021) guiding study of LGBTQ+ people's lived experiences of hypervigilance, shame was identified as a prominent theme. However, among respondents of the current study, not even a single person mentioned feeling ashamed. Half of the participants, however, did share feelings of frustration and anger instead. Kai, a 19-year-old gender-fluid person:

> I have a lot of social dysphoria, so I worry about going out into the world. Like when I'm expressing and feeling a certain way and dress a certain way hoping I'm passing as transmasc, and people still call me "ma'am" and "miss," or like people will look at me in a strange way when I'm just walking down the street, it's incredibly frustrating.

In these instances of societal judgment, older generations report shrinking themselves and feeling shamed (Rostosky et al., 2021), while within the generation in this study, there was a shift with participants being frustrated at others and expecting better from society rather than thinking less of oneself.

Deadnaming is frustrating

Deadnaming, the use of a trans persons given name after they have adopted a preferred one, can be detrimental to a trans+ individual as it strips them of their agency. As Kai touched on, deadnaming can be a major source of frustration. At least 10 other participants shared their frustrations with being misgendered. Elia, a 21-year-old nonbinary person shared:

> Every time I go to the psychologist, they always have this one nurse, and I don't know why, but she's always there when I go, and she is really, really insistent on saying, like, "Hey, deadname. Hey, deadname" every—it feels like it's every minute, and it's really, really annoying, because she's really insistent about it.

Zion, a 19-year-old transwoman accounts of being deadnamed not from a basic health institution, but from an inpatient facility after being Baker Acted, which is the involuntary admission to a mental institution for analysis of an individual:

> They would just—they'd misgender me a lot… It was frustrating, because most of the staff gendered me correctly, and most of the other patients did too, but it was really irritating, and it made me really angry. I think it was just two or three nurses would just consistently misgender me… I know I wasn't passing well at that time, and also I just don't think they understood or cared…I got really upset that they were working in the mental health field and that they don't understand how to treat patients with respect.

While there are differences between participants' situations, they point out upsetting situations not with the primary doctor but supporting staff like nurses and administrative workers. Stories

like these make it clear that the issue extends past the doctor's themselves this reliance on cisgendered notions in mental healthcare situations is actively harmful to trans+ individuals, who typically are incapable of or at the very least unwilling to conform to arbitrary ideals that were decided for them at birth.

DISCUSSION

This study investigated themes of hypervigilence and QBF within TGNB young adults' narratives of their healthcare experiences. Of the 60 interviewees, 67% expressed feelings of fear when planning or interacting with healthcare providers. Over half of the study participants, all of whom are under the age of 25, expressed symptoms of fatigue after seeking mental or physical healthcare assistance. By relying on cisnormative infrastructure, healthcare has become a challenging system for trans+ individuals to interface with, often forcing them to choose between their health and their mental state of homeostasis for what would otherwise be routine interactions. The commonality of themes of fear, anxiety, and fatigue among trans+ individuals during their healthcare visits speaks to the prevalence of hypervigilant behavior in members of the trans+ community. This could also extend to mentions of frustration found within various interviewees' narratives; however, further exploration is needed to understand the implications of this frustration on hypervigilance.

Each emotional reaction discussed above has implications for the field of medicine. Participants expressed fear that medical providers would disclose their identities to their parents through insurance paperwork reaching parents, oftentimes fearing their provider would share it under the guise of helping their patients or simply out of malice. Participants also highlighted fear associated with mistreatment when seeking medical care. Examples of potential mistreatment discussed include being expelled from a healthcare facility, withholding emergency treatment, being subjected to inappropriate questions, or being inappropriately touched under the pretext of "checking gender." Whether these concerns are justified or not, they take a toll on the participants' mental and emotional well-being, as well as keeping them constantly cautious

during interactions with healthcare professionals rather than viewing them as safe and trustworthy.

Hypervigilance, as identified in this study, has two main manifestations: first, in the form of incessant questioning regarding potential negative experiences, such as being examined by a transphobic doctor or having to disclose one's identity to someone in a position of power. Second, hypervigilance led multiple participants to meticulously plan their actions, including how they dress, and even creating escape plans to quickly leave public spaces in case of prejudicial harassment. This continuous cycle of anxious questioning and emergency safety planning contributes to the deterioration of energy, as well as mental and physical health, by subjecting them to a constant state of anxiety and vigilance long before the trans+ individual even arrives at their healthcare appointment.

There are several ways fatigue can erode one's energy. According to participants' experiences, fatigue mainly affected them when they had to conceal aspects of their identity, such as reentering the closet and not correcting being misgendered, to navigate society smoothly. Many also discussed fatigue draining them while having to do labor that cisgender people do not have to. This often includes the need to educate doctors on trans-specific care like hormone replacement therapy, the common pitfalls in etiquette when communicating with trans+ individuals, the diverse range of trans+ people, and even the extensive groundwork of searching for a trans-friendly doctor covered by their insurance, which is sometimes not feasible. Additionally, frustration was frequently encountered in various scenarios, with deadnaming being a prominent source of aggravation. Participants consistently expressed irritation, annoyance, and even anger when they were deadnamed or misgendered, regardless of the setting.

Implications

This thesis contributes several implications to scholarship on trans+ individuals. Firstly, it demonstrates that the existing criteria for hypervigilance extend beyond self-reported experiences and include lived experiences. This analysis also proposes the inclusion of 'frustration' in discussions on transgender hypervigilance. Secondly, by broadening our understanding of systems to which queer battle fatigue is applicable, we can critically examine the gender binary and comprehend its isolating and detrimental effects on individuals who cannot or choose not to conform to it. Lastly, the findings of this study further support the notion that the current medical system tends to have a negative impact on trans+ patients, while also suggesting ways to decenter cisnormativity from existing healthcare systems. By failing to meet the needs of all individuals, healthcare providers are, knowingly or unknowingly, causing harm to some of the most marginalized and under protected groups in society, including, but not limited to, the trans+ community.

LGBTQ+ Hypervigilance Research

The findings of this thesis are congruent with Rotosky et al.'s (2016) hypervigilance categories, which include anxiety, fear, and sadness. However, as mentioned above, the results of this thesis suggest that additional criteria should be added to encompass what trans hypervigilance can include. Taking into account the politicized nature of trans lives in American society, as well as the shifting attitudes towards LGBTQ+ individuals becoming more normalized with each generation, the narratives shared by these young adults are telling. As public opinion moves towards acceptance, while political rulings continue to enforce cisgendered reality, trans+ people are responding to disrespect, mainly experienced through being misgendered and deadnamed, with frustration instead of shame. Correcting the cisgendered

reality ingrained in American socio-political norms will take more than just a few years. With this in mind, considering frustration as an indicator of hypervigilance may provide insight for future studies aiming to understand the nuances of trans people's everyday lives.

Queer Battle Fatigue in Other Systems

During the analysis, many instances of QBF within the healthcare system were identified. Participants recounted experiences of fatigue while seeking ally doctors, battling systemic microaggressions, and attempting to justify the medical necessity of their gender care to insurance providers. This comprehensive list of stressors identified during the analysis, though not exclusively experienced by trans+ people, are heightened because of their identity as members of the LGBTQ+ population (Lefevor, 2019). Everything that was discussed, coded, quoted, and referenced in this study is tied to their identity as trans+ individuals.

There are various reasons why even the most privileged individuals struggle to navigate the United States' healthcare system, ranging from cost issues to life-threatening prognoses. However, for trans+ individuals, this fear is just one of several compounded fears. This additional burden on queer individuals' shoulders forms the core of QBF. The compounding worries force trans+ people to negotiate their safety on a daily basis (Wozolek et al., 2015), which eats away at their ability to be their authentic selves (Suarez, 2020). Being forced into a state of battle fatigue during medical visits leaves trans+ individuals with the difficult choice of sacrificing their mental health for their physical well-being, or vice versa.

Although these battles have been documented within the field of education (Story, 2020), the application of QBF to other systems has been neglected. Based on this analysis, I implore other researchers to explore the application of QBF to other systems, such as healthcare and beyond.

Challenging Cisgendered Healthcare

Based on the diverse range of experiences shared by the participants, there are several key changes that medical practices can implement to distance themselves from the cisgendered foundations on which the system was built. These changes have the potential to reduce distress, fear, and fatigue, and could ultimately improve the health of LGBTQ+ individuals if they become standard practice.

First and foremost, as previously mentioned, being misgendered and deadnamed led to frustration, fatigue, and in some cases, physical reactions. Addressing this issue within healthcare institutions is twofold. First, intake paperwork should include a section for individuals to indicate their preferred name. Secondly, medical staff must make a conscious effort to use the preferred name at every stage of the patient's visit. Ensuring that staff and doctors are educated on pronouns and familiar with research on gender nonconformity, such as the study being conducted, would have a positive impact on trans+ individuals.

Even before trans+ individuals seek treatment, they often find themselves needing to conduct extensive research to determine whether a healthcare provider holds harmful views or if they would need to educate the provider, even if the provider claims to be an "LGBTQ+ ally." Similar to addressing preferred names, incorporating queer identities into medical curricula can alleviate the burden on trans+ individuals, who currently have to ascertain whether a provider is knowledgeable about trans care. This would also help reduce the fatigue associated with having to educate healthcare providers who lack proper training.

Many trans+ individuals face additional stressors when seeking healthcare, in addition to the usual challenges associated with such visits. This hypervigilance leads to fatigue, which affects various aspects of their lives. By accommodating a patient's expression of gender,

healthcare providers can create an environment that improves conditions for trans+ individuals, thus contributing to their overall well-being and reducing healthcare-related fatigue.

Limitations

While reviewing the transcripts of the interviews, several participants described situations or experiences as "uncomfortable" or triggering a sense of "discomfort." In order to accurately represent the participants' stories and lived experiences, none of the quotes used or conclusions drawn were derived from information provided by participants who simply stated feeling "uncomfortable."

Given that the focus of this study was to examine whether hypervigilant behavior occurs even when unprompted, this limitation in the study design was expected. However, the existence of numerous stories without further explanation should not be disregarded.

Future Studies

In the United States, transwomen of color often experience targeted violence within the queer community. While all members of the LGBTQ+ population are subjected to hateful rhetoric and discriminatory laws, transwomen of color bear the brunt of physical violence. Efforts were made during this study to allow participants to discuss how their race and socioeconomic status influenced their experiences. However, it is worth noting that 73% of the participants are white, and 45% identify as transmen or transmasculine individuals.

In order to gain a comprehensive understanding of the prevalence and long-term effects of hypervigilance, as explored in this thesis, it would be valuable to conduct additional research specifically focusing on the experiences of transwomen of color. This would provide further insights into the manifestation of hypervigilance within an already marginalized community.

Moreover, such research would enhance the analysis of chronic hypervigilance, its impact on health, and allow for a comparison of privileges within the LGBTQ+ community.

APPENDIX A: DEMOGRAPHICS TABLE

Table 1; Demographics

Broad Demographic Category	Specific Demographic Identification	Number of Participants	Percentage of Participants
Gender Identity	Transman	26	43.3
	Transwoman	11	18.3
	Gender Non-Conforming	23	38.3
Age	18	7	11.6
	19	14	23.3
	20	7	11.6
	21	10	16.6
	22	8	13.3
	23	5	8.3
	24	9	15.0
Race/Ethnicity	Hispanic/Latinx	10	16.6
	White	44	73.3
	Black	2	3.3
	Multiracial	4	6.6
Education	No College	5	8.3
	Some College	6	10.0
	Undergraduate Student	39	65.0
	College Graduate	7	11.6
	Graduate Student	3	5.0
Insurance Status	Parent's Insurance	40	66.6
	Employer Sponsered	4	6.6
	Federal	8	13.3
	Uninsured	4	6.6
	Other/Unknown	4	6.6

n = 60

APPENDIX B: INTERVIEW GUIDE

Interview Schedule

Structure

Each interview will last at least 30 minutes and no more than 2 hours. Interviews will occur face-to-face or over telephone. The interviewer should cover all questions presented in the interview guide, but should not be limited by the guide. Probing questions are presented to aid in the event of diminished responses or need for clarity from participants. In the event of new and relevant information that needs to be addressed, the interviewer should appropriately address the issue and concern and then continue with the interview using the guide. Questions are paired with appropriate goals of the interview to ensure that the interviewer appropriately and thoroughly covers all goals.

Participants will be given adequate time to think about answers and respond appropriately, thoughtfully, and in full detail.

Goals

- Explore transgender and gender non-conforming (TGNC) young adult experiences in primary, mental, and reproductive health care.
- Investigate TGNC young adult attitudes towards health care providers and facilities in relation to themselves and within the TGNC population.
- Gain insight into the social inequalities TGNC young adults face while navigating the U.S. healthcare system.
- Gain insight into TGNC experiences of stigma and discomfort while communicating with healthcare providers.
- Gain insight into the bureaucratic and hierarchical challenges of accessing and maintaining health care.
- To identify specific practices and/or policies that promote high-quality care for TGNC young adults
- Investigate whether/how TGNC young adults disclose their gender identity to healthcare providers and facilities.
- Investigate challenges to discussing gender identity, expression, and terminology with healthcare providers.
- Explore how health care providers can improve the quality of care for TGNC individuals.

Thank you for agreeing to talk with me today. I'm Nik Lampe and here is my contact information. I am conducting in-depth interviews for my master's thesis project. In this interview, I'm interested in your experiences in utilizing and navigating health care. All of the information you give me will remain confidential – I will not ask you for your name or any information that could identify you. The interview is voluntary, and it will take 30 minutes to 2 hours. May I audio record our interview to ensure I have an accurate record of your responses? Would you like to start now?

Date: _____

I will begin with some general questions

a) How would you identify your gender?: _____

b) Pronouns (i.e. he/him, she/her, they/them, ze/zir, etc.): _____

c) Age (please state): _____

d) What sex were you assigned at birth?: _____

e) Race/Ethnicity (please state, as self-identified): _____

f) Education (please state the level completed): _____

g) Insurance status (employer-sponsored, federal or state-funded, uninsured, on parent's insurance): _____

h) Sexuality (interviewer note for our records): _____

i) When did you start to identify as transgender or gender non-conforming? _____

j) What does the term transgender mean to you? _____

The purpose of this research is to investigate the health care experiences of TGNC young adults. Specifically, this research will investigate the various ways transgender and gender non-conforming (TGNC) people experience barriers to obtaining health care, navigate the healthcare system and interact with health care providers. I would now like to ask you a few questions about your experiences.

Questions	Potential Probes
I just want to start by asking you to think about your prior experiences in health care settings - • Please describe some of your health care experiences with medical or primary care providers since you have identified as TGNC. • If any, please describe your mental healthcare experiences since you have identified as TGNC. • If any, please describe your reproductive healthcare experiences since you have identified as TGNC.	If so, what were they? Were you with anyone? Did your physician ask about your gender identity?
Have you ever talked about your gender identity with your doctor or a nurse?	If yes: What was the situation? – can you explain/recall -Do you talk about your gender identity with every new doctor or nurse that you see? -How did you know this was a safe person to tell? If no: Why?

Do you think it is helpful for your healthcare provider to know your gender identity? Why or why not? Do you let your doctor know about your gender identity? If you don't, what kinds of things make you feel like you should keep your gender identity hidden when you see a doctor for healthcare services? Have you faced any difficulties resulting from not sharing this information?	Why is it helpful for a physician to know your gender identity? -What stops you from sharing your gender identity?

Questions	Potential Probes
Have your feelings about obtaining health services changed as a young adult, compared to your feelings during early adolescence?	<u>If helpful</u>: to get better treatment, get different treatment, get counseling or preventive care that's important for me <u>If not helpful</u> -What makes you say so? -Are there any times when you think it would be important? -Is it easy or difficult for you to talk about your healthcare without revealing gender identity?
What kind of healthcare providers are you going to? How do you select a healthcare provider?	Do you consider their trans "friendliness" in your selection? Are there any clues you look for to let you know someone is trans "friendly?"
What kind of healthcare is important to you?	
Please describe any problems or concerns you ran into while seeking or utilizing healthcare services.	
How does the environment or vibe of a doctor's office, including the staff, waiting room, patient rooms, etc., impact your level of comfort when you see a doctor or nurse?	-Probe for types of biases - implicit/explicit, language, cisnormative behavior (need to ensure you provide examples, not this language – when analyzing the data, you may interpret responses using this technical language) -Do you have any specific examples of a time you felt comfortable/uncomfortable (based off of response) -What aspects of the doctor's office (or whatever specific setting within the office the respondent mentioned) gave you a good vibe/helped make you feel comfortable? -Were there any signs in the waiting room, such as pamphlets, posters, etc., that made you feel that this was or wasn't a safe space for you?
<u>If good vibe:</u> What can the doctor's office do to give you a good vibe or help make you feel more comfortable?	

If bad vibe: What can the doctor or their staff do to reduce this "bad vibe"?	

Questions	Potential Probes
Do you have any fears associated with being in a doctor's office? If yes, what are those fears? If no, what makes you feel safe and comfortable?	-How do any fears inhibit you from obtaining healthcare services? (e.g., making appointments, talking with doctors)
What qualities would your ideal healthcare provider have as a trans patient? Why are these qualities most important to you?	-Do you believe it is sufficient for physicians to focus on healthcare problems affecting trans people? -Is it important for you to be able to discuss your gender identity with your healthcare provider?
Have you spoken to a mental health provider or a counselor since you have identified as TGNC? If so, describe your experiences with your healthcare provider	
How does your healthcare needs affect your quality of life?	
What do you think would be most important to educate health care providers about transgender health and health care? Is there anything else you would like to add that I have not asked about, perhaps something I'm not asking but that I should be asking?	Listen for the need for more training, and then probe issues about which they would want their clinician to demonstrate comfort, knowledge, and skills, such as mental healthcare. Why do you believe a physician may lack these qualities?

I appreciate you taking the time to answer all of my questions. Is there anything else you would like to add that I have not asked about, perhaps something I'm not asking but that I should be asking?

Do you know any other young adults in Orlando or the Central Florida area who might be willing to participate in this research study? (procure name and contact information)

Please don't hesitate to contact me if there's anything else that you would like to add that you have not had a chance to say during this interview. Here's my contact information: [interviewer's email address].

APPENDIX C: IRB APPROVAL

UNIVERSITY OF CENTRAL FLORIDA

Institutional Review Board
FWA00000351
IRB00001138, IRB00012110
Office of Research
12201 Research Parkway
Orlando, FL 32826-3246

NOT HUMAN RESEARCH DETERMINATION

May 22, 2023

Dear Emma Tukdarian:

On 5/22/2023, the IRB reviewed the following protocol:

Type of Review:	Initial Study
Title of Study:	PREVALENCE OF HYPERVIGILANCE IN EVERYDAY QUEER LIVES
Investigator:	Emma Tukdarian
IRB ID:	STUDY00005569
Funding:	None
Documents Reviewed:	• HRP-251 SKC, Category: Faculty Research Approval; • HRP-250 Form UPDATE, Category: IRB Protocol; • Variables List, Category: Interview / Focus Questions;

The IRB determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations.

IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are research involving human in which the organization is engaged, please submit a new request to the IRB for a determination. You can create a modification by clicking **Create Modification / CR** within the study.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu. Please include your project title and IRB number in all correspondence with this office.

Sincerely,

Kamille C. Birkbeck

Kamille Birkbeck
UCF IRB

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