

Prevalence of and Intervention into Lesbian, Gay, Bisexual and/or Transgender Youth Suicide in Queensland, Australia.

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Abstract

Lesbian, gay, bisexual and/or transgendered (LGBT) youth have high rates of incompleting and completed suicide owing to the prejudice, discrimination and violence they endure. Male, rural and transgendered LGBT youth are at particularly high risk of suicide. An array of social and institutional factors in an LGBT youth's school, home and educational environment increase the likelihood of them completing suicide. Strategies for reducing such factors are discussed.

About Open Doors Youth Service and the Authors

Lisa Thorpy and Dionysius Reid work for Open Doors Youth Service, a community youth service based in downtown inner-city Brisbane. Open Doors Youth Service specifically assists lesbian, gay, bisexual and/or transgendered (LGBT) youth and is funded through the Reconnect Families Programme of the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaCSIA). Open Doors Youth Service has operated since 2001 and will implement a 12 month Queensland Department of Communities funded LGBT Youth Suicide Intervention Project in 2008/2009.

Open Doors Youth Service has clients with a broad array of ethnicities, socio-economic backgrounds, life experiences, sexualities and gender identities. This paper is informed by research, including the action research Open Doors Youth Service annually conducts to investigate clients' needs, and the authors' experiences with LGBT youth.

Introduction

Lesbian, Gay, Bisexual and/or Transgendered ('LGBT') youth endure discrimination, prejudice and violence and such treatment renders them at greater risk of suicide than non-LGBT youth (Gilchrist, Howarth and Sullivan 2003; Grossman and D'Augelli 2006; Open Doors Youth Service 2008).

Transgendered people are at greater risk of suicide compared to lesbian, gay and bisexual (LGB) people and the reasons for suicides in these respective populations are not identical (Clements-Nolle, Marx and Katz 2006; Dudley *et al.* 1998; Hillier, Turner and Mitchell 1998; Whittle, Turner and El Alami 2007). LGB youth suicide is discussed separately to transgendered youth suicide to provide a more nuanced discussion of the different risk factors these populations face, and the ways in which services can work to assist LGB and transgender youth populations.

Lesbian, Gay and Bisexual Youth

Prevalence of Incompleted and Completed Suicide Amongst Lesbian, Gay and Bisexual Youth

Queensland Department of Communities estimates that 39,619 and 54,476 Queenslanders aged 15-24 years are same-sex attracted; this represents between 8 and 11 percent of Queensland youth (Hillier *et al.* 1998; Department of Communities 2007).

Studies from the 1980s to present report that LGB youth are between 3.6 (Remafedi *et al.*, 1998) and 13.9 (Bagley and Tremblay 1997) times more likely to incomplete suicide or have suicidal intent than non-LGB youth (Gilchrist *et al.*, 2003). The 2008 action research conducted by Open Doors Youth Service found similarly colossal rates of both suicidal intent and histories of incomplete suicide amongst participating Queensland LGB youth (Open Doors Youth Service 2008). 36.6% (n=60) of participants had attempted suicide, and 82.3% (n=135) of participants reported having suicidal thoughts at some stage (Open Doors Youth Service 2008). Unfortunately rates of completed suicide amongst LGB youth remain undocumented. Nonetheless, LGB youth's higher rates of suicidal intent and incompleted suicides suggest that they are likely to complete suicides at higher rates than their non-LGB counterparts.

LGB youth populations at high risk of suicide are readily identified as those who are most isolated from social support, and those experiencing trauma associated with violence, prejudice and discrimination (Open Doors Youth Service 2008). There are, accordingly, a broad array of risk factors which must be addressed in LGB youth suicide prevention, including, amongst others, an individual's gender, rurality, and schooling environment.

Gender as a Risk Factor for Suicide Completion Amongst Lesbian, Gay and Bisexual Youth

Queensland's males are much more likely to complete suicide than its females; *Suicide in Queensland 2002–2004, Mortality Rates and Related Data* states that males completed 79.1% of suicides in Queensland between 2002 and 2004 (De Leo, Klieve and Milner 2006). Gay and bisexual males aged 18-24 are, furthermore, 3.7 times more likely to commit suicide than heterosexual men in this age cohort (Nichols *et al.* 1998). It is estimated, based on De Leo *et al.*'s (2006) and other data (Hillier et al 1998; Nichols *et al.* 1998; Department of Communities 2007) that between 23 and 29 percent of Queensland's youth suicides are completed by male gay and bisexual youth. The authors' experiences at Open Doors Youth Service suggest that gay and bisexual male youth are more likely to complete suicide than their female counterparts because the former often have less social support from others, and elect more violent means of suicide.

Services involved in youth suicide prevention will become more effective if they are aware that a high proportion of their target population are gay and bisexual males, and tailor their services accordingly. Suicide rates will reduce if youth suicide prevention services have policies and procedures that make them approachable to, and do not disadvantage, non-heterosexual clientele. Suicide prevention services will also become more effective if their staff are accepting of LGB people, are aware of the difficulties they face in their communities, and ask clients whether they are LGB.

Rurality as a Risk Factor for Suicide Completion Amongst Lesbian, Gay and Bisexual Youth

Most of Queensland's suicides, including youth suicides, are completed in urban South East Queensland (De Leo *et al.* 2006). However, Queensland's rural regions, many of which have a higher proportion of indigenous people in the population, have higher per-capita suicide rates than urban Queensland (De Leo *et al.*, 2006) (see Appendix II).

Table 1: Incidence of suicide In Queensland by Region and Age 2002-2004

Region	Actual Numbers by Age	
	0-14	15-24
Brisbane City	2	57
Outer Brisbane	1	41
Coastal (north and south)	1	33
Darling Downs and Wide Bay	3	32
Mackay/Fitzroy	3	29
North and Far North	4	24
Western	1	12
Total	15	228

Total Suicides for those aged 0-24: 243

(Data taken from De Leo *et al.*, 2006:57-82)

Rural youth are often more socially isolated than urban youth. Open Doors Youth Service staff assist a considerable number of clients who have fled rural areas because they were unable to find support or other LGB youth. Consistent with staff experiences and De Leo *et al.*'s (2006) findings that show higher suicide rates in rural areas of Queensland, it is posited that the rate of rural LGB youth suicide is higher than the rate of urban LGB suicide. It is important that community services which engage with rural youth provide LGB youth with support that acknowledges their sexuality, opportunities to make accepting friends, and visibility within the community.

School Experiences as a Risk Factor for Suicide Completion Amongst Lesbian, Gay and Bisexual Youth

LGB youth at school often endure prejudice, discrimination and violence which is employed by students and staff, and perpetuated through institutional practices (Gilchrist *et al.* 2003; Hillier, Turner and Mitchell 2006; Open Doors Youth Service 2008). LGB youth become traumatised through such treatment, internalise others' hatred of their sexuality, are isolated from social support, and their identity and struggles are often invisibilised (Gilchrist *et al.* 2003; Hillier, Turner and Mitchell 2006; Open Doors Youth Service 2008). Of the 164 young

people who successfully completed the Open Doors Youth Service (2008) survey, 78.0% (n=128) reported having been bullied at school. Queensland's LGB youth were also asked:

During your time at school or to and from school, have any of the following happened to you (Tick any that apply)

- Threatened: 43.9% - Yes (n=72)
- Called name: 72.6% - Yes (n=119)
- Received offensive notes: 31.7% - Yes (n=52)
- Excluded from groups: 45.1% - Yes (n=74)
- Graffiti on property/locker: 18.9% - Yes (n=31)
- Bullied: 53.7% - Yes (n=88)
- Offending emails/texts/messages: 37.2% - Yes (n=61)
- None of the above has happened: 17.1% - Yes (n=28)

And how much of the time do/did you feel unsafe or afraid at school (or on the way to or from school)?

- Always: 15.2% (n=25)
- Sometimes: 51.2% (n=84)
- Never: 33.5% (n=55)

In Hillier *et al's* (1998) study of 14-21 year old same sex attracted youth also discovered high rates of homophobic and biphobic violence at school; 46% of respondents reported they had been verbally abused because of their sexuality and 16% reported experiencing physical abuse.

Queensland's LGB youth were also asked by Open Doors Youth Service (2008):

During your time at school, have any of the following groups of people harassed/bullied you because someone thought you were gay, lesbian or bisexual?

Respondents answered yes to:

- Students: 70.7% - Yes(n=116)
- Student's Parents: 12.2% - Yes (n=20)
- Young people who are not students: 35.4% - Yes (n=58)
- School teachers: 11.0% - Yes (n=18)
- School administrators (Principals, secretaries, etc) 9.1% - Yes (n=15)
- No one has harassed me: 18.9% - Yes (n=31)

It could be suggested that the youth were experiencing interpersonal homophobia. However, upon asking LGB youth how the school responded to others abusing them on the basis of their sexuality (Open Doors Youth Service 2008):

- 55.6% reported that the school ignored it (n=69)
- 33.9% of the 128 respondents in total reported that the person was not disciplined (n=42);

All Queensland schools have policies against bullying. The inadequate response of Queensland schools to homophobic and biphobic harassment and violence demonstrates their institutionalised prejudice against LGB students.

Gilchrist *et al.*'s (2003) study, of an Australian school community's response to a youth's experience of school homophobia, may demonstrate the means through which school institutional practices may enable homophobia and biphobia to occur:

Informants tended to be fatalistic or accepting of prevailing attitudes [to gay people] at best, and resigned to "the way things are". They either didn't feel that anyone in particular was responsible for [homophobic] scenarios arising or if they did they tended to feel it was society in general (but what can you do), otherwise they felt that (the young person) must take some blame himself... A degree of acceptance of bullying and homophobia can also be seen in comments that (the young person) should change schools and how teacher's hands are tied. There is little acceptance of any responsibility on the part of the school for assisting (the young person), or changing its culture.

The trauma of extensive and ongoing prejudice, discrimination and violence endured by LGB youth at school is compounded by their school's evasion of its duty to address and prevent such treatment (Gilchrist *et al.* 2003; Hillier, Turner and Mitchell 2006; Open Doors Youth Service 2008).

Open Doors Youth Service staff frequently encounter schools with policies and procedures which deny LGB students their legal rights, and make it difficult for LGB-supportive staff to advocate for these students. LGB youth's distress at school will only reduce when school policies, procedures and staff training specifically address homophobic bullying and comply with anti-discrimination legislation.

Prejudice and other forms of misunderstanding about LGB people are pervasive, and it therefore is essential that staff are educated about sexual orientation so that they can recognise and address sexual prejudice amongst students and

staff. It is also essential that anti-bullying training provided to students addresses sexual prejudice and enables students to develop more accepting attitudes to LGB people.

Many clients of Open Door Youth Service inform our staff that they are suicidal because of their social isolation at school. Distressed LGB youth become much happier once they obtain supportive peer relationships, and once they can observe their sexual orientation is visibly accepted at school. LGB or gay-straight alliance style student clubs at school, and normalising mention of LGB identities by school staff, would result in a considerable reduction of distress amongst LGB students. It would also be beneficial if school staff, such as counsellors, have an awareness of LGB supportive counselling services to which they could refer students and their families.

Transgendered Youth

Who are Transgendered People?

People who are transgendered have genders that differ, in a socially significant way, from the gender to which they were attributed at birth. Transgendered people are born transgendered and cannot change this part of themselves (Harry Benjamin International Gender Dysphoria Association [HBIIGDA] 2001; Kruijver et al. 2000; Zhou et al. 1995). Some transgendered people are inherently distressed by their sex characteristics, as well as their attributed gender, and need to change their sex characteristics through hormones and/or surgery (HBIIGDA 2001).

Suicide and Incompleted Suicide Rates Amongst Transgendered People

Transgendered youth endure intense discrimination and prejudice, and are at high risk of experiencing violence (Couch et al. 2008; Grossman and D'Auguelli 2006). Such treatment ensures that transgendered youth, as for other populations that endure similar treatment, are at a greater risk of suicide than the general population (Grossman and D'Auguelli 2006).

The exact prevalence of completed suicide amongst transgendered people remains undocumented. Nonetheless, rates of incompleted and completed suicide amongst transgendered people appear to be dramatically greater than rates amongst the general population. Members of the transgendered community informally describe the transgendered suicide rate as the '50/50 rule', which refers to there being a 50% chance a transgendered person will kill themselves before the age of 50. The 50/50 rule would equate to a 50 000 per 100 000

transgendered suicide rate, which is over 3300 times the 15 per 100 000 suicide rate amongst Queensland's general population (De Leo *et al.* 2006).

Transgendered people's rates of incompleting suicide infer that they are at considerable risk of completing suicide. Notable UK and US studies but no Australian studies exist regarding transgendered people's rates of incompleting suicide. San Francisco Department of Public Health surveyed 515 transgendered San Franciscans in 2006 and found that 32% of participants had incompleting suicide (Clements-Nolle, Marx and Katz 2006). A 2007 UK Government commissioned study surveyed 872 British transgendered people and discovered that 34% of participants had incompleting suicide at least once, with 14% of participants having incompleting suicide three times or more (Whittle, Turner, and El Alami 2007). The UK and US studies only surveyed transgendered individuals who had not already committed suicide; higher rates of incompleting suicide would likely be found if such individuals could be surveyed.

Queensland has a comparable sociocultural milieu to the UK and US. Furthermore, amongst the general population, Queensland has a higher but comparable suicide rate to the UK and US, which have suicide rates of 7 per 100 000 and 11 per 100 000 respectively (De Leo, Klieve and Milner 2006:40; World Health Organisation [WHO] 2007a, 2007b). Such Queensland/UK/US similarities infer that incompleting suicide rates amongst transgendered Queenslanders are probably similar to, or higher than, rates found in the UK and US. It could therefore be estimated that at least one third (33%) of transgendered Queenslanders have incompleting suicide.

Transgendered people under the age of 18 are particularly likely to attempt or complete suicide, because they have less knowledge, self determination, and cognitive skills to negotiate their lives than is possessed by those aged over 18 (Reid 2007). Transgendered youth face profound challenges within their social, medical, familial and schooling environments because of the misunderstanding and misrepresentation of their identities (Reid 2007).

Factors Influencing the General Social Wellbeing of Transgendered Youth

Transgendered youth often become intensely afraid of expressing themselves and interacting with others because of transphobia within their social milieu (Couch *et al.* 2008; Grossman and D'Augelli 2006; Reid 2007). Social pressure to act in a normatively gendered manner, and social sanctions incurred for demonstrating gendered performativities and subjectivities which feel comfortable, mean that many transgendered youth hate themselves and have inadequate opportunities to develop honest and supportive relationships with others (Couch *et al.* 2008; Grossman and D'Augelli 2006; Reid 2007).

Youth are also disempowered through age-associated legal, institutional and social restrictions. Such restrictions may prevent transgendered youth from obtaining sex reassignment, a safe, stable and accepting home, a safe and supportive schooling environment, information about gender through which to understand themselves, access to counselling, and access to environments in which they may develop friendships and relationships (Couch et al. 2008; Grossman and D'Auguelli 2006; Reid 2007). Transgendered youth frequently report that they feel alone and trapped in their distressing circumstances, in which they experience distress about their body, as well as stigmatisation, violence and debasement of their subjectivity (Grossman and D'Auguelli 2006; Reid 2007). Many transgendered youth incomplete suicide because they have so little ability to obtain honest and supportive relationships within safe social, familial and school environments(Grossman and D'Auguelli 2006; Reid 2007).

Transgendered teenagers often attempt to diminish with their distress through alcohol or drugs, and attempt to reduce their stigmatisation through enacting hyper-masculine or hyper-feminine performativities that hide their transgendered subjectivity (Reid 2007). Unfortunately such strategies are associated with suicide during adulthood (Reid 2007).

It is important that youth are socialised in all of their environments to understand the socially constructed character of gendered worth; such awareness would dramatically reduce the distressing transphobia and isolation that transgendered youth experience. It is particularly important that transgendered youth have significant access to accepting social environments in which they are able to make friends, enact performativities with which they are comfortable, and learn healthy ways of managing the distress they experience from others' transphobia.

Challenges for Transgendered Youth at School.

Transgendered youth face intense abuse and social isolation at school, regardless of the degree to which they understand their gender, live according to their gender, or disclose they are transgendered to others (Grossman and D'Auguelli 2006; Reid 2007). Students and staff often observe a transgendered youth's non-normatively gendered performativity and subjectivity, for instance as found in their body language, speech patterns, interests and choices of friends, and abuse them for not conforming to dominant ideals about gendered performativity and subjectivity (Grossman and D'Auguelli 2006; Reid 2007).

Authors' observations are that those transgendered youth who attempt to live according to their gender are pervasively discriminated against by schools. Schools are often unaware of transgendered people's legal rights and may prohibit transgendered youth from living according to their gender. Many transgendered youth report that the intense systemic and social negation of the value of their emotions and identity at school contributes to their suicidal intent.

Queensland's transgendered youth at school will become less likely to complete suicide if schools educate themselves on the rights of transgendered students, adequately identify and address transphobic bullying, and implement policies and procedures through which transgendered youth can live according to their gender at school. Transgendered students' distressing social isolation could be reduced if school LGB specific clubs or groups visibly welcome transgendered students. Furthermore, it would also be beneficial if school staff, such as counsellors, have an awareness of informed and supportive counselling services to which they could refer transgender students and their families.

Transgendered Youth's Family Relationships

Transgendered youth are often abused by their families because relatives do not accept or value their child's transgendered subjectivity and performativity (Reid 2007). Furthermore youth have limited legal rights, awareness of services, and problem-solving skills, and so may be compelled to retain cohabitation with and dependency abusive family members (Reid 2007). Many transgendered youth incomplete or complete suicide as an employment of agency to escape further rejection and traumatising by their family (Reid 2007).

Much transgendered youth suicide could be prevented if services with which family members may engage, such as medical clinics, are able to educate them about transgender people. It can be extremely difficult for abused transgendered youth to obtain independence, and therefore a less distressing home, through government services such as Centrelink. Much transgendered youth suicide could also be prevented through educating youth about how they may obtain help through government services, and government services altering their policies so as to recognise the profound difficulties transgendered youth encounter.

Physical and Cognitive Development

A transgendered youth who is distressed about their sex characteristics becomes more distressed as their body changes through puberty (HBIGDA 2001; Reid 2007). Transgendered people frequently report that they completed suicide as youth because they were distressed about their body (Reid 2007).

Australian transgendered adults face profound difficulties in their attempts to change their sex, nevertheless, it is even more difficult for Australian transgendered youth (Couch et al. 2008; Reid 1993). Transgendered youth are only permitted to apply for a name change and medication to postpone further pubertal development (HBIGDA 2001; Reid 1993). However, Australian

transgendered youth must have parental approval to access such changes, undergo expensive and lengthy psychiatric assessment, and have their applications passed by federal court (HBIGDA 2001; *Re A* 1993). It is exceptionally rare for a transgendered youth to have the support, skills and finances to access the name change and medication they need.

Legal reform is needed so that transgendered youth are able to access access a name change and puberty-blocking medication without attending court. If mental health practitioners are trained to recognise, support and assist transgendered youth who wish to undergo sex reassignment, then this will also contribute to a reduction in their suicide rates.

Youth initially have simplistic understandings of gender but as they age they develop more a more nuanced understanding of this social construct (Reid 2007). Youth, including transgendered youth, are however typically aware of their gender from an early age (Reid 2007). A transgendered youth can only value their own gendered subjectivity to the extent that they are able to critique normative constructions of gendered self worth to which they are exposed (Reid 2007). Transgendered youth will have greater self-esteem and less distress if services clearly articulate their acceptance of gender diversity, educate youth about gender diversity, and ensure their environments, such as youth drop-ins and therapy groups, maintain transgender-supportive social norms.

Discussion

There are many achievable ways through which to reduce LGBT youth's completed and incompleting suicide rates. It is essential that professionals involved in crisis suicide prevention work are accepting and knowledgeable about LGBT youth issues. However, the majority of LGBT youth suicide prevention involves ensuring services with which LGBT youth come into contact are LGBT friendly, decreasing LGBT youth's invisibility, generating opportunities for LGBT youth to obtain supportive relationships, and educating community members about LGBT people. It is vital that schools develop their policies and procedures to specifically address bullying based upon student's sexuality and gender identity. The authors hope that services will take these achievable efforts to reducing LGBT youth suicide and so improve the wellbeing of Queensland communities.

Appendix I

The Action Research of Open Doors Youth Service

The data used in this paper is based both on other people's more rigorously academic research and our own research and experiences through our work at Open Doors Youth Service. A requirement of the FaCSIA Reconnect Program service agreement is to undertake action research each year of funding. This research is not designed to be academically rigorous but rather to inform our work with young people. Interesting though the statistics gathered are similar.

In order to meet this funding requirement Open Doors Youth Service Inc. developed a questionnaire to further the *Coming Out about Coming In* action research report published by Open Doors Youth Service Inc. in 2006. It was an anonymous online survey comprised of nine sections:

1. Personal Details
2. General
3. Health
4. School
5. Sex and Sexuality
6. Housing
7. Emotional Health
8. Drugs
9. Mental Health

The format of the survey was greatly influenced by the *writing themselves in again 6 years on, the 2nd national report on the sexual health & wellbeing of same sex attracted young people in Australia* (Hillier *et al.*, 2006) The Open Doors Youth Service Inc. survey was uploaded onto the Open Doors Website from November 2006 until September 2007. It was directed at LGB people 20 years and younger living in Queensland. As action research, the survey was predominantly quantitative research; however there were some qualitative questions. There were a total of 180 responses, of which 164 were deemed valid and compiled. The 16 responses not used were deemed invalid as:

- Respondent was not living in Queensland
- Respondent was over 20 years of age
- Entries were handed in blank

The initial data collected from these 164 responses from LGB young people in Queensland is presented directly throughout this paper. An action research report further analyzing all the data collected is currently being drafted by Open Doors and will be published this year.

Appendix II

Queensland Suicide Rates by Region and Gender 2002-2004

Region	Rates per 100 000	Male
Brisbane City	14.57	78.0%
Outer Brisbane	12.67	79.1%
Coastal (north and south)	14.23	74.4%
Darling Downs and Wide Bay	12.95	81.6%
Mackay/Fitzroy	15.00	78.2%
North and Far North	17.19	82.4%
Western	23.40	79.6%

Data taken from De Leo *et al.*, 2006:65-80.

References Cited:

1993 *Re A* (2003) 16 Fam LR 715. Australia.

Bagley, C., and P. Tremblay

1997 Suicidal behaviors in homosexual and bisexual males. *Crisis* 18(1): 24-34.

Clements-Nolle, R., M. Marx and M. Katz

2006 Attempted suicide among transgender persons: The influence of gender-based discrimination and victimisation. *Journal of Homosexuality* 51(3):53-69.

Couch, M., M. Pitts, H. Mulcare, S. Croy, A. Mitchell, and S. Patel

2008 *Tranznation: A Report on the Health and Wellbeing of transgendered people in Australia and New Zealand*. Melbourne: Australian Research Centre in Sex, Health and Society.

Department of Communities

2007 *Young Lesbian, Gay, Bisexual and Transgender Suicide and Self-Harm Awareness Initiative*. Department of Communities. Brisbane: Queensland State Government.

De Leo, D., H. Klieve and A. Milner

2006 *Suicide in Queensland 2002–2004, Mortality Rates and Related Data*. Brisbane: The Australian Institute for Suicide Research and Prevention.

Dudley, M. N. Kelk, T. Florio, J. Howard and B Waters

1998 Suicide among young Australians, 1964 –1993. *Medical Journal of Australia* 169: 77-80.

Gilchrist H., G. Howarth and G. Sullivan

2003 *School's Out: Homosexuality, Bullying and Suicide*. Sydney: University of Sydney. [online] <http://www.aare.edu.au/02pap/gil0254.htm> (accessed 30/6/2008).

Grossman, A. and A. D'Auguelli

2006 Transgender youth: Invisible and vulnerable. *Current Issues in Lesbian, Gay, Bisexual and Transgender Health* 51(1):111-128.

Harry Benjamin International Gender Dysphoria Association

2001 *HBIGDA Standards of Care for Gender Identity Disorders, Sixth Version* [on-line]. Available from: <http://www.wpath.org/Documents2/socv6.pdf> [Accessed 11 July 2008].

Hillier, L., D. Dempsey, L. Harrison, L. Beale, L. Matthews, and D. Rosenthal
1998 *Writing Themselves In: A National Report on the Sexuality, Health and Well-Being of Same Sex Attracted Young People*. Melbourne: Australian Research Centre in Sex, Health and Society.

Hillier, L., A. Turner and A. Mitchell
2006 *Writing Themselves In Again: 6 Years On. The 2nd National Report on the Sexual Health and Well-Being of Same Sex Attracted Young People in Australia*. Melbourne: Australian Research Centre in Sex, Health and Society.

Kruijver, F., C. Zhou, C. Pool, M. Hofman, L. Gooren, and D. Swaab
2000 Male-to-female transsexuals have female neuron numbers in a limbic nucleus. *The Journal of Clinical Endocrinology and Metabolism* 85(5):2034-2041.

Open Doors Youth Service
2008 *Coming Out About Coming In*. Brisbane: Open Doors Youth Service.

Reid, D.
2007 Cultural Conceptions, Personal Paradoxes: Transgendered Identity Development in the English Speaking West. Brisbane: The University of Queensland. Available online at http://www.qahc.org.au/files/u17/trans_thesis.pdf

Remafedi G., S. French, M. Story, M. Resnick and R. Blum
1998 The relationship between suicide risk and sexual orientation: results of a population-based study. *American Journal of Public Health* 88(1): 57-60.

Whittle, S., L. Turner and M. El Alami
2007 *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*. London: The Equalities Review.

World Health Organisation [WHO]
2007a *Suicide Rates (per 100,000), by Gender, United Kingdom of Great Britain and Northern Ireland, 1950-2004* [on-line]. Available from: http://www.who.int/mental_health/media/unitkingd.pdf [Accessed 8 July 2008].

2007b *Suicide rates (per 100,000), by gender, USA, 1950-2002* [on-line]. Available from http://www.who.int/mental_health/media/unitkingd.pdf [Accessed 8 July 2008].

Zhou, J., M. Hofman, L. Gooren, and D. Swaab
1995 A sex difference in the transsexual brain and its relation to transsexuality. *Nature* 378(6552):68-70.