

Chapter 4

Suicide and Nonsuicidal Self-injury

Case of Andrea

I was eight when I saw my psychiatrist. I was referred for therapy for my school phobia. Going to school was a fight that my parents and I would go through every day. I would cry endlessly and physically struggle with my parents until one of us gave in. My parents yielded most of the time so that I ended up not going to school for a few months. But before resorting to the intervention of a psychiatrist, my parents tried to resolve the problem in a variety of ways. Although well-meaning, some of these solutions may have done more harm than good. I was belted every day as punishment. The next thing they tried was offering me bribes. When none of these worked, I was brought to a priest for a pray over. Even after twenty years, I still remember the confusion and pain I felt going through all these. I started to go back to school on my own volition when finally an adult, in the form of my psychiatrist, started to listen and tried to understand what was going on. With that simple intervention, I was able to push through with school and attended it without incident until I graduated college.

Little did I know that my struggle with my mental health will continue to my adulthood. After twenty years, I again found myself in a psychiatrist's clinic. This time around I had to contend with clinical depression. I have been in the field of psychology since university but even with the training and exposure to these conditions, it actually took me four years to realize and admit that I needed professional intervention.

Within that four years, I went through phases of sadness and numbness in different cycles. Feeling sad was more frequent than numbness. I would even consider my "numb days" as the good days. During that time, I thought that I was going through a quarter life crisis and that these feelings of sadness were a given. I had been rejected by the schools I applied to and was employed sporadically. "Sayang" was the word I would hear often from others due to being an "achiever" in both high school and college. Coming from a Filipino-Chinese family, a girl my age, late 20's, is already expected to have a family of her own or at the very least, have a good paying job. None of that was happening for me. In the years that followed, I had two cancer scares due to the growing lumps in my breast and being that my mom and most of my aunts were diagnosed with breast cancer.

I thought that maybe the sadness and feelings of failure came with the uncertainty of my life and once I figure it all out, the sadness will go away. I trudged on hoping that these feelings were fleeting and that one day it will eventually get better. But one day, that little ray of hope inevitably died out and I found myself swallowed into the darkness of my own making. I can't remember how and when that day came and I felt like I just woke up to it. I couldn't fathom how I got there. Being in the dark felt like all these monsters in my head could just engulf me into oblivion. The anticipation of when these monsters would come out preoccupied my mind and I felt that I always had to be on guard. What's worse is that I didn't even know what these monsters looked like. I was just afraid period. And this made me feel helpless.

When I started opening up to my friends and family about what I was going through, I either got puzzled looks or the ones that said, "Here she goes again."

"Maybe you're just having an identity crisis."

"Maybe you're just too sensitive."

"Maybe crying is just your way of coping with things."

"Maybe it will just go away."

"Maybe you're just overthinking things."

No one ever told me that "maybe it's clinical depression" or

"Maybe it's not your fault."

"Maybe you need professional help."

"Maybe it's something you cannot get out of on your own."

I did not choose to be sad and making me feel that this was my own decision spiralled me further into the depression. Because I felt that this was a "decision", I also decided to take matters into my own hands and make myself "happy". I turned to faith so I prayed and prayed and prayed. That didn't work. I then decided to get into buddhism and meditate the sadness out of my system. That didn't work. I turned to travelling, going to even the dangerous areas. That didn't work. I started to smoke weed regularly, drink, cigarettes and tire myself partying until dawn came. That didn't work. I realized that I had to stop all these when I was driving and I then I started thinking about driving just a little closer to the trucks and buses that flew by me. I felt that if someone tried to kill me or I was in an accident, I wouldn't even bother to fight for

my life anymore. I imagined that on my grave, it would say "suicide by apathy and passivity".

The last straw for me was when I started to feel tired every day. I was crying most of the day, even for no reason at all. I didn't want to wake up and I wanted to sleep through the day. I couldn't interact with others without crying. I started to withdraw from everyone else. My family couldn't understand and I also saw how much they were also in pain seeing my cry all the time. I pushed everyone away because I was tired of hearing their "maybe hypotheses" and it just made me feel bad to be around people. I couldn't live.

Finally, a friend who was diagnosed with MDD was the first to tell me that maybe I needed professional intervention. It was through her encouragement and sharing of her experience that I was able to admit and consider that I needed to see a psychiatrist.

During my first session, I was not able to speak much. I just cried the whole hour I was with my doctor. She patiently tried to understand the words in between sobs and offered the comfort that no one has ever given me during my struggle. It felt good that someone could finally understand and help me. I was prescribed to take sertraline, an SSRI. I had to contend with the side effects which included nausea and headaches. I also had panic attacks during the first week of medication. But side effects meant that the drug was working on me. The crying stopped. The thoughts were still there but these did not feel as powerful. I felt calm despite the negativity. My psychiatrist ensured that I regularly saw her for psychotherapy during my treatment. We talked through my negative thoughts, such as being a failure and how that has contributed to where I was. In retrospect, all those sessions were just spent on surfacing these fears. Once I put a name to all these negative feelings, accepting and countering them became easier for me.

After four months I stopped medication and fears of relapsing started to cross my mind. It takes a little more effort to settle myself down compared to when I was taking anti-depressants but it's now manageable. I also informed my friends and family of my status and they supported me through the transition. Without the depression, I realized that my friends and family were on my side after all. They have also started to notice the change in my behavior. My sister even commented that if only I took medication way before then our relationship would

have not been so strained. I started going out more with people and engage myself in different projects. I still feel sadness, fear, anxiety but this time, these things make sense to me now. I guess the depression also helped me by familiarizing me with these negative emotions. I am not afraid of them anymore. If anything, I learned how to listen to how I am feeling and actually accept what brought these on.

For the next two years, I stopped going to therapy and even discontinued my medication. However, I would take medication every now and then whenever I felt anxious or overwhelmingly sad. After a while, I started to notice that it's the same things that triggered these negative thoughts and feelings. I thought I could just brush everything aside and let the medication do its work. For some months, I started to feel more stable so I decided to stop medication. But then it started to go worse as the depression turned into irritability and anger. Soon, I started to engage in behaviors that I did not recognize anymore. I still managed to work and go through the daily grind but it was filled with pent up energy that made me feel tired all day. More so, I couldn't sleep well at night. I woke up feeling caffeinated and a bit tranced. I thought this was just a phase so that I brushed it off again. But one day, I found myself almost getting hit by a bus because I suddenly had the urge to race with it. I wanted to smoke which I don't do. When I got home, the feeling started to feel more pent up and then I found myself crying and hyperventilating. I felt the room was getting stuffy so I thought I'd open my sliding doors which led to a balcony. For a second, I looked at the balcony and thought maybe I could just jump off it and see what happens. This is when I started to realize that something else is going on. I sat through the tears and closed my sliding doors. This wasn't me. This isn't me speaking. After an hour, the impulse went away. But then I got scared. It felt like I didn't know myself anymore and more so, that I didn't have control of myself. I thought I was just experiencing withdrawal effects but I still went to my psychiatrist to consult her. It turns out, it was a manic episode rather than a side effect. This new diagnosis was difficult to accept. I cannot say that I am better now but it feels like there's a part of me that keeps unfolding as I go through life. Hopefully soon, everything will make sense.

Case of AP

Maria Naval C. Rivas, MD

AP, 18 year old, was referred for professional help because of a suicide attempt in July, 2017. On the day of the attempt, AP was found lethargic in the living room. Her father persistently tried to wake her up until she regained consciousness. She then admitted taking at least 40 tablets of different medications including: Decolgen, Neozep, Tramadol, and Mirtazapine. She was immediately rushed to the ER where she was managed.

AP was diagnosed with Major Depressive Disorder (MDD) in October, 2016 based on symptoms of depressed mood, loss of interest in school, troubled sleep, feelings of worthlessness, and repeated suicide attempts. She was reportedly bullied in school for the past 10 years but never disclosed this to anyone. At 15 years old, AP harmed herself each time she was distressed. She would flick a rubber band on her arm until it was painful and sore. She only stopped doing this when her friends took notice. At this point, her tendency to engage in non-suicidal self-injury progressed to suicidal ideations. The following year, she attempted to commit suicide twice. On both occasions, she tried to drown herself by submerging her head in a pail filled with water. Those attempts were discovered and stopped by her family members. From then on, AP continued to plan for her suicide by consulting the internet for various methods. She wanted to make sure that her next attempt will be discreet, painless, and completed.

In April 2017, AP was informed that a friend, whom she knew only from the internet, killed himself. "He was disappointed in her" and "She was not good enough as a friend," AP was told that those were the reasons why her friend took his life. She mourned her friend's death for 5 months and ruminated how inadequate, unreliable, and useless she was. "I cannot do anything to help;" "I freeze when someone comes to me in distress;" "I make things worse instead of better." These were the thoughts that constantly plagued her mind. One day, she received a call from this friend, apologizing that he faked his own death. Feeling immensely betrayed and worthless, AP decided to carry out her suicide plan. She then wrote a suicide note and drank 40 tablets of different medications. She remembered feeling calm after a while. And for the first time in a long while, the rumination stopped.

She wrote....

"I don't know what to do and what to say. I feel so lost. I don't think there is a way out but please... bear with me as I gather my last thoughts. And I hope you understand...."

Thank you mom and dad for the love you give.

Thank you brother and sister for loving mom and dad.

Thank you relatives for the time we shared even if I barely knew some of you.

Thank you friends for being there and making things better when things are awry.

This is not just a spur of the moment thing. I have thought about this a lot. I actually thought about it everyday. And yes, I have considered the consequences.... What will happen to people around me, those close to me when I'm gone? I have desensitized myself to everything and this is the only way to solve the problem.

The problem is ME! Nobody else to blame but me. I am a burden... a dead weight. I will never know enough. It hurts to see people I love being bothered by me.

Everyone will be better off without me."

AP survived the attempt and has been safe for a year now. She shared that the thought of her father crying when he found her almost motionless that day has kept her from attempting to take her life once again. Nowadays, her suicidal thoughts occur less frequently. She also feels that she is able to rationalize other people's behaviors better than before. Now, she tries to understand their actions in ways that would make her feel less offended. She is also currently taking an antidepressant for maintenance and goes to psychotherapy regularly.

Suicide

Suicide is defined as “death caused by self-directed injurious behavior with an intent to die as a result of the behavior” (Klonsky, May, & Saffer, 2016, p.14.3). Other suicide-related behaviors include suicide attempt, which is defined as a “nonfatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior even if the behavior does not result in injury” (p.14.3). Suicidal ideation, on the other hand, refers to “thinking about, considering, or planning suicide” (p.14.3).

Among the above-mentioned behaviors, suicidal ideation was found to be experienced by many. However, most individuals who engage in suicidal ideation do not necessarily attempt to commit suicide. Suicidal ideation is prevalent because it is associated with psychological disorders, states of mind, maladaptive personality traits, temperaments, and stressful life events. Joiner (as cited in Klonsky, May, & Saffer, 2016, p.14.16) also mentioned that there are several factors that will push an individual with suicidal ideation to end one’s life. These factors include—overcoming fear of death, lower pain tolerance, and availability of practical means.

Epidemiology

Suicide is currently considered as a prevalent mental health issue. Statistics from the World Health Organization (2014) indicate that the suicide rates worldwide increased by 60 percent in the last forty-five years. It is estimated that one million people die from suicide each year. This figure can be translated to one death every 40 seconds. By 2020, it is predicted that the suicide rate will increase approximately to one death every 20 seconds (World Health Organization, 2014). Across all age groups, adolescents and young adults are considered to be at highest risk as youth suicide rates have been increasing at an alarmingly quick pace. Globally, suicide is the second leading cause of premature death among people between fifteen and twenty-nine years old (World Health Organization, 2014).

Developing countries have also seen an increase in suicide rates. In the Philippines, suicide figures are lower than the global statistics and are the lowest among ASEAN member countries (Lapena, 2015). However, suicide rates in the Philippines have been rising steadily for the past twenty years. According to the National Statistics Office, the suicide rate from 1984 to 2005 increased from 0.46 to seven out of every 200,000 men and from 0.24 to two for every 200,000 women. In 2012, there were approximately 2,558 cases of reported suicide in the Philippines, based on 2013 Young Adult Fertility and Sexuality Study (Uy, 2012). The increasing trend in suicidal behavior is also relatively high among adolescents and young adults within the fifteen to twenty-four-year-old age group, mirroring the global rates (Lapena, 2015).

Although suicide rates in the Philippines are relatively low, the numbers may not necessarily paint an accurate picture of the phenomenon. A study which examined the suicide trend in the Philippines found that there is an underreporting and inaccurate

reporting of suicide incidents. They surmised that this tendency to underreport is affected by sociocultural factors such as—strong religious presence in the country that denounces suicidal acts, and the social stigma that pervades in the society towards suicidal individuals and their families (Redaniel, Lebanan-Dalida, & Gunnell, 2011).

Etiology

Suicide is a complex phenomenon which results from the interaction of individual and social factors such as—biological contribution, childhood experiences, family history, socio-cultural environment, and the historical and socio-economic contexts. Thus, to get a holistic understanding of suicide, there is a need to broaden the lens of how suicide is viewed and investigated in research (Minayo, Cavalcante, & de Souza, 2006).

Biological Factors

The neurobiological basis of suicide has been studied through examining various biological markers obtained from individuals who exhibit suicidal behavior and from post-mortem brains of suicide victims. The main thrust of neurobiological studies in suicide is to identify biological markers linked with suicidal behavior, for the purpose of developing specific and targeted pharmacological treatment (Chang, et al., 2016).

Genetic Predisposition

Genetic studies indicate that suicide risk is higher among individuals who have relatives diagnosed with mood disorders (King & Merchant, 2008). However, it must be noted that not all patients diagnosed with psychological disorders engage in suicidal behaviors. Prevailing models in understanding suicide, such as the Biopsychosocial Model and the Stress-Diathesis Model emphasize the interaction between genetic predisposition and environmental factors in the development of suicidal behaviors. It states that a genetic vulnerability is not a sufficient cause that will result to suicide (King & Merchant, 2008).

Serotonin Level

Low levels of serotonin and its metabolite, 5-HIAA, were found in the blood samples and cerebrospinal fluid of individuals who have attempted suicide and in the post-mortem brains of suicidal victims (Pandey, 2013). The link between suicidal behaviors and low serotonin levels may be explained through impulsive-aggressive traits, which are also associated with abnormalities in the serotonergic system of the brain. Impulsivity and aggression, which are considered as traits, predispose an individual to enact one's suicidal thoughts. Thus, studies have found that impulsivity is a significant predictor of suicidal behavior (Pandey, 2013).

Hypothalamic-Pituitary-Adrenal Axis (HPA Axis)

Previous studies have found that abnormal functioning in the HPA axis is strongly associated with suicide (Pandey, 2013). The paraventricular nucleus of the hypothalamus facilitates the production of corticotrophin releasing factor, which then stimulates the release of cortisol from the pituitary gland. Studies have then established that individuals who attempted to commit suicide had significantly elevated cortisol levels, compared to those without a history of suicidal behaviors (Pandey, 2013). Depression is widely considered to be a significant risk factor for suicide. Similarly, individuals diagnosed with depression also show an abnormality in the HPA axis, as well as higher levels of cortisol in the blood and cerebrospinal fluid (Pandey, 2013).

Psychological Factors

One aspect of suicide research looks into individual characteristics of those who are at risk of engaging in suicidal behaviors. These studies aim to identify demographic and psychosocial variables which serve as risk and protective factors related to suicide. Internal characteristics such as persistent mental illness, isolation, hopelessness, impulsivity, and ineffective coping skills were found to be significant risk factors which exacerbate suicidal tendencies (Roen, Scourfield, & McDermott, 2008). Demographic variables such as gender, marital status, and religion tend to vary depending on the population. A general trend, however, shows that having a socially disadvantaged background, characterized by lower socioeconomic status, lesser education, and unemployment, places an individual at elevated risk of attempting suicide (Zhang, Sun, Conwell, Qin, Jia, Xiao, & Tu, 2015; Singh, Jindwani, & Sahu, 2012; Agerbo, Qin, & Mortensen, 2006).

Phenomenological studies have explored the subjective experience of suicidal individuals. Studies which employed this method revealed that people struggling with suicidal behaviors experience mental pain, accompanied by negative emotions towards the self. These emotions range from despair, hopelessness, emptiness, loneliness, shame, guilt, anger, and frustration for their suffering. They also report a sense of being trapped in their life situation. For them, suicide was viewed as a means to gain control over their lives and as a viable way to escape from their adverse life situation (Segal-Engelchin, Kfir-Levin, Neustaedter, & Mirsky, 2015; Rimkeviciene, Hawgood, O'Gorman, & De Leo Orri, 2015; Paduanello, Lachal, Falissard, Sibeoni, & Revah-Levy, 2014).

Theoretical frameworks aim to explain how individuals develop suicidality. Beck's theory of the negative cognitive triad, a commonly used model for depression, is also generally used to explain the dynamics of the suicidal experience (Segal-Engelchin, Kfir-Levin, Neustaedter, & Mirsky, 2015). It claims that depressed individuals adopt dysfunctional beliefs about themselves, their experiences, and their future. These negative beliefs further foster hopelessness and helplessness, which trigger the ideation that taking one's life is the only solution to deal with one's problem (Segal-Engelchin, Kfir-Levin, Neustaedter, & Mirsky, 2015; Orri, Paduanello, Lachal, Falissard, Sibeoni, & Revah-Levy, 2014; Chu, Goldblum, Floyd, & Bongar, 2010).

The Interpersonal-Psychological Theory of Suicide by Joiner (2005) is also a widely used theory in explaining suicide. This theory indicates that there are three necessary factors to complete suicide—thwarted sense of belongingness, perceived burdensomeness to society, and an acquired capability to overcome the pain and fear of suicide (Langhinrichsen-Rohling, Snarr, Slep, Heyman, & Foran, 2011). This particular theory implies that the presence and quality of social relationships an individual has may either facilitate or impede the development of suicidal behaviors. If social support is available, an individual has access to emotional affirmation and validation, as well as concrete assistance. Social support then equips a person with more resources to solve problems and adapt to difficult situations. Hope is instilled as there are more resources which can help a person overcome difficulties, through emotional and instrumental means (Hirsch, & Barton, 2011; Bille-brahe et al., 2007).

Sociocultural Factors

Several theories recognize that suicide is influenced by social factors. Although suicidal behavior occurs within an individual, the broader context in which it occurs can provide necessary insights for understanding suicide. One of these is Durkheim's theory which asserts that suicide is not an individual act. Instead, he suggested that suicide is a social phenomenon that is influenced by social integration and regulation (La Fontaine, 2012).

Social integration refers to the feeling of belongingness within a society (La Fontaine, 2012). An integrated individual feels a sense of security and being accepted and needed by others (La Fontaine, 2012). Lack of social integration may lead people to feel lost and worthless in the society where they were born and raised (La Fontaine, 2012). Social regulation, on the other hand, refers to the ways in which the society attempts to control the behaviors of its members (La Fontaine, 2012). This can be enforced explicitly through written laws or implicitly through norms, customs, and traditions (La Fontaine, 2012). Through this, an individual learns how to control one's own and others' behaviors in order to function in the society (La Fontaine, 2012). According to Durkheim, when there is a balance in both social integration and regulation, an individual is protected from the likelihood of committing suicide (La Fontaine, 2012).

Durkheim proposed that suicide is a socially patterned form of behavior that has culturally specific definitions, depending on the context. Hence, he mentioned that meaning people attach to suicide is socially constructed. There are variations in the meaning ascribed to suicide across cultures. The interpretations also vary depending on who expresses it (La Fontaine, 2012).

From a cultural perspective, individuals are seen as embedded in contexts where certain emotion rules, behavioral patterns, and cognitive frames are normative (Mueller & Abrutyn, 2015). Within this framework, suicide can be seen as a symbolic act which may be used to express distress or hopelessness towards themselves and others. Thus,

Suicide and Stigma

Despite the implementation of suicide awareness programs, suicide still continues to be a taboo subject. Existing literature on suicide stigma shows that negative attitudes towards individuals who attempt suicide are still pervasive and exists in different settings (Barik, Maple, & McKay, 2015; Rimkeviciene, Hawgood, O'Gorman, & De Leo, 2015).

Individuals with a history of suicidal behaviors also reported that they experienced social stigma from others. They perceive that others consider their illness as severe, to the extent that there is no possibility for recovery. Paradoxically, they also perceive that other people tend to trivialize their suicide attempt by saying that it is not serious or that it was a way to seek attention (Rimkeviciene et al., 2015).

In general, individuals who attempted suicide felt lack of care from institutions, medical professionals, and even family members. Suicide attempters also report having experienced social exclusion and alienation from others, including their family members and friends. They reported avoidance and distancing as the most common discriminatory behavior they experienced after attempting suicide (Rimkeviciene et al., 2015; Segal-Engelcin, Kfir-Levin, Neustaedter, & Mirsky, 2015; Chung, Caine, Baron, & Badaracco, 2015). These results have implications on help-seeking behaviors and decision to disclose suicidal intent.

an individual is exposed more frequently to suicide, the script of engaging in suicide as a means to cope with distress is further reinforced.

Intervention

The Behavioral Research and Therapy Clinics from the University of Washington indicated that psychotherapy approaches, which were found to be effective in reducing suicidal behaviors, had two characteristics. First, the therapy must directly address the suicidal behaviors, not the psychiatric diagnosis. Studies have shown that treating the psychological disorder does not necessarily decrease suicidal risk. It was suggested that the treatment must focus on targeting the problems that serve as the source of suicidal behaviors such as capacity to problem solve, intense emotional dysregulation, reasons for dying, and lack of reasons for living. The second characteristic of an effective suicide intervention treatment is the use of a collaborative approach, which is built upon empathy and genuine understanding of what the client is going through (Comtois, n.d.).

Cognitive Behavioral Therapy (CBT). The most common therapy approach used in dealing with suicide is cognitive behavioral therapy (Cox & Hetrick, 2017). In therapy, clients are engaged to examine the chain of antecedent events, thoughts, emotions, and behaviors that led to the suicide attempt. They are also given psychoeducation on

Cultural Variations in Suicide

Chinese: A quantitative study by Zhang, Sun, Conwell, Qin, Jia, Xiao, and Tu (2015) revealed that risk factors which were found significant in Western-based studies were also applicable in the Chinese sample. The risk factors they identified were—family suicide history, hopelessness, negative life events, impulsivity, and deficient coping skills. However, some factors which were found protective in Western studies were found to be significant risk factors in the Chinese sample. Specifically, they found that religious beliefs and marriage were associated with engagement in suicidal behavior. (Zhang, Sun, Conwell, Qin, Jia, Xiao, & Tu, 2015).

Iranians: A phenomenological study that contextualizes adolescent suicide in Iranian culture, found that difficulty in romantic relationships was considered as one of the main reasons for committing suicide. The traditional expectations and pressure imposed by their society on the characteristics of an “ideal partner” create a frustration among individuals as they search for a partner. Some participants reported concealing their relationship to avoid strong family opposition, while others were forced by the family to separate from their significant others as the partner did not meet the family’s standards. These interpersonal struggles tend to trigger suicidal behaviors among Iranian youth (Keyvanara & Haghshenas, 2011).

Asian-Americans, African-Americans, & Latin Americans: Chu, Goldblum, Floyd, and Bongar (2010) found that ethnic culture affects how suicidal thoughts and attempts are expressed. They were able to identify distinct variations across ethnic groups in terms of how suicidal symptoms are manifested and the chosen means of implementing a suicidal act. Results showed that Asian-Americans tend to keep suicidal thoughts and intent private. This tendency to engage in hidden ideation was related to the Asian culture’s emphasis towards preserving honor and minimizing disgrace. In contrast, African-Americans who have completed suicide exhibited high levels of disclosure and talked about their suicidal tendencies before they carried out the suicidal act. In terms of carrying out the suicidal act, Latinos and Asian Americans commonly used methods such as hanging, suffocation, jumping, or use of poison. On the other hand, African-Americans frequently use firearms as a method for taking their lives.

developing skills that will allow them to expand their reasons for living, regulate their emotions, improve goal setting and problem solving skills, and increase their threshold for handling distress. The approach also encourages clients to seek and strengthen social support.

Interpersonal Psychotherapy (IPT). In this approach, interpersonal problems are viewed as the main source of suicidal behaviors. It states that maladaptive patterns of communicating and relating to others could lead to personal difficulties. Thus, the

therapy aims to address issues related to interpersonal conflicts, interpersonal sensitivity, role transitions, and grief (Cox & Hetrick, 2017).

Caring Letters. These letters are personalized messages written by therapists. Its content includes reminders regarding personal safety and encouragement to seek follow up treatment, if necessary. Caring letters are sent to patients who attempted to commit suicide, thirty days after their discharge from the hospital. Results from randomized control trials showed that individuals who received caring letters had a lower propensity to engage in suicidal behaviors, compared to those who did not receive the letters (Luxton, et al., 2014). Researchers attribute the effectivity of this approach to instilling the feeling among suicidal patients that they are cared for.

In 2000, a group of suicide clinicians and researchers convened in Aeschi, Switzerland and developed guidelines for health professionals on how to deal with the client exhibiting suicidal behavior (Michel, 2011). The abstract of the six guiding points are described in this chapter.

The AESCHI Working Group: Highlights of the Guidelines for Clinicians (Michel, 2011).

1. The goal for the clinician must be to reach, together with the patient, a shared understanding of the patient's suicidality. The goal stands in contrast to a traditional medical approach where the clinician is in the role of the expert in identifying the causes of a pathological behavior and to make a diagnostic case formulation.
2. The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect. After a suicide attempt, there is a "window" in which patients can be reached. At this moment, they are open to talk about their emotional and cognitive experiences related to the suicidal crisis.
3. The interviewer's attitude should be nonjudgmental and supportive. An empathic approach is essential to help patients reestablish life-oriented goals. The clinician must be open to listen.
4. A suicidal crisis is not just determined by the present. It has a history. The interview should encourage the person to deliver their self-narratives.
5. New models are needed to conceptualize suicidal behavior to reach a shared understanding of the patient's suicidality. An approach that does not see patients as objects displaying pathology but as individual that have their good reasons to perform an act of self harm will help to strengthen the rapport.
6. The ultimate goal should be to engage the patient in a therapeutic relationship, even in a first assessment interview. In a critical moment in a patient's life the meaningful discourse with another person can be the turning point that life-oriented goals are reestablished.

Suicide Hotlines in the Philippines

HOPELINE

For Suicide Prevention & emotional crisis
24 Hours a Day | 7 Days a Week

804-HOPE

0917-558-HOPE

2919*

*For GSM and 3G Services

**Suicide Prevention
HOTLINES**

If you need someone to speak with,
a patient and listening ear,
you may call the following hotlines:

Manila Lifeline Centre
02-896-9191
0917-854-9191

The Natasha Goulbourn Foundation
Call 02-804-HOPE (4673)
0917-558-HOPE (4673)



Chapter 8

Gender Dysphoria

Case of Devine

Devine David

My parents named me John Dave Mare. But now, I prefer to be called "Devine" (De-Vi-Ni). I have worked for the government as a health worker since 2010. I started working *na mukha at kilos lalaki* (looking and behaving like a man). But I definitely know that I'm a female at heart. I decided to transition last May 2014.

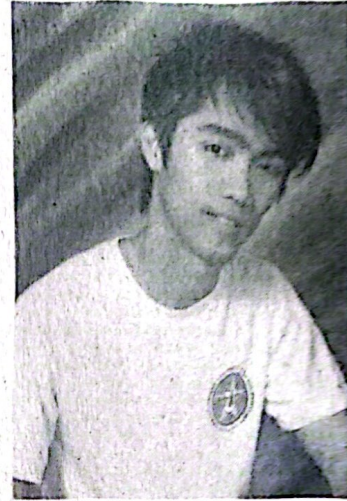
When I was seven, *alam ko na na babae ang puso ko*. It started *nang nakita kong umihi ang kalaro kong babae*. *Nakaupo sya*. I felt *na parang dapat ganun din ako dahil alam ko na babae ang puso ko*. *Dahil alam kong mali, ginagawa ko lang umihi nang nakaupo kapag walang nakakakitang tao*. Since then, I knew that *babae ako pero alam kong mali sa paningin ng iba lalo na sa magulang ko*. *Kaya* I decided to hide my feelings. In short, *nagpakalalaki ako sa kilos*. I thought my feelings were wrong, *na makasalanan*. *Yun naman kasi ang tinuturo sa'tin, na mali ang maging isa sa LGBT*. *Kaya sinubukan kong baguhin ang nararamdaman ko*.

(I knew that I am a woman at heart. It started when I saw my playmate, who is a girl, peeing. She was sitting. I felt that I should be like her because I know that I am a woman at heart. Because I know that it was wrong, I only pee sitting down when nobody was around. Since then, I knew that I am a girl, but I know that it is wrong in the eyes of other people, especially my parents. That's why I decided to hide my feelings. In short, I tried to act like a man. I thought my feelings were wrong, that I am sinful. Because that's what we're taught, that it is wrong to be one of the LGBT. That's why I tried to change what I felt at the time.)

Nakarinig ako ng usapan ng mga lasing na ang bakla raw kapag nakatikim ng babae, magiging tunay na lalake na. *Napaisip ako that time*. *Dahil sa gusto ko ding maging normal, maging "straight guy," sinubukan ko 'yun*. *Kapag may nagkakagusto sa akin na babae, hinahayaan ko lang hanggang sa sila magyaya ng sex*. *Hindi ko sila pinigilan dahil iniisip ko nga na magiging normal ako, hanggang sa kung sino-sino na ang nakasex kong babae*. *Nagkaroon pa ako ng listahan noon kung sino na ang mga nakasex ko dahil gusto ko alalahanin lahat*. *Sa pagkakaalala ko, ang dami ko nang nalista*. *Pero wala pa ring nabago*. *Still, babae pa rin ang puso ko*. *Kahit na anong gawin ko, walang nagbago sa nararamdaman ko*. *Yes, I had sex with so many girls*. *But after that encounter, naiinis ako sa babae*. *Nakararamdam ako ng pandidiri sa sarili ko after ng sex*. *Pero sa lalaki,*

masaya ako. Talagang masasabi kong 'yun ako at hindi ko na ito mababago.

(I heard before in conversations over alcohol that when a gay "tastes" a woman, he will become a real man. I thought about it at the time. Because I also wanted to be normal, to be a "straight guy," I tried it. When a girl seemed to like me, I just allowed it, up to the point that she would invite me to have sex with her. I did not discourage her because I was thinking that it will make me normal. It reached a point when I had sex with different girls. I even had a list of whom I had sex with because I wanted to remember everything. From what I remember, there were a lot of girls on my list. But still, nothing changed. I am still a female at heart. No matter what I did, my feelings did not change. Yes, I had sex with so many girls, but after the sexual encounter, I felt annoyed towards them. I felt disgusted with myself after having sex. But with men, I felt happy. I can really say that I was being true to myself and I could not change it anymore.)



I never had any exposure sa LGBT Community before *kasi lagi kong kasama mga straight na lalake dahil nga nagpapanggap akong lalaki noon. Kaya 'di ko masasabing nabawa ako sa ibang tao tulad ng iniisip ng ilan. May nagsasabi din na baka hindi ako close sa father ko o wala akong father figure na kinalakihan. Pero I live with my parents, kaya nga lang hindi kami close. Ayoko din mahusgahan ng tao noon kaya tumagal ng twenty-four years ang pagpapanggap ko sa mundo. Hanggang sa dumating yung time na hinanda ko na ang sarili ko sa mga sasabihin ng ibang tao, lalo na ng pamilya ko kung magdedesisyon akong umamin sa nararamdaman ko. Nagsimula akong umamin sa pagkatao ko sa Facebook. Tulad ng inaasahan, ang dami kong natanggap na negative comments sa pamilya ko. But still itinuloy ko pa din ito.*

(I never had exposure to the LGBT community before because I was always surrounded by straight men, I was still pretending to be straight then. That's why I cannot say that I adopted their behavior, contrary to what others believe. Some said that maybe I was not close to my father or that I had no father figure while I was growing up. I live with my parents, but we're not that close. I also didn't want to be judged by people then, that's why I pretended to be straight for 24 years. It reached a point when I prepared myself to tell others, especially my family, about my decision to admit what I feel. I started coming out about my identity on Facebook. As expected, I received negative comments from my family. But I continued to pursue it.)

Becoming Devine



I started taking Diane pills last June 2014, initially once a day in one year. Then I tried it 2x a day in a month, then 3x a day in a month, just to enhance more of my breast and hips. *Pero binalik ko din sa once a day dahil nagpapalpitante po ako* (But I went back to taking it once a day because I had palpitations). Unfortunately, no one advised me *na magtake ng pills. Yung mga kilala kong doctors dinidiscourage nila ako magtake dahil nga daw masama sa katawan* (The doctors whom I knew discouraged me from taking it because it's not good for the body). Well, I still took the risk just to enhance my femininity, with the help of my trans colleague. *Nagbase na lang ako sa mga experiences niya sa pagtake* (I just drew from my friend's experience of taking the medicine).

Nagsuot ng pambabaeng damit at pinag-aralan ang magkilos babae. Medyo mahirap sa umpisa dahil sanay nga ang katawan kong magpakalalaki. Masasabi kong pangit sa umpisa pero habang tumatagal ay unti-unting umaayos ang kilos at itsura ko. Nawala ang muscle, naging feminine ang mukha at yung dating flat chested, medyo may umbok na.)

(I wore women's clothes and I studied how women behaved. It was difficult at the beginning because my body is used to being masculine. I can say that it was unpleasant at the start but as time passed, my appearance and behaviors improved little by little. My muscles disappeared, my face became feminine, and my previously flat chest started developing breasts.)

After the Transition: The Challenges and Triumphs

After almost four years of transition, I can say that I'm very much different from inside and out. *Bukod sa nagbago na ang pangangatawan ko, lalake sa hitsurang babae, nagbago din pati paraan ng pag-iisip ko. Mas naging babae ang ugali ko, mula sa kilos, pananamit, at maging sa pagdedesisyon. Mas kalmado at mas masaya na daw ako. Mas madaling makisalamuha sa ibang tao dahil nga mas kampante na ako sa kung sino ako, na walang tinatago.*

(Aside from the changes in my body, from man to woman, my way of thinking also changed. My attitude became more feminine, from my behavior, way of dressing, and decision-making. They say that I am calmer and happier. It is also easier to interact with people because I am more at peace with who I am, with nothing to hide.)

Pero hindi pa din maiiwasan na gawan o pag isipan ka ng masama ng ibang tao. Dabil nga sa kilos babae na ako, narwala na ang mga babae at bakla na nagpaparamdam sakin. Mga straight guys na lang dabil nga akala nila babae ako. Advantage para sa'kin dabil 'yun naman talaga ang attraction ko, pero iba ang isip nila sa katulad ko. Akala nila sex lang ang habol ko kaya nagpaka babae ako. May instances pa na muntik akong ma-rape at dun ko napansin na ang hina na ng katawan ko. Hindi ako makapiglas sa hawak ng kamay. Epekto din siguro ng pills na iniinom ko. Ayaw kong gawin yun dahil hindi ko naman sya kilala. Pero sa mga salita niya, akala niya gusto ko din yung gagawin namin. Kaya sumigaw nalang ako para umalis sya. Dun ko naisip na iba parin talaga ang tingin ng tao sa mga kagaya ko lalo sa usapin ng sex. Pero personally, gusto ko lang siya gawin sa taong mahal ko at mahal ako.

(However, it could not be avoided that some people will think or do something negative to you. Because my ways are more feminine now, women and gays are not drawn to me anymore; only straight guys, because they think that I am a woman. It is an advantage for me because I am attracted to them [straight guys], but they think differently of me. They think that sex was the main reason why I decided to transition. There were instances when I was almost raped, and I noticed that my body is weaker now. I could not break free from his grasp. Maybe that was also an effect of the pills that I am taking. I do not want to do that [have sex] because I don't know him. But based on what he said, he thought that I wanted to have sex with him. That's why I shouted, so that he will leave. That's when I thought that people really think differently about people like me, especially with issues related to sex. But personally, I would only want to do that [have sex] with someone whom I love and who loves me too.)

Nakakatawa nga kasi nung lalake pa ang katawan ko hindi ako tumatanggi sa sex, pero ngayong nagpakababae na ako, pati isip ko nagbago din; nagpapaligaw na parang isang tunay na babae. Nagka-boyfriend din, pero hindi labat nagtagal. Dabil una, 'di parin maaalis na pera ang habol sa mga kagaya ko. Pangalawa, may seryoso nga, kaso yung magulang naman ang tutol dahil sa hindi ako totoong babae at di ko sila mabibigyan ng apo. Madaming issues sa love life kapag Pilipino ang partner ko. Pero ngayon, I'm in a relationship with an American. Long distance, pero sa tingin ko mas may pag asa ako makatagpo ng seryoso sa mga foreigners kasi mas open sila at mas tanggap ang katulad ko. At ang pinaka importante sa kanila, tinatrato akong isang tunay na babae. Still, we haven't met in person but I'm looking forward to meet him, para masabi kong seryoso talaga ang isang tao sa'kin.

(It's funny how when my body was still male, I never refused sex. But now that I transitioned to becoming a female, even my mind changed. I let guys court me now, like

a real female. I had a boyfriend before, but it did not last. Because first, we can't change the idea of engaging in a relationship with someone like me for financial reasons. Second, some may have been serious about me, but their parents objected because I am not a real woman and I will not be able to give them grandchildren. There are many issues related to love life when my partner is a Filipino. But now, I'm in a relationship with an American. Long distance, but I am more hopeful in finding a serious relationship with foreigners because they are more open and accepting of who I am. More importantly, they treat me like a real woman. We still haven't met in person, but I'm looking forward to meeting him, so I can say that he is really serious about me.)

From 2010 to 2016, I worked as a peer educator and HIV counselor who works in the community to educate them about HIV & AIDS and to conduct HIV testing. After a series of trainings, I was also given a chance to conduct seminars in the community and with my colleagues. *Ngayon, hindi na lang ako isang HIV advocate. Isa na rin ako sa mga trainer ng Sexuality-SOGIE (Sexual Orientation, Gender Identity and Expression), na kung saan pinapaliwanag ko, para mas maiintindihan ang pagkatao ng mga LGBT. Nagagamit ko rin ang personal kong karanasan para mas marealize nila ang nangyayari sa mga kagaya kong nasa LGBT. Ngayon, masasabi kong mas kampante ako sa buhay at mas masaya.*

(Now, I am not only an HIV advocate. I am also a trainer of Sexuality-SOGIE, where I explain to people and allow them to understand the LGBT better. I also get to use my personal experiences, so they will understand the experiences of people like me from the LGBT. Now, I can say that I am more at peace with my life and happier.)

Tulad ng mga tanong ng ibang tao kung gusto kong magpa-sex reassignment, it's a case-to-case basis. Dahil unang una, I can not afford it. Pangalawa, takot ako sa pain. Pero personally, gusto ko. Siguro mas posible ko magawa muna ay breast at hips implant para mas maging confident ako sa pagsuot ng kahit anong damit at makadagdag sa confidence ko na mamuhay bilang isang babae.

(Other people ask me if I would like to undergo sexual reassignment, but the answer to that is on a case-to-case basis. Because first of all, I cannot afford it. Second, I am afraid of pain. But personally, I want to. For now, it might be more realistic for me to have breast and hip implants, so that I'll be more confident in wearing any kind of clothes, and it will also add to my confidence as I live out being a female.)

My identity is FEMALE. "Transgender woman" is just a label to identify my sex at birth, although it is contrary to how I feel. But still I am a WOMAN, regardless of what I have in between my legs.

Gender Dysphoria

Sexuality is an important aspect of an individual's identity (Kring, Davison, Neale, & Johnson, 2012). Its influence ranges from a person's daily functioning to gender roles in society (Oliver & Hyde, 1993). The DSM-5 has included a group of disorders pertaining to disturbances in thoughts, feelings, and behaviors associated with sexuality. Gender dysphoria (GD) is part of this group of disorders. Individuals with GD experience significant distress because of a marked incongruence with their expressed gender and biological sex. It is, however, important to note that not all individuals who identify as LGBTQ+ fall under the diagnosis of gender dysphoria. GD is marked by significant impairment in daily functioning due to this experience of incongruence.

Clinical Description and Epidemiology

A common feature of the symptoms of GD is the desire to be either of the opposite of the assigned gender or an alternative gender. The incongruence between gender identity and biological sex is evident in Devine's experience, as she described herself being a woman at heart, despite having a male body.

In children, this could manifest in preference for toys, games, and activities typically expected of the other gender. A preference for cross-dressing may also be observed. There could also be an aversion towards their present anatomy and a desire to change it to the opposite gender. The box on the next pages lists these symptoms in more detail. It is important to note that these symptoms occur for at least six months, and cause distress and impairment to the individual.

Currently, there are no available statistics for the prevalence of gender dysphoria. There are, however, approximations of the prevalence of transgenderism in the Asia-Pacific region. These figures come from specialist clinics for transpeople. Therefore, the estimates in this region does not account for much of trans population who do not seek medical assistance (Health Policy Project, Asia Pacific Transgender Network, United Nations Development Programme, 2015). Estimates of the adult transgender population in Asia-Pacific range from 9 to 9.5 million (Winter, 2012). In 2002, 2 percent of male-born Filipinos aged fifteen to twenty-seven years old stated their wish to be female (Winter, 2009). Whether these transpeople experience significant distress and impairment is not reported.

DSM-5 Criteria for Gender Dysphoria

Gender Dysphoria in Children

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's

assigned gender)

2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender
 5. A strong preference for playmates of the other gender
 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
 7. A strong dislike of one's sexual anatomy
 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender
- B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Gender Dysphoria in Adolescents and Adults

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Etiology

Biological, psychological, and social aspects contribute to the formation of *gender identity*. A lone cause for the development of gender dysphoria in children and adolescents has yet to be discovered (Di Ceglie, 2015).

Biological Factors

Sex differences have been observed in both the structure and function of the brain. There are brain structures that differ in size between sexes. Areas such as the caudate nucleus, hippocampus, Broca's area, anterior commissure, and right parietal lobe are larger in females. On the other hand, the hypothalamus, stria terminalis, and amygdala are larger in males (Goldstein et al., 2001). Sex-dependent hormones such as androgens have also been implicated in gender identity and sexual orientation. It has been hypothesized that early exposure to androgens can play a role in the development of sexual behavior and gender role. A study found that girls with congenital adrenal hyperplasia, meaning an increased androgen production, were observed to have an increased preference to clothes and games commonly affiliated with boys (Furtado et al., 2012).

Psychological Factors

Young children generally do not have a concept of gender constancy—a child's understanding that gender is a stable part of the self. Until children develop concrete operational thinking—between five to seven years old—children conflate gender identity with gender expression (Ruble, Martin, & Berenbaum, 2006). Therefore, the behavior of a four-year-old who believes that she becomes a boy when she wears boys' clothes and plays with games for boys would not be considered odd (Zucker, Wood, Singh, & Bradley, 2012). Children with GD, however, showcase a lag in acquiring gender constancy. It has yet to be established if this lag predisposes children to develop gender dysphoria (Zucker et al., 1999). However, the developmental lag may be understood as a perpetuating factor. These cross-gendered behaviors may contribute to maintaining confusion about one's gender (Zucker et al., 2012).

The persistence of gender dysphoria is most apparent during a period of social transition in childhood, especially in boys (Steensma et al., 2013). This, as well as verbally expressing the desire to be another gender, are predictors for the persistence of gender dysphoria (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). People who persisted with gender dysphoria explicitly identified that they felt like the other sex. Individuals who desisted from gender dysphoria, on the other hand, only stated that they wished to be of the opposite sex. The period between ten and thirteen years proves to be crucial for adolescents experiencing dysphoria. Those who persisted in their gender dysphoria, as well as those who didn't, held that this timeframe served as an avenue to experience changes in their bodies, and to experience falling in love and sexual attraction. These experiences increased (for persisters) or decreased (for desisters) their interests, behaviors, and feelings of discomfort about their gender (Ristori & Steensma, 2016).

Sociocultural Factors

Ancient Asian cultures have regarded transpeople with respected societal roles—spirit healers, actors, and entertainers. However, colonization, urbanization, and modernization, as well as the spread of Christianity, caused transpeople to take on less significant roles—beauty work, solicitation, and sex work (Winter, 2009).

Transpeople in Asia experience stigma and discrimination in the forms of gender coercion, marginalization, and violence. Transgendered individuals opt not to disclose their gender identity to their families for fear of rejection, violence, or expulsion from their homes. Thirty percent of transgendered *pinays* (*transpinays*) believe that society rejects them, and that they are more vulnerable to verbal abuse, sexual harassment, violence, being called sinful, being called sexual perverts, or being called sick because of their gender identity variance (Winter, 2014). Sixteen percent of *transpinays* have thought of committing suicide more than once (Winter, 2014). Transpeople may also experience gender coercion from school authorities, and taunting and abuse from their peers. Forty percent of *transpinays* reported being rejected by their parents during their transition phase. School officials impose heteronormativity on gender variant students (Winter, 2009). These perceptions on transgenderism could make access to health care services for transgender individuals difficult.

Girl-Boy-Bakla-Tomboy (Garcia, 2013)

There exist no local terms for homosexuality, bisexuality, or heterosexuality. "Bakla" refers to the male homosexual. It also pertains to effeminate men who cross-dress. It should be noted that there is no Filipino term for transgenderism, as it is often conflated as being "bakla" (Macapagal, Ofreneo, Montiel, & Nolasco, 2013).

The use of the term "bakla" in modern times implies that a person is "confused" and/or "cowardly." Even the discourse pervasive in the Philippines remains largely heteronormative. Discourse revolves around the male/female dualism. The playground chant of "girl-boy-bakla-tomboy" showcases the hierarchy of genders in the Philippines—with male and female being the norm. "Bakla" and "tomboy" exist merely as subordinate genders (Garcia, 2013).

Interventions

Sex Reassignment Surgery

The American Psychiatric Association has identified guidelines towards a full sex transition (Barlow & Durand, 2014). The treatment starts from the less invasive methods such as conduct of psychological tests to use of hormones (Barlow & Durand, 2014). The final step is sex reassignment which is irreversible (Durand & Barlow, 2014). In the Philippines, sex reassignment surgery costs up to \$6,300, while breast implants

cost \$2,100. Recent figures report that breast implants now cost \$2,800, and \$7,100 for sex reassignment surgery. Because of these high costs, transwomen in the Philippines opt for the inexpensive yet common option—injecting silicone (Winter, 2009). Gender transitioning in Asia, especially Southeast Asia also involves the use of easily available hormones. Pharmacies in Thailand make available up to 20 products containing cross-sex hormones (Winter, 2009). Transpeople in the Philippines do not consult medical professionals when they use cross-sex hormones (Winter, 2009). Instead, transwomen who wish to transition obtain over-the-counter contraception pills from local health centers.

Psychotherapy is also employed to relieve psychological distress but its effects are temporary and ineffective unless sex reassignment surgery is done (Barlow & Durand, 2014).

The Case of Jennifer Laude

Laude was found lifeless on October 11, 2014 in a hotel bathroom. Investigations found that the cause of her death was asphyxiation through drowning. Developments pointed to US Marine Joseph Scott Pemberton as the suspect. Pemberton purportedly availed of sex services from Laude. Further fact-finding revealed that the murder of Laude was a crime of hatred because of Pemberton's discovery that Laude is a transwoman (Francisco, 2014).

Joaquin, Mangubat, Nepomuceno, and Romero (2015) compiled a total of 1,170 comments from news articles posted on Facebook about the murder of Laude. The researchers analyzed the comments through Foucauldian Discourse Analysis. Facebook comments constructed Laude as immoral. Commenters positioned Laude as a "deceiver," which justified Pemberton killing her because Laude failed to disclose her natal sex to him (Joaquin et al., 2015). Commenters positioned her as an adulterer to her fiancé Marc Sueselbeck. Social media comments also positioned Laude to be sexually promiscuous. She is therefore denied of sympathy for what had happened to her, and is made to feel ashamed for what she has altered in her body (Joaquin et al., 2015).

Another construction which emerged from the discourse analysis is that of Laude being "bakla" and/or "bayot." This shows the lack of knowledge and the lack of terms referring to transgenderism. These comments fail to acknowledge Laude's gender identity (Joaquin et al., 2015). There were also remarks on Laude as "mukhang pera" (greedy opportunist). Commenters position her as "baklang bayaran" (gay prostitute), "walang respeto sa sarili" (someone who has no self-respect), and "mababang-uri" (of low form) (Joaquin et al., 2015). Lastly, discourses of Jennifer Laude as "makasalanang" (sinful) emerged from Facebook comments. Many commenters positioned Laude as a sinner. This is because of a strong belief in the Catholic faith in Philippine culture (Joaquin et al., 2015).



Session area of The Victoria Clinic, a health and wellness center in Pasay City that caters specifically to the needs of transgender people.



Society of Transsexual Women of the Philippines
not all girls and women were assigned female at birth

Organizations such as STRAP (Society of Transsexual Women of the Philippines) provide support to transgender women in the country. According to STRAP, the organization “envisions a nurturing society that affirms, respects, and upholds the dignity, the right to self-determination, and good quality of life of all. The organization encourages all transpinays (transsexual Filipinas) to empower themselves and to live a life that inspires.”