

# Don't look back in anger: Possibilities and Problems of Trans Equalities

**Kath Browne**  
**Leela Bakshi**

---

*Questioning the 'new age of austerity' relies on an (implicit) understanding of a previous era where something other than 'cuts' were occurring. During the early part of the 21st century in the United Kingdom, not only did lesbians and gay men gain significant rights including equalities in the provision of goods and services, civil partnerships and so on, by the end of the New Labour era in 2010, 'transsexual' had become a legally 'protected characteristic' under the Equalities Act.<sup>1</sup> Yet these new legislative gains were not uniformly experienced, practiced and deployed. This paper explores the ways in which initiatives played out 'on the ground', engaging with the possibilities, as well as the problems, of new equalities landscapes. Using the Count Me In Too research (see [www.countmeintoo.co.uk](http://www.countmeintoo.co.uk)), we examine progress in trans 'rights', whilst simultaneously identifying the ongoing harm trans people experienced through gaining these 'rights'. More specifically, we critically appraise 'treatment' pathways and public funding, arguing that whilst these are positive and welcomed, they are also flawed in their implementation, as well as their conceptual basis. Continuing from this, we contend that critical academics/academics need a spatially informed consideration of 'new normativities', while being wary of forgetting the positives while they are happening, and romanticising them when they are in the past.*

*Keywords: Cuts, Austerity, GP, Doctors, Health Services, Transgender/ Transsexual, Transition, Spatial, Homonormativity*

---

## **'All the things that you have seen will slowly fade away'?<sup>2</sup>: Introduction**

There can be little doubt that the political, social and cultural climate in the UK is undergoing significant change. Questioning this 'new age of austerity', relies on an (implicit) understanding of a previous era where something other than 'cuts' were occurring. Thus, challenging

the 'new era' requires an interrogation of the supposed 'golden era' that preceded it. This 'golden era' is examined here in terms of the massive legislative, and arguably, social shifts in the arena of gender and sexual identities. The early 21st century witnessed extra-ordinary legislative developments that altered the landscapes of many who were once 'sexual/gender deviants'. We saw in the UK, for example:

- The right to have gender surgery on the National Health Service;
- The development of legislation that enabled (some) trans people (under certain restrictions) to change their legal gender, birth certificate and so on, potentially questioning the fixity of born sex and the assumptions of bodily adherence to gender/sexual norms;
- -This culminated in the groundbreaking equalities Act of 2010, which contrasted starkly with discourses of the 'looney left' and 'section 28' in the 1980/90s.

However, throughout the first decade of the 21st century, legislative changes, particularly with regards to sexualities, were fraught with difficulties, exclusions, and 'new marginalisations'. Specifically, there are extensive discussions of 'new homonormativities', where some who were once sexual/gender dissidents have been celebrated and validated, creating new normativities, while others have been marginalised, othered and excluded (see, for example, Bryant, 2008; Duggan, 2003; Vidal-Ortiz, 2008). Classed, gendered and racial exclusions have been shown through intersectional analyses to (re)create new 'homonormativities' that value particular forms of gay (sic) identities, bodies and practices (e.g. Hines, 2007b; Miyake and Kuntsman, 2008; Taylor,

2007; 2009). These agendas are, of course, important, and indeed we will follow some of these critical engagements. However, alongside this, we call for recognition of what was made possible in particular places through eras of legislative acceptance, (forced?) dialogue/consultation, and considerations of lesbian, gay, bisexual and trans rights (that were undoubtedly contained with particular neo-liberal contexts). Currently the requirements of the Equalities Act are being questioned, and the 'teeth' of the Act are being eroded through the discarding of targets, reporting mechanisms and other forms of transparency and accountability, along with massive public sector cuts, and moves to 'restructure health services', under the guise of 'removing red tape' (The Red Tape Challenge, no date). In this context there is a pressing need to critically engage with what has come before. There is a danger that what we have questioningly termed the 'golden era of equalities' (and investment) may be (implicitly) glorified, without critically exploring continuing needs in these areas, as well as the learning created during this time in a place where there was hope that things might 'get better'.

Attention to the spatial specificities of everyday life is pressing, because the ways in which legislation, cuts and other state interventions are enacted will create uneven topographies that need consideration and critical attention, both spatially

and temporally. Taking account of political/economic time-spaces enables us to examine how political change/regime change plays a part in constituting (although not determining) everyday lives. This takes us to the realms of social policy, an arena which cannot be ignored when considering the legislative change and its effects, and yet could be augmented through an examination of the spatial topographies afforded by geographies. Within social policy, discussions have raged about the 'success' and failure of the New Labour era, particularly in terms of welfare reform. Here, we are interested in the 'social questions', in which, arguably, New Labour helped to educate the Conservatives (see Heffernan, 2011).<sup>3</sup> In terms of the focus of this paper, in the early part of the decade, Munro argued that, 'New Labour allows considerably more space for the development of transgender politics than previous administrations because it emphasises the inclusion of marginalised communities' (2003: 441). Critically exploring this era through trans people's experiences 'on the ground', we argue that national and temporal legislative contexts cannot be ignored in examinations of social/sexual lives. Moreover, such accounting needs to attend to, not only the continuities of overarching metanarratives (such as neo-liberalism), but also to the positive, if flawed, social effects of national recognition and investment (see also Weeks, 2007).

Thus, this paper examines 'what went right', alongside critical investigations of what trans people wanted 'to be better'. It seeks to inform considerations of the 'new era', through examining the 'progress' made and the work that remained to be done after the 'old' one.

Rather than seeking overarching narratives around this question, we are interested in the specifics of one supposedly liberal, open and pleasurable place; Brighton, situated on the South Coast of England, sold as the 'gay capital of the UK'. Focusing on Brighton enables an examination of what went right and what could be done better, in part because there was a will during the first part of the decade to question what was good and what was not, to produce evidence and to address gaps through 'dialogue' between statutory bodies and Lesbian, Gay, Bisexual and Trans 'communities'. In Brighton, one mechanism through which evidence was collected and dialogues were undertaken, was through Count Me In Too (CMIT), a research project where LGBT people worked with service providers and others to develop evidence and promote positive social change for LGBT people (see [www.countmeintoo.co.uk](http://www.countmeintoo.co.uk)). As these dialogues now close down and the political, social and economic 'climate' moves away from evidence based practice, there is a danger in valuing only the positive aspects of an era of investment and support, and neglecting what still

needed to be improved, particularly as the gains made are under threat.

The data created by, and about, trans people from the Count Me In Too (CMIT) research enables us to point to the importance of the gains made during the early 21st century, yet refuses a romanticisation of the 'golden era of equalities'.<sup>4</sup> Following an exploration of trans identities and their complexities, this paper will examine the publicly funded 'treatment' pathways for 'transition', finishing with an investigation of health care and GP's. In this way, we clearly illustrate the positive aspects of trans 'rights', whilst simultaneously identifying the ongoing harm and everyday abuse experienced by trans people in the first decade of the 21st Century. We use this discussion to argue for both attending to the successes, or what we might want to keep of social change, as well as addressing that which we might want to improve and/or radically reformulate. The paper's title articulates that anger about contemporary and previous eras should not eclipse what could be learned from what went before.

### **Complexities and Fluidities of 'Trans' Identities**

Trans identities and lives have been the subject of much gender theorizing and contestation. Most famously (and controversially), perhaps, Judith Butler's (1990, 1993) work on gender performativities used transvestites/drag queens to

illustrate the ways in which gender/sex is fluid, and gendered performances are not delimited to particular sexed bodies. In other writing, the 'transgressiveness' of gender expressions has been seen to call into question the naturalness of gender/sex social norms, and illustrate that gender is 'more complex and varied than can be accounted for by the currently dominant binary sex/gender ideology of Eurocentric modernity' (Stryker, 2006: 3). Theoretical work, such as Butler's, has been actively contested by some trans theorists who argue that certain gender theorists use trans people but do not speak to them, and thus negate the ways that trans people live and experience their gendered lives (see for example Namaste, 2000; Noble, 2006; Prosser, 1998). Perhaps questioning this division, Roen (2001) argues that the binaries between radical politics of gender transgression (the deconstruction of gender binaries) and liberal transsexual politics (seeking rights based on being a man/woman) are complexly interrelated and negotiated by trans people.

We follow what might be termed a 'liberal politics', focusing on legal protections, and the provision of services for trans people. In part this is because this terminology was wanted by the trans people in this participatory project who worked to create the research, in order to progress positive social change in Brighton. Thus these accounts

are different from queer examinations of subjectivities, which, whilst important, should not be the only ways in which LGBT lives are examined (see Brown et al., 2011).<sup>5</sup> Furthermore, a focus on Brighton recognises the specificities of trans/LGBT political actions and the spatial deployment of gender terms and labels. Understanding these labels and identifications as spatially based and hybridised forms of global-national-local interconnections enables multiple political engagements with everyday lives that speak, but are not beholden, to North American based academic thinking.

Using the Count Me In Too research, we have shown elsewhere that identification within the category 'trans' in this research was complex and fractured (see Browne and Lim, 2010; Lim and Browne, 2009). We have noted how the range of trans identities calls into question the category itself (see also Munro, 2003; Johnson, 2007; Stryker, 2006; Valentine, 2007). Yet, we argue that this category is useful and important both in terms of recognition for trans people and also as a basis to make claims for services and provision (see Browne and Lim, 2010; Lim and Browne, 2009, West, 2004). Thus, recognising the internal heterogeneity of the category of trans (as with all gender and sexual identities including heterosexuality) might not encompass all who may be recognised through it; it is ac-

tively resisted by some, and is fluid and unstable (see Namaste, 2000; Johnson, 2007; Stryker, 2006; Valentine, 2007). We use it here and in our research because it enables a voice both within and outside of the broader category Lesbian, Gay, Bisexual and Trans.<sup>6</sup> Thus, following Halberstam (1998), we mobilise this category for political purposes, whilst recognising the heterogeneity of how people defined themselves as 'trans' (see also Munro, 2005).

There can be little doubt that given the complexities of trans identifications, quantitatively categorising 'trans'/gender identities is also problematic.<sup>7</sup> The question in the Count Me In Too survey read: 'Do you identify yourself as being trans or have you ever questioned your gender identity?' 5% of the sample identified as trans (n. 43, with 92% n. 739 saying no and 3% n. 23 unsure).<sup>8</sup> Despite the complexities of defining trans identities, such quantitative categories can be useful for attending to key differences between those who identify with/are willing to tick the trans box and those who are not. Throughout the paper we will explore these differences to highlight key areas of need. In order to discuss the differences identified in the data we used the flawed, yet necessary, terms 'trans people', 'trans respondents' and, in contrast, cisgendered or non-trans respondents.

In spite of the complex ways in which trans people understand

themselves and negotiate liberal/deconstructionist (identity) politics and the multiplicities of trans identifications, categories may recognise you, even if you do not recognise the category. Such (mis)recognitions play a role in the reconstitution of identities, genders and lives (see Butler, 2007; Browne, 2005). This is not always negative, although it can reify particular characteristics. For example, identities are stabilised and congeal around specific attributes in legal landscapes, in order to be recognised as a 'protected characteristic' for equalities purposes, (see Herman, Didi-CN 1994; Nash, 2006). The category of those who are encompassed and thus 'protected' under the 'protected characteristics' of the 2010 UK Equalities legislation is 'transsexual', and defined:

A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.<sup>9</sup>

The focus on 'reassignment' is important as a key aspect of provision that trans people nationally have lobbied for. However, 'change' is loosely defined as not only physiology but any 'attribute of sex'. Where sex is understood in part through gender roles, this Act could cover a multitude of gender/

sex positionings. However, as we move to discuss the provision of health services, this and other legal moves retain a binary of male/female and often (but not always) presume a permanent movement between these ('reassignment') to define trans, access services and receive 'treatment'. The limitations of these medical contexts are clear when examining how they are experienced by trans people.

### **Public Funding and Experiences of Transition**

The right to have gender reassignment surgery using public funding has existed from 1999 in the UK. This followed legal battles fought in 1998 that resulted in health authorities being unable to bar funding for 'recognized, treatable medical disorders' (Green, 2010: 158). Since this time, it is reported that over 850 operations have taken place on the National Health Service. Currently the funding of these surgeries, hormones and other health services is far from secure and these are far from uncontroversial. They have recently been challenged by right wing newspapers because 'sex-change operations are a waste of valuable NHS resources when people are dying and suffering because of healthcare rationing. Opponents also cannot understand why people need a sex change for what they interpret as a psychological malaise' (Condron, 2009). There has also been opposition to those sur-

geons who undertake these interventions and a lack of respect within the medical profession afforded to them and the procedures they have developed and use (Combs et al, 2008). 'Press for Change', a trans advocacy group, argues that there is a 'postcode lottery' in the access to surgery and other health services for trans people, such that these may not be considered 'essential' in particular areas and can thus be indefinitely postponed or denied (see Cowen, 2009).<sup>10</sup> Therefore, spatial differentiations were created through, and in turn recreated, an earlier backdrop of (uneven) investment and legal requirements, which devised 'treatment pathways' for transition. These pathways emphasise a medicalised and psychiatric (as a 'psychological malaise') route to deal with what is termed 'gender dysphoria'. Elsewhere, we have considered the implications of defining trans as a 'mental health' problem and pathologising people using these interventions. We found that the system itself causes harm to trans individuals, who seek 'help' (see Browne and Lim, 2010; Lim and Browne, 2009; West, 2004). Thus, whilst the need for the existence of publicly funded trans health care should not need to be debated, the ways 'treatment pathways' are implemented may not be desired/desirable. In this section, we develop this discussion, focusing on private/public health care and pointing to ongoing needs that should not be

forgotten in an era of austerity and potential retrenchment.

Table 1 illustrates that 48% (n. 20) of trans people say that a question regarding the quality of care delivered by NHS gender identity clinic is 'not applicable', indicating a use of private services and/or a disengagement from health services. Although 18% (n. 4) people said their experiences were good/very good, over 68% (n. 15) of trans people who have used NHS gender identity clinics say that the quality of care they received was poor or very poor. A distinction was made between publicly and privately funded care for trans people, which pertained to 'hoops' that needed to be 'jumped through' in the publicly funded care, that did not exist in the private sector (West, 2004). Such 'hoops' encourage the privatisation of care where it can be afforded, and illustrate variation of experiences based on economic capital. The desire for a better service for all was clear in the data:

Provision for better and local treatment via the NHS so we don't have to travel up to Charing Cross in London. Treatment there is appalling anyway. I was referred there after a consult at a Brighton hospital, and after the first appointment was motivated to go private as it was so crap (Questionnaire 142)

West (2004) found that trans people sought private treatment,

because of its speed and care, and because of the lasting detrimental effects of using NHS services. Trans people can move into and out of NHS 'care' pathways depending on their experiences with the NHS and their ability to pay for the services they seek. Although the 'result is the same', there are significant differences in the experiences trans people have between publicly funded and private health care (see West, 2004). In particular, these pertained to the time delays and 'the manner in which they were treated' (West, 2004: 9). The classed basis of gender transition is clear, affecting not only the speed of treatment but also the experiences of transition (see also Cowen, 2009; Hines, 2010; Roen, 2002):

Sally: Trans issues are generally associated with class, that you can't differentiate. That when people are middle class the issues are few. When people are, well not exactly working class, but on the lower social spectrum, that's when the trouble begins. Somebody that I know is a barrister. She's a real cool barrister in London, savage intelligence. She just negotiated the transition like she would a legal case. Done. Let's get on with work.

If you've got money, you're okay [laughs]. If you haven't got money, you can be in trouble.

(Individual Interview)

#### TABLE 1

In contrast to the US, where only

'economically empowered' people can receive surgery (Nataf, 1996; Green 2010), in the UK there is a more complex spatialisation of access. As Charing Cross is the sole NHS provider in the South of England, trans people in Brighton are restricted to using its services or else seeking private care. More than the 'postcode lottery', Count Me In Too found a complex spatiality, whereby the empowerment some people felt in Brighton through 'having a say' was eroded by the necessity of travel to London in order to access services (Browne and Lim, 2010). Thus, even though Brighton has not cut funding for trans people to engage in treatment pathways, Charing Cross is seen to have damaging effects on trans people, and there is also perceived lack of consistency between the treatment and advice offered by its different departments and professionals (see also West, 2004). Experiences of these services then, go beyond considerations of access and funding:

Joanne: For your entire course of treatment to be monitored by psychiatrists when I had my first psychiatric assessment with a well-known professor, he was absolutely insulting and 'do really think you're a woman? You're a 55, you're a 50 year old man you're not a woman' and it was that sort of attitude coming throughout. There are people who have broken down in tears at that first interview because it's been so hostile



and then, it's all throughout that. If you turn up to an assessment not wearing a skirt, you're wearing trousers, what are you wearing trousers for? The skirt was supplying their stereotype. You can point out that most women, I mean how many women here are actually wearing a skirt as opposed to trousers? [LAUGHTER & GENERAL NOISE] They expect us to follow the stereotype so it is absolutely humiliating and demeaning sometimes. (Speakers Corner, April 2009)

Johnson (2007: 67) notes that 'gender is more than anatomical difference' and trans people are 'engaged in the problematic task of becoming a different gendered being', a process that cannot be achieved 'only through the realignment of the physical body'. Joanne notes the ways that gender roles are judged as (un)fit by medical 'professionals' through bodily adornment (in this case dress). Not only does this reiterate simplistic dichotomies of sex/gender and associated gender roles, reiterating the ways gender 'should' be performed and enacted within particular (exaggerated) social norms, it also negates the import of accepting and playing with 'inconsistencies of our self-narratives' (Johnson 2007: 68). Moreover, it demands a performance of gender, which other women are not asked to do, and indeed the audience that Joanne addresses during this

speakers corner failed to perform. Although some may have had good/very good experiences, most trans people in this research said that they perceived Charing Cross as unhelpful, damaging and not actually dealing with 'the problem' (see Browne and Lim, 2010). The view at Charing Cross that 'transsexualism was a psychological disorder..., for which the most successful treatment was often hormonal or surgical therapy' (Whittle and Lewis, 2007: 3.13), has remained unchanged for over 40 years.

Kate: One of the really key factors that needs to be dealt with as to what needs to be changed is how the equivalent of the gender clinics, whether it be at Charing Cross or wherever else it is, in how they deal with our medical condition and not treating it as a psychiatric illness and not being this kind of gender dysphoria, but actually treating it as the condition that it is, because to me gender dysphoria is something wrong with the person's mind as to how they perceive them to be, rather than actually have them accepting the possibility that it could be an actual physical condition rather than a mental condition and how they and kind of in the service that they provide us at the gender clinic and they way they provide it. (Trans focus group 1)

The conflation of trans identities with mental health 'illness' by

medical professionals was a common complaint in *Count Me In Too*. Participants argued that their mental health difficulties were not necessarily related to their trans identities and that trans identities were not mental health difficulties (see also Browne and Lim, 2010; Johnson, 2007). The system itself was understood as damaging to mental health because of the way in which health service providers conflate trans issues with mental health issues. The *Count Me In Too* research showed that mental wellbeing was adversely affected for many who used NHS services in order to receive 'treatment':

Sally: How many people that break their legs go and have private treatment? Why would people go and have private treatment? Curious huh? So that means that's a measure of extreme dissatisfaction. Give us a break. It was a £1,000 or something for a blood test that costs £35. There's huge profit making in on this. It's one of the main cash cows for the West London Mental Health Trust. So they don't want to let go of that or their monopoly on treatment. This is the complications of what's going on behind all of this.  
(Individual Interview)

Just after the creation of the public duty to 'treat' trans people, Munro (2003) argued that private treatment for gender reassignment put pressure on the NHS to improve services

in less stereotypical gendered, and 'more user-centered', ways. In contrast to this, Sally describes a (profitable) monopoly in the provision of publicly funded treatment pathways and dissatisfaction with the public health services. The possibility of change, whilst welcomed, was seen as limited. However Sally and other trans activists in Brighton nonetheless worked to 'wedge a little crack here in Brighton'. Yet, because Charing Cross is located outside of Brighton, it is also beyond trans activists reach, contrasting with the influence they felt they had in Brighton (see Browne and Lim, 2010). There were calls for a specialist local gender reassignment service, in order to improve the experiences of trans people (see also West, 2004). Key to this was the desire to see change in how trans people are treated, and a meaningful engagement with trans issues and the complexities of gendered lives, discriminations and vulnerabilities:

Brighton is quite obviously an open city in which many LGBT move to just to feel accepted, so why should we have to travel anywhere else (London) for treatment? (Questionnaire 284)

The calls for a local Gender Identity Clinic were based on the inclusion and empowerment that some trans people felt in Brighton, as well as the 'obviousness' of geographical imaginings of 'gay Brighton' that facilitates particular claims to

service provision (see Browne and Bakshi, forthcoming, Browne and Lim, 2010). Thus, Kate's argument (above) that 'wherever else it is', relates to the desire for trans people to be treated better, regardless of location. Nevertheless, due to the geographical imaginings of this city, trans activists argued that Brighton should be leading the way in these initiatives. These claims were set in a context where there was a legal imperative to consult with marginalised and minority groupings, (see Munro, 2003), and where activists groups in Brighton were working with service providers to inform their practice.<sup>11</sup> This led to targets that addressed key areas raised through research such as Count Me In Too and other forms of legally obliged consultation. In our reading, many services had an 'open door' and a (limited) amount of willingness and money to undertake meaningful engagements with trans people and work to deal with pressing health and other social issues. Thus, the rhetoric was being actioned through meetings with trans people. Although some change had occurred locally, by 2010 there was still much to be done, and not only in the area of gender transition 'treatments'.

### **Health Care beyond Transition**

The dissonance between legislative support, compared to the experiences of trans people who received this 'care' in Brighton, meant that

rights-based claims were made, not only for transition, but also pertaining to ongoing health provision:

Local trans services - not just limited to achieving transition - e.g. ongoing counseling and support groups and social groups (Questionnaire 651)

Ongoing care for trans people relates to physical and mental health care. In the Count Me In Too research there were significant differences in terms of the general health of trans and non-trans people. Trans respondents were significantly more likely to consider themselves as having poor or very poor physical health (30%, n. 13) than those who are not trans (8%, n. 64). 77% (n. 581) of non-trans respondents say they have either good or very good physical health, compared to less than half (44%, n. 19) of those who identify as trans ( $p < .0005$ ). Kate suggests that her trans embodiment is rarely accounted for, even where it may be relevant:

Kate: I've got a whole part of mind stream which is not heterosexual, part of it that's bisexual, but there's a bit of it that's trans. So unless the health providers understand that and they understand the issues around that, it's very hard for them to diagnose what the hell's wrong with me. Do they take into account in their diagnosis the fact that I'm trans-gendered and that fits other parts of my health system. They don't take that into ac-

count and even when I tell them it's important they still don't take it into account.

(Trans focus group 1)

Kate and other trans participants, however, did not reduce their physical and mental health difficulties to their trans status. Experiences of the health care system were often problematic, not because of issues related to transition, but rather because of the ways in which trans people were treated across the health service:

Sally: [I had a friend] who went to have a back operation in Haywards Heath, you know, that hospital in Haywards Heath, and the surgeon demanded to see on a genital check. This is so abusive and so has a little peek and says 'looks fine to me'. Oh that's okay! When there was a 'why', 'it's because of catheters, if we need to

use a catheter'. Which is a load of bullshit. They just felt nervous and had no idea that they should behave within certain boundaries. And my friend wasn't that sure of herself and so complied. I'd just tell them to piss off, 'bring me your superior now' [laughs]. But that's because I am who I am you see. I think there's quite a lot of trans people have had their sort of self-confidences been broken by the process.

15 years after surgery [another friend] had a prolapse, vaginal prolapse, and so needed medical attention. Went to her GP, not a good one, and the GP said 'transsexual, oh I don't know'. So she gets referred to a local psychiatrist. 'Oh yes I think you're transsexual, you can go to Charing Cross.' Gets sent to Charing Cross at £900 an hour.

I said 'what did they ask you?'

**Table 1: Overall, how do you rate the quality of care delivered by your NHS Gender Identity Clinic?**

	Frequency	Percent	Valid %	% without those who said N/A
<b>Very good</b>	2	4.7	4.8	9
<b>Good</b>	2	4.7	4.8	9
<b>Neither good nor poor</b>	3	7.0	7.1	13.6
<b>Poor</b>	5	11.6	11.9	22.7
<b>Very Poor</b>	10	23.3	23.8	45.4
<b>Not Applicable</b>	20	46.5	47.6	
<b>Total</b>	42	97.7	100	
<b>Missing</b>	1	2.3		

She said 'when did you first think you might be transsexual?'. She said '15 years post-op and they're asking me that'. So, in other words, the suggestion would be that she might be found to be not transsexual, therefore couldn't get treatment. Then months, and months, and months, and months go by and then the surgeon treats her. But he's the surgeon that works up the road in Brighton. He works at the hospital up in Brighton. She could have just nipped up the road and got it fixed. So this cost thousands of pounds and she was mightily abused by this process. It still goes on and people aren't that willing to look at these issues. They don't like them. They feel uncomfortable with it and don't want to do it.

(Individual Interview)

It's not uncommon for trans people to lose their jobs and incomes during and after transition. Where trans people could afford private healthcare in the past, they often lose this privilege (Whittle et al., 2007). Thus, even where transition may not have been traumatic, ongoing healthcare can be 'mightily' abusive and the option to 'buy better' is no longer available. Sally describes numerous examples of medical professionals feeling 'nervous', 'uncomfortable' with 'no idea that they should behave within certain boundaries', 'breaking' trans people in the process. As she also illustrates with

her last example, 'checks' are put in place for trans people that have no medical basis, but rely on understandings of discordant bodies, and can be unnecessarily costly. Such health experiences are also spatialised, and this spatiality of 'being sent' outside of Brighton (even when it is unnecessary) adds to the trauma of health 'care'.

Perhaps surprisingly, given the experiences recounted in this paper, almost the entire trans sample (88%, n. 37) have disclosed their sexuality and/or gender identity to their General Practitioners (Family Doctors), a significantly greater proportion than the rest of the sample (58%, n. 440) ( $p = .0005$ ). Table 2 shows that the majority (62%) of trans people think that their current GP is good or very good, with 16% saying that their GP is poor or very poor. 7% said that the question was 'not applicable' suggesting a disengagement from these services. GPs can act as a very important initial point of contact for trans people seeking to transition or in need of support regarding their trans identities. They can be invaluable in supporting trans people in accessing appropriate services. Trans respondents noted that they often have to come out to their GPs, in part because, as Kate says this 'fits with other parts of my health system'. The 'choice' to remain 'closeted' is not possible, as it is for some gay men (who were the least likely to be out to their GP's, see Browne and

**Table 2: Overall, how do you rate the quality of care delivered by your GP?**

	Frequency	Percent	Valid Percent
Very good	11	25.0	25.6
Good	16	36.4	37.2
Neither good nor poor	6	13.6	14.0
Poor	3	6.8	7.0
Very poor	4	9.1	9.3
Not applicable	3	6.8	7.0
<b>Total</b>	<b>43</b>	<b>97.7</b>	<b>100</b>
Missing	1	2.3	
<b>Total</b>	<b>44</b>	<b>100</b>	

Lim, 2008- General health)

Because of the imperative to come out, and the health needs of trans bodies, 'finding a good GP' was crucial in all of the stories told by trans people in the Count Me In Too research. Thus, the positive rating of GP services must be read in context of the journey to find a GP that trans people undertake. This journey was often described in terms of 'lucky' moments, as well as careful planning and the importance of social and support networks:

Heidi: I was very fortunate in that I got pointed to probably one of the best GPs in Brighton in terms of knowledge-ability on trans health issues so I pretty much fell on my feet there. But prior to moving to Brighton, my GP was very helpful and when I came out to her. It wasn't a negative, you know, it wasn't kind of "I can't deal with this patient any more". So I was fortunate there that in how smoothly

that went really. They were definitely, to me, LGBT friendly. Coming back to the present now – the NHS obvious always had me as male since birth really. But my current practice [they] put me down in their files as being female and so all the stuff they send out to me ensured that the title was appropriate and also asked me what did I want to be referred to as Miss, Ms, etc. which I think is kind of very taking into [account] sort of trans issues more. They had to kind of swiftly get things changed on my NHS card, which I was slightly surprised about but they were able to kind of help get things amended without you having to kind of write up loads and loads of letters or give any weird explanation there to help you through that.

(Trans focus group 1)

For Heidi, a reaction that 'wasn't negative' was considered 'LGBT

friendly' and 'fortunate'. Her positive experiences were both pleasing and surprising, as she expected to have to give a 'weird explanation'. In many ways this can be seen as an example of good practice. Yet, consistency of GP care for trans people was lacking, and finding 'safe' GPs is a key issue:

Sally: I was talking to people yesterday about this, that their GPs can't handle the trans thing. The training and understanding of trans issues is very low. In Brighton and Hove you have to go to the right GP. If you go to the wrong one, you're in trouble.

You go to the right one. I get excellent treatment. I get treated very, very well. I mean the only issues, medical issues I have to being trans are because I take hormones. I mean I take hormones and every year I go to see an endocrinologist. I get treated very well. And if I had issues going on? Not a problem, because I'm at the right GP. But also everybody knows who their GPs are and they go to them, so now she's stopped taking them because she just can't handle anymore.

(Individual Interview)

In *Count Me In Too* it was clear that information about health care was being passed through social groups and support networks in order to enable trans people to access non-discriminatory services that would adequately care

for their needs. 'Excellent' service was something that was sought, and found by some. However 'if you go to the wrong one, you are in trouble'. Once again the illusion of choice for trans people came to the fore. For many trans people, past experiences with their GPs can be alienating, with health professionals being unaware of how to deal with trans issues and acting in inappropriate ways. The choice of a trans friendly GP may not be an option for everyone, and even where GP's are friendly, other health professionals may not be. Moreover, the journey to find a friendly and safe GP is rarely an easy one:

Kate: [There] was a GP in this case, who I assume was a quite strong Roman Catholic who told me 'why couldn't I just be an ordinary gay man instead of wanting to be trans-gendered?' as if I had a choice about it. Another one who had to examine my legs and proceeded to cover my body with the white bit that we normally lie on because she couldn't actually look at my genital areas which, you know, my penis hadn't been removed at that stage, and then proceeded to tell me that I was a sinner, etc. Since I've been in Brighton most of the people I've related to either at the front desk or the GPs have actually been relaxed about me being trans-gendered on the service. My major concern is access. When I go to GP surgery I had absolutely no

choice at all of whether I can investigate, is this GP friendly to me or are they not friendly. It's rather like playing Russian Roulette and we've already explained, twice I got shot in the head and maybe an equal amount of times I got lucky. I was fortunate in that I could afford to pay for my transition privately, if I hadn't and I had to stay with one of my negative experiences then I think it would have been incredibly painful and very stressful and maybe damaging to my transition.

(Trans focus group 1)

Although Kate has been 'lucky' she is aware of the risks she takes by accessing services and points to the damage 'one of my negative experiences' could have inflicted if she couldn't afford to transition privately. When Kate says that 'it's rather like playing Russian Roulette', the impact of not identifying trans-friendly GPs becomes clear. Choosing an inappropriate and ill-informed GP can, for some trans people, be life threatening. In Count Me In Too, we found that trans people are more likely to experience mental health difficulties, suicidal distress and to have attempted suicide (see Browne and Lim, 2008).

These narratives paint a very particular picture of the 'inclusive' health services that were purported to exist in the legislative contexts of the first decade of the 21st Century. Whilst there can be little doubt of

the importance of access to transition pathways, the ways in which these are felt, experienced and enacted, reproduce particular gendered norms (within specific understandings of male/female boundaries) and remake normative gender orders in health and other everyday spaces. In Brighton, these demands were being addressed through a multi-agency trans strategy, lead by the Primary Care Trust (the local commissioning body of the NHS) and in 2008 discussions were underway regarding local provision for trans people. The Count Me In Too trans analysis group argued that training was a key issue in addressing negative experiences with GP's (see Browne and Lim, 2008- trans, Browne and Lim, 2008- health). As Sally (above) notes, this 'training and understanding of trans issues' is poor amongst GP's, leading to harmful experiences. However, during the course of the first decade of the 21st century, GP's were on independent contracts. This meant that any mandatory training/information/requirement was not locally possible/enforceable as part of GP contracts, and would have to be nationally instigated. Nonetheless, in Brighton there was training undertaken, and front line staff (such as receptionists) equipped as well as key people within the Primary Care Trusts who commissioned services, including Charing Cross. There were also discussions of changes to the NHS Direct telephone line to



make the questions more appropriate and clinically relevant for trans people. Following contemporary political changes, the time and energy spent undertaking LGBT training, and the upskilling key people in health services in trans and other LGBT issues, as well as the possibilities of local treatment, have been lost. Activists may see no benefit from much of the time and effort they put into individuals and committees (that have now disappeared, moved roles or been made redundant) to make the health service more trans friendly and catering better for trans people. Indeed the shifting ground has meant that many of the possibilities of even having these discussions have closed down; dispersed in ways that mean activist resources cannot access them. The skills, knowledge and spaces for dialogue that were so painfully fought for, and in, are now threatened. Given this data and our experiences of trying to inform GP's of trans people's needs and the changes that need to be instigated in their practices, the discussion of GP consortiums are then perhaps the most nerve-wracking of the proposed government reforms.

**'Today is gonna be the day when we're gonna throw it back to you  
By now, you should have somehow realised what you got to do'<sup>12</sup>: Conclusion**

We wrote this paper with the aim of inspiring critical reflection on the 'golden era of equalities work'.

There can be little doubt that the sexual and gendered legislative landscape of the UK changed irrecoverably during the first decade of the 21st century. Whether the UK Conservatives' 'social education' will 'stick', has yet to be seen (Heffernan, 2011). Nonetheless, critical exploration of the changes of the first decade of the 21st Century for trans people, reveals that they are positive and welcomed, yet flawed in their implementation, as well as their conceptual basis. Whilst, there can be little doubt that those who want to be legally recognised as male/female should have this right, there is still a need to challenge this binary, seeking gender liberation beyond man/woman. Similarly, publicly funded trans health care should not need to be debated, and whilst the provision of publicly funded health services to trans people, including surgical options, is a positive development, its implementation requires significant reworking. What 'trans health care' means and how/whether the current 'treatment pathway' fulfills those needs should be open to question and change. This needs not only take into account data such as Count Me In Too, generated with the cooperation of trans communities, but also should arise from the empowerment of trans people in local, regional as well as national arenas.

The increasingly vocal politics of resentment are gaining further traction in the UK, with discourses

including; 'minorities' getting 'more than their fair share'; 'waste'; and the 'inappropriate' use of dwindling public funding. Contesting these discourses is an ongoing battle that we believe must be fought, while simultaneously considering how to improve the opportunities that we seek to defend, so that they are more 'fit for purpose' and perhaps 'less wasteful' of people's lives and energies, as well as public monies. The questions that we believe now faced by activists and academics are; should UK trans/LGBT politics be focused on not 'losing ground', rather than seeking to improve current provisions?; what are the possibilities for progressive considerations of gender in this new era? We hope for answers that are multiple, spatially sensitive and empowering for those directly affected by the outcomes.

So have we 'realised what you got to do?' For academics, it is much easier to 'find' and look for the critical, and it is important to point to what continues to be wrong in the hierarchised, power-laden experiences of trans people. Acting as a kill-joy (Ahmed, 2010) is important when it is productive; making space for difference, allowing for other ways of doing, knowing and working. Understanding social difference in shifting and geographical diverse legislative contexts, however, questions overarching critical narratives that lead to hopelessness (see Gibson-Graham, 2006; Sedgwick,

2003). It is necessary to make/allow space to reflect and comment on what is 'going/went well', even when what we see as socially progressive might be shifting and spatially specific, only partially known and nameable. This becomes even more apparent when perceived gains are 'taken away' or threatened, removed and retracted. In the UK context in 2011, we note the threat to the public funding for transition, when, it is argued, 'people are dying' [of course Trans people do not figure in this rhetoric], along with the devaluing of the equalities agendas (enacted in part through the removal of targets, accountability as well as commissioning bodies such as PCTs). Without doubt, that which is being threatened was flawed, inadequate and imperfect, yet many invested in and valued it.

Certain perspectives are often overlooked, including investment and work 'within' the state to change LGBT lives, possibilities and hopes of inclusion, and achievement of positive social change in places such as Brighton. Explicating neo-liberalism, critiquing capitalisms which create class and racial normativities, and pointing to the problems of identity categories and the rights claims and politics built on these, renders intellectually stimulating engagement with some of the literature. However this may neglect recent geographical writing that has questioned the monolithic readings of homonormative subjects (see for example,

Brown, 2009; Elder, 2002; Oswin, 2005, 2008). The events unfolding around us also need further nuanced engagements - engagements that refuse monolithic discourses, and reject the aspatial imposition of gender, sexual, class, raced normativities and the discourses that support them. Critical insights are of course essential for framing how we might work towards better worlds, and identifying 'the problem' is key (although see Sedgwick, 2003 on the dangers of strong theorising). Nevertheless, they are often undertaken without suggesting better worlds (however imperfect these positive social changes might be), that question the monoliths of capitalism, neo-liberalism and so on (see Sedgwick, 2003; Gibson-Graham, 2006). We might end up with scholarly interventions into social worlds that neglect possibilities, hopes, cracks and fissures in normativities. There is a risk that we forget to mention that the positives when they are happening, and romanticise them when they are lost. Perhaps this is in part about the processes of the academy that value critique above other forms of knowledge generation. It could be that what we 'have to do' is to look at our ways of working, reconsidering earlier feminist impulses that sought to move beyond cultures of 'trashing' (see Pratt, 1996; WGSG, 1997), inspiring care for selves and each other (see Heckert, 2011; Horncastle, in this edition of the

GJSS). In other words, work with each other to inspire critique with a purpose. The purpose not just being critique, but also creating/acknowledging (flawed, imperfect, critique-able) possibilities, actions and social change.

### **Acknowledgments**

We would like to thank the many individuals, organisations and services that have helped make Count Me In Too such a success. Thank you to everyone who completed a questionnaire or attended a focus group for your time and trust. Particular thanks goes to those whose contribution forms the basis of this article. We hope your stories will make a lasting difference. This project, as a community-university partnership, was possible because of the amazing work undertaken by Spectrum and particularly thanks is owed to the Arthur Law who work tirelessly for positive social change for LGBT people, we are proud that our work in Count Me In Too can be part of this effort.

Thank you to everyone who volunteered with the project at each stage, including the Count Me In Too Community Steering Group; Action Group; Monitoring Group and the Count Me In Too Analysis Groups, particularly the trans analysis group. The project couldn't have happened without you. Thank you to the local organisations that provided support in kind by making available staff and resources to work with the project.

Your collaboration has enhanced the project's work immeasurably.

Thank you to the following organisations and services who provided financial support throughout the project: University of Brighton, Brighton & Sussex Community Knowledge Exchange, NHS Brighton & Hove (formerly Brighton & Hove City Teaching Primary Care Trust), Brighton & Hove City Council, CUPP, South East Coastal Communities (HEFCE), Brighton & Hove City Council Social Care and Housing, Partnership Community Safety Team, Sussex Police, Sussex Partnership NHS Foundation Trust, Drugs & Alcohol Action Team.

We want to thank everyone else who in various ways has helped to make this research happen: including all who designed, debated and contributed questions to the questionnaire, all who offered comments and help on the process, all who attended stakeholder and community meetings and feedback events.

Thank you to those who read and offered comments on earlier versions of this paper, particularly Camel Gupta, Catherine Nash, Julie Nichols, Craig Haslop and the referees.

### Endnotes

<sup>1</sup> We deliberately exclude bi[sexual] people from this statement to recognise the ways in which it is often lesbian/gay or 'same sex' relationships that are legally recognised and 'protected'.

<sup>2</sup> Oasis, Song Lyric. 'Don't Look Back in Anger', copyright Noel Gallagher

<sup>3</sup> This assertion supported by recent proclamations on foster ing, and Lesbian, Gay, Bisexual and Trans (LGBT) events in Downing Street. However, a full discussion of this is beyond the scope of this paper, but does require further critical interrogation. <sup>4</sup> For full details of the research see Browne, 2007 or [www.countmeintoo.co.uk](http://www.countmeintoo.co.uk). Suffice to note here that this research was based on a large scale questionnaire (819 valid responses), 20 focus groups (69 people), a series of stakeholder meetings and key informant interviews. The research used participatory methods which sought to empower LGBT people to work with service providers and others to work for positive social change for LGBT people.

<sup>5</sup> We are using queer here as a methodology for exploring gender and sexual (as well as other social) norms, rather than as an identity category (see Browne and Nash, 2010; Giffney, 2004; Oswin, 2008 for a further discussion of this distinction). See also the GJSS special issues that address Queer Methodologies (<http://www.gjss.org/index.php?Vol-5-Issue-2-December-2008-Queer-Methodologies.html>; <http://www.gjss.org/index.php?Vol-6-Issue-1-April-2009-Queer-Studies-Methodological-Approaches.-Follow-up.html>).

<sup>6</sup> This is a contested point and one we address elsewhere (see Browne and Lim, 2010; Browne and Bakshi, forthcoming).

<sup>7</sup> This should be read alongside the categorisation of sexual identities using quantitative tools, where these tools force/create categorisations and identities rather than simply reflecting them (see Browne, 2008; 2011).

<sup>8</sup>For further sample details see Browne, 2007. It is unclear who makes up the 'unsure' category and therefore this category was not used as a basis for analysis. Anecdotal responses after the questionnaire suggested that many people who 'played' with gender initially responded 'yes' to the question, 'Do you identify yourself as being trans or have you ever questioned your gender identity?'. When routed to 'trans' questions they returned to the question and clicked 'unsure'. In order to produce reliable data, a distinction between the categories of 'trans' and 'non-trans' was created and statistical tests ran with this binary category. Further research is needed to explore those who defined as 'unsure'.

<sup>9</sup> For full details see the Equalities and Human Rights website: <http://www.equalityhumanrights.com/about-us/vision-and-mission/our-business-plan/transgender-equality/>

<sup>10</sup> Despite being termed a 'National Health Service', this is broken down into a series of regional bodies who make funding decisions and define local priorities. These regions can act independently of each other.

<sup>11</sup> In Brighton & Hove the LGBT population is seen as the 'largest minority', with estimates placing the proportion between 15-20%, see Browne and Lim, 2010 for a discussion of how the

'large' LGBT population is used to legitimate trans issues and place them 'on the agenda' on the city.

<sup>12</sup> Oasis, Song Lyric. 'Don't Look Back in Anger', copyright Noel Gallagher

## References

- Ahmed, S. 2010. *The Promise of Happiness*. Durham, NC: Duke University Press.
- Brown, G. 2009. Thinking Beyond Homonormativity: Performative Explorations of Diverse Gay Economies. *Environment and Planning A*. 41(6): 1496-1510.
- Browne, K. 2007. Count Me In Too: Academic Findings Report. Spectrum. Brighton, UK. <http://countmeintoo.co.uk> (last accessed July 4 2011)
- Browne, K. and L. Bakshi. 2011. We are here to Party?: Lesbian, Gay, Bisexual and Trans Leisurescapes. *Leisure Studies*. 30 (2): 179–196.
- Browne, K. and J. Lim. 2010. Trans Lives in the 'Gay Capital' of the UK. *Gender, Place and Culture*. 17(5): 615-633.
- Bryant, K. 2008. In Defense of Gay Children? 'Progay' Homophobia and the Production of Homonormativity. *Sexualities*. 11(4).
- Butler, J. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.
- Butler, J. 1993. *Bodies that Matter: On the Discursive Limits of "Sex"*. London: Routledge.

- Combs, R. L. Turner and S. Whittle. 2008. Gender Identity Services in England: Mapping Project Report. [http://help.northwest.nhs.uk/storage/library/Gender\\_Services\\_Mapping\\_Study\\_Report2.pdf](http://help.northwest.nhs.uk/storage/library/Gender_Services_Mapping_Study_Report2.pdf) (last accessed July 4 2011)
- Condron, S. 2009. 'Sex Change Ops on the NHS have Trebled... Since the Procedure Became a 'Right''. <http://www.dailymail.co.uk/health/article-1196024/Sex-change-ops-NHS-trebled--procedure-right.html#ixzz1Mhc1srzA> (last accessed July 5 2011)
- Duggan, L. 2003. *The Twilight of Equality: Neoliberalism, Cultural Policy, and the Attack on Democracy*. Boston: Beacon Press.
- Elder, G. 2002. Queer Patriarchies, Queer Racisms, International. *Antipode*. 34: 988-991.
- Gibson, K. and J. Graham. 2006. *A Post-capitalist Politics*. Minneapolis: University of Minnesota Press.
- Green, R. 2010. *Transsexual Legal Rights in the United States and United Kingdom: Employment, Medical Treatment, and Civil Status*. *Archives of Sexual Behavior*. 39(1): 153-160.
- Heckert, J. 2011. Intimacy with Strangers/intimacy with Self: Queer Experiences of Social Research. In *Queer Methods and Methodologies: Intersecting Queer Theories and Social Science Research*. eds. K. Browne and C. Nash. Farnham: Ashgate.
- Heffernan, R. 2011. Labour's New Labour Legacy: Politics after Blair and Brown. *Political Studies Review*. 9(2): 163-177.
- Herman, D. 1994. *Rights of Passage: Struggles for Lesbian and Gay Legal Equality*. Toronto: University of Toronto Press.
- Hines, S. 2007. *TransForming Gender: Transgender Practices of Identity, Intimacy and Care*. Bristol: Policy Press.
- Hines, S. 2010. Queerly situated? Exploring negotiations of trans queer subjectivities at work and within community space. In *Gender, Place & Culture*. ed. S. Hines. London: Routledge.
- Johnson, K. 2007. Changing Sex, Changing Self. *Men and Masculinities*. 10(1): 54-70.
- Lim, J and K. Browne. 2009. Senses of Gender. *Sociological Research Online*. 14(1).
- Miyake E. and A. Kuntsman. 2008. *Out of Place: Silences in Queerness/Raciality*. York: Raw Nerve Books.
- Munro, S. 2003. Transgender Politics in the UK. *Critical Social Policy*. 23(4): 433-452.
- Namaste, V. 2000. *Invisible Lives: The Erasure of Transexual and Transgendered People*. Chicago and London: University of Chicago Press.
- Nash, C. 2006. Toronto's Gay Village

- (1969–1982): Plotting the Politics of Gay Identity. *The Canadian Geographer*. 50(1): 1-16.
- Noble, J. 2008. *Sons of the Movement: FtMs Risking Incoherence in a Post-Queer Political Landscape*. Toronto: Women's Press.
- Oswin, N. 2005. Towards Radical Geographies of Complicit Queer Futures. *ACME: An International E-Journal for Critical Geographers*. 3(2): 79-86.
- Oswin, N. 2008. Critical Geographies and the Uses of Sexuality: Deconstructing Queer Space. *Progress in Human Geography*. 32(1): 89-103.
- Pratt, G. 1996. Trashing and its Alternatives. *Environment and Planning D: Society and Space*. 14(3): 253-256.
- Prosser, J. 1998. *Second Skin: The Body Narrative of Transsexuality*. New York: Columbia University.
- Roen, K. 2001. "Either/Or" and "Both/Neither": Discursive Tensions in Transgender Politics. *Journal of Woman in Culture and Society*. 27(2).
- Sedgwick, E. K. 2003. *Touching Feeling: Affect, Pedagogy, Performativity*. Durham: Duke University Press.
- Spectrum and University of Brighton. 2008. Bi People: Count Me In Too Additional Findings Report.
- Stryker, S. 2006. An Introduction to Transgender Studies. In *The Transgender Studies Reader*. eds. Stryker, S. and S. Whittle. New York: CRC Press.
- Taylor, C. 2007. *A Secular Age*. London: The Belknap Press of Harvard University Press.
- Taylor, Y. 2009. *Lesbian and Gay Parenting: Securing Social and Educational Capital*. Basingstoke: Palgrave Macmillan.
- The Red Tape Challenge <http://www.redtapechallenge.cabinetoffice.gov.uk/equalities/> (last accessed July 5 2011)
- Vidal-Ortiz, S. 2008. The Puerto Rican Way is More Tolerant: Constructions and Uses of 'Homophobia' Among Santeria Practitioners Across Ethno-racial and National Identification. *Sexualities* 11(4): 476-495.
- Weeks, J. 2007. *The World We Have Won*. London: Routledge.
- West, P. 2004. Report into the Medical and Related Needs of Transgender People in Brighton and Hove; The Case for local Integrated Service. <http://www.spectrum-lgbt.org/trans/> (last accessed July 4 2011)
- Whittle, S. and L. Turner. 2007. "Sex Changes? Paradigm Shifts in 'Sex' and 'Gender' following the Gender Recognition Act?" *Sociological Research Online*. 12(1).

Women and Geography Study Group  
of the Institute of British Geogra-  
phers. 1997. *Feminist Geogra-  
phers: Explorations in Diversity  
and Difference*. London: Longman