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Gender Dysphoria and Islamic Perspectives: Navigating Faith and identity

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Abstract

Gender dysphoria is an increasingly recognized global phenomenon, yet its prevalence remains underreported due to stigma and lack of research, particularly in Muslim-majority societies. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) estimates that gender dysphoria affects 0.005% to 0.014% of individuals assigned male at birth and 0.002% to 0.003% of individuals assigned female at birth, though these figures likely underestimate the true prevalence. Within Islamic contexts, discussions on gender identity are often shaped by religious, legal, and cultural perspectives, leading to varied responses ranging from acceptance to complete denial.

This paper explores gender dysphoria through both medical and Islamic lenses, addressing biological, psychological, and sociocultural factors. It examines the complex interplay between faith and identity, highlighting how Islamic jurisprudence has historically acknowledged intersex individuals while showing ambivalence toward transgender identities. Key fatwas and legal rulings from different Muslim-majority countries illustrate the diverse approaches taken by Islamic scholars and governments regarding gender-affirming medical interventions.

Additionally, the paper discusses the significant stigma faced by transgender individuals in Muslim societies, where they often encounter discrimination, violence, and socioeconomic marginalization. While Western nations have made strides in legal protections and medical support for transgender individuals, the Muslim world grapples with reconciling traditional religious teachings with contemporary understandings of gender identity.
Ultimately, this article underscores the need for a nuanced approach that integrates medical advancements with theological considerations. Encouraging informed discussions within Muslim communities can foster greater awareness, reduce stigma, and ensure compassionate care for individuals experiencing gender dysphoria.

Introduction

Gender dysphoria is a condition characterized by a deep and persistent discomfort or distress due to a mismatch between an individual's assigned sex at birth and their experienced gender identity. Often the term transgender is used as well, this relates to a person who has taken on the gender identity not corresponding to their registered sex at birth. Gender dysphoria is recognized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as a condition that can lead to significant psychological distress, social

difficulties, and emotional struggles. While gender dysphoria itself is not classified as a mental disorder, the distress it causes can have profound mental health implications, including anxiety, depression, and suicidal ideation if left unaddressed.

In recent years, discussions surrounding gender identity have become more prominent globally. The prevalence of gender dysphoria is estimated to be between 0.005% to 0.014% for individuals assigned male at birth and 0.002% to 0.003% for individuals assigned female at birth, this figure from the DSM-V only reflects those who have attended a clinic and have been given a diagnosis of gender dysphoria. Hence these figures are likely underreported (Zucker et al 2017). In a 2016 CDC (Centre for disease control) survey found about 0.6% of U.S. adults identify as transgender. There has been a shift in approach since the DSM-5's rewording from "Gender Identity Disorder" to "Gender Dysphoria a move to help reduce stigma.

In the Muslim world, however, gender dysphoria remains a largely underexplored topic due to sociocultural stigma, legal restrictions, and religious debates. Many Muslim-majority societies hold strict gender binaries, which can create significant challenges for individuals experiencing gender incongruence.From an Islamic perspective, the discussion around gender and identity is deeply rooted in religious teachings, cultural traditions, and jurisprudential interpretations. Islam traditionally recognizes two primary sexes, and religious obligations, inheritance laws, and social roles are often structured around this binary framework. However, Islamic scholars and jurists have also acknowledged individuals who do not fit into these binary categories, such as intersex individuals (khuntha) and effeminate males (mukhannathun), and have historically provided legal and social guidelines for their integration into society.

The discourse surrounding transgender identity and gender dysphoria in Islam is complex and varies across different Islamic schools of thought. While some scholars argue that gender-affirming interventions contradict Islamic teachings on preserving one's natural form, others support medical transitions in cases of biological and psychological necessity. Countries such as Iran, Pakistan, and Egypt have issued religious fatwas permitting gender reassignment surgery under certain conditions, while others, like Saudi Arabia and the UAE, strictly prohibit such procedures for transgender individuals without intersex conditions.
This paper aims to explore the intersection of gender dysphoria and Islamic perspectives, focusing on the medical, psychological, and theological dimensions of the issue. It will examine Western medical treatments, analyse Islamic jurisprudential views, and discuss the challenges faced by transgender individuals in Muslim-majority societies. The goal is to provide a nuanced understanding of how gender dysphoria is perceived, treated, and debated within the framework of Islamic faith and identity.

Stigma

While theological interpretations and legal frameworks shape the discourse on gender identity in Islam, the everyday experiences of transgender individuals in Muslim-majority societies tell a different story. Beyond religious doctrine, deeply ingrained cultural stigmas, social exclusion, and systemic discrimination create significant challenges for those navigating gender dysphoria. In many communities, public discussion on gender variance remains taboo, leading to marginalization, limited healthcare access, and heightened mental health struggles for affected individuals. Understanding the impact of stigma and societal attitudes is crucial to grasping the full complexity of gender dysphoria within the Muslim world.

Data from numerous contemporary western studies have shown that transgender individuals have been abused, stigmatized, bullied and have been victims of prejudice both overtly and covertly. The 2011 National School Climate Survey conducted in the USA reported that as many as 90% of the transgender students had suffered harassment, and 25% had experienced physical assault merely because of their gender expression. However, gender dysphoria awareness is growing in Western countries. They are opening up to transgender individuals and talking about the issues that transgender communities face. Western societies have begun instituting rapid sociopolitical reforms in favour of transgender rights and medical assistance is freely accessible to those opting for gender-affirming surgery in line with their gender expression (National Gay and Lesbian Task Force 2008, Reisner et al. 2015a).

Although gender dysphoria has been contested globally, it is challenged to a greater extent in the Muslim world and is a culturally sensitive topic. Juristic debates aside, the lived reality of transgender individuals in Muslim societies is shaped by social attitudes and stigma. A literature review carried out by Taslim et al (2021) discovered that social and economic statuses of transgender individuals are a cause for concern in some

Muslim countries such as Malaysia, Indonesia, and Pakistan. They are marginalised, stigmatised and live in poverty. They are victims of violence, neglect and lack of education, healthcare and employment opportunities (Gibson et al. 2016, Saeed et al. 2018, Shah et al. 2018). Furthermore, transgender individuals in Pakistan reported depression, isolation, violence, and rejection in families and from society and their communities. Such experiences raise their lifetime risk of anxiety, depression, and suicidal ideation to higher levels than in the general population (Faiza et al 2024). Research has demonstrated familial rejection as one of the largest stressors, most of the transgenders are rejected or kicked out of their homes, thereby becoming homeless and economically helpless (Brennan et al., 2017). There is minimal or no representation of transgender individuals from Arab nations or the rest of the Muslim countries indicating avoidance or lack of attention on transgender matters in these countries.

Additionally, high prevalence of human immunodeficiency virus and other sexual transmitted diseases among local transgender individuals in these developing countries further stigmatises them and is also a major public health issue that has raised international concern (Akhtar et al. 2012, Wong 2012, Gibson et al. 2016, Barmania&Aljunid 2017, Vijay et al. 2018, Akhtar et al. 2020, Robbins et al. 2020)

Scientific Explanations of Gender Dysphoria

Beyond societal perceptions, scientific research has sought to understand the origins of gender dysphoria through biological, genetic, and psychological lenses. While stigma and cultural opposition persist, emerging evidence from neuroscience and endocrinology suggests that gender identity is influenced by complex biological and environmental factors.

The aetiology of gender identity remains elusive. There are no definitive extrinsic or intrinsic stimuli or motivators identified that can fully explain why transgender individuals are as they are.This uncertainty about transgender aetiology has caused scepticism about its legitimacy and is the root cause of the universal debate and controversy that surrounds it. However, transgenderism has gained huge media attention, public interest, and awareness over the last 2–3 decades, at the global level. During this time, academic literature and multi-disciplinary research output on this subject have also increased exponentially to highlight the social, economic, behavioural, and health aspects of the transgender community.

Biological factors

The presentation of gender dysphoria has been considered as a complex interaction of genetic, hormonal, and environmental factors. There may also be some evidence of differences in brain development and physiology. Twin studies have implicated a genetic role in the formation of gender identity with additional environmental contributors. In a large-scale CBCL study of Dutch twins (N=23,393) aged 7 and 10 (Coolidge et al, 2002), monozygotic (MZ) and dizygotic (DZ) twins were compared; genetic factors contributed to 70% of cross-gender behaviour (as assessed via the two CBCL gender items). Another study of 314 monozygotic (MZ) and dizygotic (DZ) twins (mean ages 9.4 and 10.1 years, respectively) roughly replicated this finding, with genetic factors contributing up to 62% of the variance on a DSMIV-based gender dysphoria scale (Coolidge et al, 2002). In animal studies, where prenatal hormones can be manipulated, the strong effect of prenatal testosterone on gender role behaviour is clear (Hines, 2011). Individuals with a disorder of sex development may be exposed to high levels of prenatal testosterone, and individuals with two X chromosomes with congenital adrenal hyperplasia (Merke& Bornstein, 2005) do have higher rates of gender dysphoria and cross-gender identification (Pasterski et al, 2015). However, the majority of female-raised individuals with congenital adrenal hyperplasia (CAH) (95%), appear to develop a female gender identity (Dessens et al, 2005). Other evidence for the importance of prenatal testosterone comes from studies in XY individuals with complete androgen insensitivity syndrome who lack the receptors necessary to respond to endogenous testosterone. The vast majority of these patients develop a female gender identity, suggesting that downstream testosterone signalling may be important for the development of a male gender identity (Hines, 2015). Some have noted that these patients were reared unambiguously as females and that social factors may have played a strong role in their female identity formation (Hines, 2009). Some studies have shown that those with complete androgen insensitivity syndrome have lower scores on female identity scales (Richter-Appelt et al, 2005) and there are case reports of gender dysphoria ultimately leading in these patients to gender affirming surgeries (T'Sjoen et al, 2011). This could be secondary to the psychological stress of learning about the diagnosis, as well as the possibility of undetected functional androgen receptors (Steensma et al, 2013a). Overall, studies of gender identity in individuals with disorders of sex development, while implicating androgens in the development of gender identity, have yet to show a direct relationship.

Psychosocial factors

There have been no proven psychosocial factors in the development of gender identity. Mothers of gender dysphoric boys have been noted to have higher scores on the Beck Depression Inventory and the Diagnostic Interview for Borderlines (Marantz & Coates, 1991), but these higher scores might be due to external pressures placed on these parents by unaccepting social environments and such studies cannot determine the direction of causation. One study noted that gender dysphoric boys were rated as more feminine and "beautiful" by blinded college students (Zucker et al, 1993), while another study of gender dysphoric girls showed that these girls were rated as less "cute" (Fridell et al, 1996), raising the question of whether perceived physical appearance and resultant social treatment may contribute to gender incongruence.

Cultural factors

Culture plays an important role in the gender determination of patients with atypical somatic sex development (Kuhnle&Krahl, 2002; Meyer-Bahlburg, 1998). Cultural influences may contribute to patients with Disorders of Sexual Development (DSD) and their families' acceptance or rejection of their assigned gender, to the psychosexual development of the patient, and medical management. There are reports from several countries such as Saudi Arabia (Taha, 1994), Turkey (Özbey, Darendeliler, Kayserili, Korkmazlar, & Salman, 2004), and Egypt (Zainuddin and Mahdy 2016) that indicate increased rates of assignment to the male gender regardless of karyotype, gonadal makeup, and fertility potential, because the male gender has a dominant role in society and is thus the preferred sex. In India and Pakistan, DSD children are more likely to be raised as males simply in order to ensure a better future for these children when they grow up (Warne & Raza, 2008). Even if they are infertile as males, they are more likely than infertile females to achieve economic independence.

Gender identity and Autism

People who do not identify with the sex they were assigned at birth are three to six times as likely to fall on the autistic spectrum compared to cisgender (denoting or relating to a person whose gender identity corresponds with the sex registered for them at birth) individuals according to the largest study yet to examine the connection (Warrier et al 2020). Gender-diverse people are also more likely to report autism traits and to suspect they have undiagnosed autism. A number of studies show that autism spectrum disorder (ASD) symptoms are over-represented among transgender individuals. Autistic females seem to experience this more than Autistic males (Cooper et al 2018). The rate of ASD among the general population is estimated at around 1% (Lai et al, 2014). Clinical level rates of ASD symptomatology in transgender adults have been reported in 5-20% (Jones et al, 2012; Pasterski et al, 2014; Pohl et al, 2014). Although to date definitive findings have not been shown.

Gender Identity and Islam

As scientific research continues to uncover the underlying mechanisms of gender dysphoria, these findings raise important theological and ethical questions. How do Islamic teachings reconcile the existence of gender dysphoria with religious doctrines on gender and creation? The following section explores how Islamic scholarship has historically addressed gender variance and how contemporary scholars interpret these developments.

Historically, Middle Eastern, North African and European cultures recognized and had terms for transgender individuals. This includes "hijra" in subcontinent, "Mukhannath" in Islam and Arabic cultures, "Phrygia" in ancient Greek, and "Cybele" in ancient Roman. These individuals were often intersex people or natal males castrated for religious or other reasons. It is important to note that the recognition did not necessarily protect these individuals from stigma and marginalization, and in some places like the subcontinent, Hijras, although believed to have power to remove a "bad spell" from newborns, were highly stigmatized. Meanwhile there have been new movements to support and protect transgender individuals in this region. The Rights of Transgender Persons Bill, which provisions anti-discrimination and employment for transgender individuals, was introduced in 2014 in India; it may result in positive changes in the future.

The traditional gender binary constitutes an integral aspect of Islamic social ethics, which has a pivotal role in shaping religious obligations, legal proceedings, and interpersonal judgments within Muslim communities. Within the familial sphere, this gender binary underscores fundamental responsibilities encompassing parenthood, filial duties, and inheritance rights.

Unlike gender dysphoria, intersex individuals have a clearer standing in Islamic law. Intersex are individuals who have reproductive or sexual anatomy that doesn't fit

into an exclusive male or female classification. Out of every 1000 to 4500 births, approximately one case involves the presence of atypical genitalia, previously referred to as ambiguous genitalia (Congress House Report, 2023). Besides ambiguous genitalia, other disorders of sex development (DSDs) also include genetic conditions such as Klinefelter or Turner syndrome that rarely present ambiguous genitalia (Nowotny&Reisch, 2023). DSDs are not restricted to medical discussions, but their psychosocial aspects have also attracted much attention from gender and sexuality researchers, who have also investigated the religious aspects, such as in the field of Islamic jurisprudence
It is agreed that the Quran unequivocally states that there exist two biological sexes. This distinction is fundamental to the Shariah, permeating various aspects of life and articulated in the chapters of Islamic juristic texts from the chapter of cleanliness (taharah) to matters of inheritance (mirath), each gender carrying its own set of rights and responsibilities. It is essential to understand that gender dysphoria, the feeling that one's biological sex does not align with their gender identity, is recognized in Islam as a valid emotional experience. Within these variations, one can categorize individuals. as intersex (khuntha), effeminate (mukhannath), or masculine women (Mutarajjilah). Notably, Islamic jurisprudence (fiqh) literature addresses these distinctions by assigning distinct legal regulations to each of these categories (Haneef, 2011) Shariah respects the complexity of human emotions and identities but underscores the significance of adhering to established gender roles and distinctions, recognizing that human beings are multifaceted and that not every feeling should lead to action (Fiqh Council of North America, 2022). In fiqh, the matters concerning intersex and transgender individuals are typically considered exceptional cases, as they involve atypical sexual development and ambiguity in biological sex recognition, which fall outside the norms and generally perceived notions discussed in the Quran and ḥadith.

Further exploration of how these were described and managed historically are found in the following definitions. Khuntha (hermaphrodite/intersex) refers to an individual who either does not have male and female genitalia or has both (Al-Kasani, 1986). Al-Nawawi (1991) classified hermaphrodites into two distinct groups: (1) those with ambiguous or problematic genitalia (khunthamushkil) and (2) those with non-problematic or unambiguous genitalia (khuntha ghayr mushkil). The latter group includes individuals with both male and female genitals, yet their social/legal gender assignment is typically based on the genitalia with more predominant functionality. In contrast, the former group includes individuals who do not conform to the conventional binary gender classification because their genital organs may be either fully functional or non-functional, but they have an alternative anatomical structure for excretion.

In a report from Sunan al-Darimi, Ali ibn Abi Talib, companion of the Prophet (PBUH) and the fourth Caliph, was asked about the inheritance rights of an intersex person, specifically regarding whether their inheritance should be determined based on their male or female characteristics. His response was, "according to how they urinate" (Book 21, Hadith 2880). This tradition appears to have fixed the benchmark of social/ legal gender assignment in the case of khuntha. Classical Muslim jurists recognized the social/legal gender of Khuntha based on the functioning of urinary orifices and also by the signs of puberty as a secondary option.

Additionally, in cases where no conclusive biological indicators were present, these jurists considered feelings or sexual attraction as a means to determine social/legal gender (Collier et al 2013). Following progress in medical technology, the above-mentioned criteria of social/legal gender assignment have been updated and “the distinction today should be between a ‘real hermaphrodite’ (who has both testicles and ovaries) and a ‘pseudo-hermaphrodite’ (khuntakadib), who is born with either ovaries or testicles but has external sexual characteristics that are different from those expected when looking at the gonads” (Tolino, 2018, p. 233). With the aid of modern medical tests and scientific advancements, it has become possible to recognize the biological sex of intersex individuals with greater precision. This can be achieved through examinations to identify the presence of internal structures such as testicles or ovaries, sex chromosomes, the womb, fallopian tubes, and other characteristics that may not be externally visible.

Social/legal gender assignment of intersex individuals can also be based on psychosocial studies, which demonstrated that some disorders of sex development arising from specific genetic conditions predispose individuals to identify more predominantly with one particular gender. For example, in the case of individuals with 46, XX CAH (congenital adrenal hyperplasia) with Prader stage 4 or 5, assignment to the female gender at birth appears justified even in severely masculinized cases whereby the intact and functional clitorophallus is commonly surgically reduced, because of a much higher incidence of serious gender identity problems among

those raised as males compared to those raised as females (Dessens et al., 2005). Nevertheless, for such individuals raised as females who develop gender dysphoria later in life, as reported by the case study of Zainuddin and Mahdy (2017), gender reassignment may be considered. For individuals with 46, XY CAIS (complete androgen insensitivity syndrome), assignment to the female gender at birth is justified by the relatively low incidence of gender dysphoria (1.7%) among those raised as females (Babu& Shah, 2021), even though the testes may be fully functional but are often removed. By contrast, for individuals with 46, XY 5-alpha reductase deficiency who were raised as females, there was a significantly higher incidence of gender dysphoria (53%), which made gender assignment at birth much trickier (Babu& Shah, 2021).

Mukhannath (effeminate male) is indirectly referred to in the Quran by the term ghayr uli al-Irbah (This term also refers to old men and those with low IQ who have lost any sexual desire) which literally means “male attendants free from sexual desire” in Surah al-Nur: 31 (al-Qurtubi, 2003). Mutarajjilah is the corresponding term to Mukhannath which refers to a masculine woman. Efeminate male (Mukhannath) refers to those who are anatomically male but exhibit female traits like gait, speech, dressing, and posture (Haneef, 2011). The masculine woman (Mutarajjilah) is vice versa. Regarding Mukhannath, a ḥadith reported by Ummu Salamah gives some important insights. She said, "When the Prophet (PBUH) was with her, there was an effeminate man in the house. The effeminate man said to Ummu Salama's brother, ʿAbd Allah ibn Abi Umayyah, if Allah should make you conquer Taif tomorrow, I recommend that you take the daughter of Ghailan (in marriage) for (she is so fat) that she shows four folds of flesh when facing you and eight when she turns her back. Thereupon the Prophet (PBUH) said (to us), this (effeminate man) should not enter upon you (anymore)" (Al-Bukhārī, 1987). This ḥadith portrays two aspects of the treatment of Mukhannath. Firstly, Mukhannath was identified along with their distinctions, generally accepted in so far as they were permitted to mingle with females in a society where gender segregation was a predominant social norm (Mohamad Rusli&Azmi, 2021).

It must be the Prophet (PBUH)'s tacit approval for mukhannath as a special case, giving them freedom of interaction with women (Tolino, 2018). But, once they were noticed as describing women with intimate details that were likely to arouse erotic feelings in a man, they were banished.

Contrasting Healthcare Approaches: West vs Islam

Available treatments

Given the diverse Islamic perspectives on gender identity, the question of medical intervention remains a subject of debate. In Western contexts, gender dysphoria is typically managed through a combination of psychological support, hormone therapy, and surgical options. However, these treatments raise theological and ethical concerns within Islamic discourse, particularly regarding bodily modification and the notion of altering God's creation.

The approaches to treating gender dysphoria in the West and the Islamic world differ significantly due to variations in medical, psychological, socio-cultural, and religious perspectives. The West has developed a structured medical framework for gender-affirming care, whereas Islamic perspectives, influenced by religious jurisprudence, show a spectrum of responses ranging from acceptance to prohibition.

In Western societies, treatment for gender dysphoria has evolved into a multi-faceted approach that includes medical, psychological, and surgical interventions. Psychological therapy plays a critical role in supporting transgender individuals before and after transitioning.Gender identity clinics offer counselling, voice training, and peer support to help individuals cope with dysphoria.Social transitioning, such as changing names, pronouns, and appearances, is encouraged as a non-invasive step.

Medical interventions for gender dysphoria range from hormonal treatments to moreinvasive surgical procedures. Oestrogen is given to transgender women to induce feminization.Testosterone is given to transgender men to induce masculinization. Hormonal interventions have been linked to improvements in mental health and quality of life, reducing depression and anxiety. Puberty blockers were previously used to delay puberty for transgender youth, allowing them time to explore their identity before making irreversible changes. This has been severely restricted in the UK pending safety reviews since 2024due to concerns over safety and long-term outcomes, but is still available in some parts of the US and Europe.

Lastly, surgical interventions include top surgery which involves breast removal for trans men or augmentation

for trans women and bottom surgery which involves genital reconstruction surgeries such as vaginoplasty or phalloplasty. Other procedures are facial feminization/masculinization which involves procedures to alter facial features.The effectiveness of surgeries in improving quality of life is debated, with some studies showing improvements while others highlight risks such as regret or medical complications.

Evidence So far

A growing body of evidence suggests that medical interventions can significantly improve mental health outcomes for gender dysphoric individuals. Studies show notable improvements in anxiety, depression, and overall quality of life (Costa & Colizzi, 2016; Nguyen et al., 2018; Rowniak et al., 2019).Hormone therapy has been linked to better psychosocial well-being and mental health resilience. Surgical procedures have been found to enhance quality of life, particularly for transgender men (Defreyne et al., 2017; Passos et al., 2020) and transgender women (Zagami et al., 2019).Most studies indicate no immediate post-operative mental health improvements, but significant benefits emerge after more than six months.Some research suggests a ceiling effect, where prior hormonal therapy already improves mental health, limiting the additional gains from surgery. The quality of studies varies from medium to weak, often due to small sample sizes, high risks of bias, and lack of control for confounding factors (Baker et al., 2021; Dhejne et al., 2016).There is a lack of qualitative research capturing the personal experiences of gender dysphoric individuals before and after medical interventions.

For some gender dysphoric individuals, medical interventions may not be necessary or available. Alternative interventions include gender-affirming psychotherapy. This provides a supportive environment to explore gender identity (Austin & Craig, 2015).Peer-support groups help individuals build resilience and reduce isolation. Other non-medical strategies can also help manage gender dysphoria, including:Breast binding (for transgender men), genital tucking (for transgender women), body sculpting exercises and voice and communication therapy. There is little research on the mental health impact of these non-medical interventions.No known systematic reviews examine their effectiveness in reducing gender dysphoria.
Even with medical and non-medical interventions, mental health outcomes for gender dysphoric individuals depend on broader social factors.Peer-support networks, community connectedness, and safe spaces play a critical role in mental health resilience (Matsuno& Israel, 2018; Pflum et al., 2015; Puckett et al., 2019). The use of chosen names by family members is associated with reduced depressive symptoms and suicidal ideation (Russell et al., 2018).Having role models and supportive online communities contribute to better mental health outcomes (Pilecki, 2015).Post-surgical psychosocial well-being improves when individuals receive strong social support (Schultz, 2002).Furthermore, recent research suggests that the presence of autism spectrum disorder (ASD) is higher among transgender individuals (Thrower et al 2020), raising questions about informed consent and decision-making capacity.

There is a need for high quality research and rigorous, prospective studies measuring pre- and post-intervention outcomes.Future reviews need to examine all types of interventions, including medical, psychotherapeutic, social, and adaptive strategies.Research should also focus on the relative effectiveness of different interventions on mental health outcomes.Addressing gender dysphoria alone may not be sufficient to improve mental health.Social, psychological, and structural factors must also be considered.

This evidence so far highlights the positive impact of gender-affirming medical interventions while emphasizing the importance of social support and alternative interventions. It also underscores the gaps in current research, particularly the need for higher-quality studies and qualitative research. A holistic approach that integrates medical, psychological, and social support systems is crucial for improving mental health outcomes in gender dysphoric individuals.

Islam

Islamic perspectives on gender identity are more complex and vary across different schools of thought. The approach to treatment largely depends on whether gender dysphoria is considered a valid medical condition or a social/religious issue.

Traditional Islamic texts recognize intersex individuals (Khuntha) and have legal frameworks for their social inclusion.The concept of transgender identity (Mukhannath) existed historically but was often linked to eunuchs or those with ambiguous biological traits.There is a clear divide in Islamic rulings:Permissive Stance (Shia View):Iran allows gender-affirming surgeries based on Ayatollah Khomeini's 1987 fatwa.The Iranian government provides financial aid for transgender individuals to transition.Restrictive Stance (Sunni

View):Countries such as Saudi Arabia, Egypt, and the UAE prohibit gender transition unless the individual has a disorder of sex development (DSD).Fatwas from Sunni scholars emphasize the immutability of biological sex, discouraging transitions based on gender identity alone. Lastly, there is the conditional stance (some Sunni scholars):Some scholars, such as Sheikh Tantawi of Egypt, have allowed surgeries if they are medically justified by a doctor.

Mental health support for gender dysphoric individuals is minimal due to stigma and a lack of medical recognition.Social rejection is high, with many transgender individuals facing economic hardship, homelessness, and violence.Unlike in the West, where gender clinics exist, Muslim-majority countries often lack formal institutions to support gender-diverse individuals.Hormone therapy is rarely provided unless medically justified by a diagnosed intersex condition.Gender reassignment surgery is mostly illegal or inaccessible, except in Iran.Alternative approaches include religious counselling and psychotherapy, often aimed at discouraging transition rather than affirming gender identity.

In managing Muslim patients with disorders of sex development (DSD), clinicians should not focus purely on the medical and psychological aspects, but also recognize the religious aspects in communities where religion plays a large part in the daily lives of the individual and the family (Al Jurayyan, 2011; Dessouky, 2001; Warne & Raza, 2008): “The clinician’s role is not to superimpose her/his cultural values on those of others, but to come to a decision that likely minimizes potential harm to the patient in his/her cultural environment” (Meyer-Bahlburg, 2001). The Muslim DSD patient may be living in a community where the Muslim culture is not dominant in which case the Islamic aspects of gender-related issues may not be recognized or considered unless the patient his/herself or the family or the clinician are aware of these and bring it up for consideration.

There is a disparity in Islam on how gender dysphoria and DSD are managed, it would make sense to include a religious authority in the multidisciplinary team that manages these patients in Islamic countries. As many decisions made in the course of the clinical management of individuals with gender dysphoria and DSD affect the religious aspects of life and, therefore, the outcome of the individual patient, their families, and the community. It will be helpful to consider both the religious authorities and medical experts to cooperate with and educate each other about the various aspects of care of the patient with gender dysphoria/DSD. The confidentiality of information exchanged with regard to the patients and their families is highly important, keeping in mind that the aim is the achievement of optimal outcome for the patient and families living in still quite stigmatising societies

Persistence of Gender Dysphoria from Childhood to Adolescence

A key consideration in the medical and religious discourse on gender dysphoria is whether the condition persists from childhood into adulthood. Some Islamic scholars argue that early signs of gender dysphoria may be temporary and, therefore, should not warrant irreversible medical interventions. However, longitudinal studies suggest that while some children may desist, others continue to experience gender incongruence well into adulthood

Follow-up studies have classified participants as either “persisters” or “desisters” with regard to gender dysphoria using various metrics (semi-structured interviews based on DSM criteria for gender identity disorder, dimensional scores on standardized questionnaires, etc.). A 10-year follow up study (Ristori and Steensma 2016) summarized and reported that the percentage of participants classified as persisters ranged from 2% to 39% (collapsed across natal boys and girls). In one study (Wallien& Cohen-Kettenis, 2008), the percentage of natal girls who were “persisters” was substantially higher than the percentage of natal boys (50% vs. 12%), but in two other studies from the same clinic the percentage was similar across natal sex (Drummond et al, 2008; Singh, 2012). A criticism of these studies is that either formal diagnostic criteria were not used or that subthreshold cases were included. These subthreshold cases may have included individuals with cross-gender interests or behaviours who did not actually identify as transgender. Hence these patients did not identify as transgender at follow-up. Some studies have found that threshold cases were more likely to be classified as persisters (Steensma et al, 2013b), but other have not (Singh, 2012).

It has also been suggested that more recent cohorts (after the year 2000) have found higher rates of persistence (12% to 39%) (Zucker& Bradley, 1995; Wallien& Cohen-Kettenis, 2008; Drummond et al, 2008; Singh, 2012) than older cohorts (2% to 9% prior to 2000) (Green, 1987; Zucker et al, 1999), suggesting that, as society becomes more accepting of these individuals,

fewer report "desisting," which may represent going back into the closet due to social pressures rather than a true desistence of cross-gender identification. Comparisons of persisters with desisters have found that the intensity of gender dysphoria (using dimensional metrics), older age at the time of assessment in childhood, a lower social class background, and having a female gender assigned at birth are associated with higher rates of persistence (Steensma et al, 2013).

Despite this work, it remains difficult to predict the likelihood of cross-gender identification persistence from childhood into adolescence for an individual child (Steensma et al, 2013). Persistence of gender dysphoria from adolescence to adulthood in contrast to the low rates of persistence from childhood into adolescence, it seems that the majority of transgender adolescents persist in their transgender identity (Cohen-Kettenis&Pfäfflin, 2003). In a study of 55 transgender adolescents receiving gender affirmative care, 100% continued to identify as transgender in young adulthood (deVries et al. 2014). Larger longitudinal studies such as this are needed. Childhood Gender Variant Behaviour and Sexual Orientation Childhood gender variant behaviour has been found to be a strong predictor of a same-sex sexual orientation in adulthood (using gender assigned at birth as a reference point). In a study of 879 Dutch boys and girls, gender variant behaviour was assessed using the Child Behaviour Checklist (CBCL) and sexual orientation was assessed 24 years later (Steensma et al, 2013c). It was found that the prevalence of a same-sex sexual orientation was, depending on the domain (attraction, fantasy, behaviour, and identity), between 8.4 and 15.8 times higher in the gender variant subgroup as compared to the non-gender-variant subgroup.

In summary, the current literature, though limited, suggests that the majority of gender nonconforming pre-pubescent children will grow up to endorse identification as cisgender individuals with either a bisexual or a same-sex sexual orientation (Wallien& Cohen-Kettenis, 2008; Singh et al, 2021; Green, 1987).

Two main contemporary fatwas that were issued to do with gender dysphoria.

The first one was by a Sunni Mufti of Egypt, Tantawi. This was following the case of a male patient who experienced gender dysphoria affecting his mental health. The psychologist treating him referred him for sex reassignment surgery. The surgeon referred him for a second opinion to another psychologist who concurred that he needed sex reassignment surgery to treat his depression. The patient then addressed herself as female.The medical university he was studying at didn't accept his new gender. This case was eventually brought to Tantawi. He satisfied all criteria in making an ijtihad, by first referring to the scriptures (Quran and Hadiths) before moving to the second stage: doing ijtihad through his opinion (ray) and analogy (qiyas) (Alipour 2017). As a Sunni scholar under the Shafii school of thought, Tantawi followed this legal school in resorting to ijtihad by only doing it if: a) one has sufficient knowledge and skill to first return issues into Quran, Hadiths, and a consensus of Muslims; when these sources are found not to deal sufficiently with certain topics, one may then return the cases involved to qiyas or analogy (Al-Shafii, 1938). Transwomen did not nominally exist during the Prophet (PBUH)'s time, hence resulting in this ijtihad decision. In Alipour's work, the explanation of the Tantawi fatwa is clarified: Based on Al-Tabari's understanding of the Hadith, Tantawi acknowledged that the Prophet (PBUH) did not forbid the hermaphrodite and mukhannath from entering the women's quarters until he heard them giving a description of the women in great detail. Tantawi thus concludes that the person who is naturally a hermaphrodite or a mukhannath is not to be blamed but, as s/he has a disease, s/he must be cured. Tantawi, however, excludes persons who are not mukhannath by nature.

The second main fatwa issued was by Khomeini. This was prompted again by a male who felt like a female and started dressing up like one. He personally took his case to Khomeini who then after consulting 3 medical doctors gave the fatwa. He did not cite the Quran or Hadith sources that influenced him in making his fatwa. However, he used a similar ijtihad method within the Shia context. He applied the ijtihad method of al-Qawaid al-Fiqhiyyah (Islamic legal maxims) and al-Usul al-Amaliyyah (procedural principles) because there is nothing in the scriptures, Quran, or hadiths that clearly refers to being transgender (Alipour, 2017). There are two legal maxims through al-Qawaid al-Fiqhiyyah that Khomeini used in making the decision. Firstly, the "principle of permissibility" (isalat al-ibahah) and secondly, the "principle of lawfulness" (isalat al-hillyyah), support the Shi'a belief that everything, or every action, that cannot be clearly regarded as being forbidden or permissible in Islam, is permitted and lawful (Alipour, 2017).These general maxims are also in line with the Islamic jurisprudence principle of "necessity overrides prohibition", as long as those things or actions are not clearly prohibited in conventional Islamic sources.

One of the points of difference between the fatwas is that Khomeini's fatwa on gender-affirming surgery was more insistent in getting a medical doctor's permission, it states "In the Name of God sex-reassignment surgery is not prohibited in sharia law if reliable medical doctors recommend it. Inshallah you will be safe and hopefully the people whom you had mentioned might take care of your situation" (cited in Alipour 2017).

Alipour concludes his explanation of Tantawi's fatwa when he states:"To sum up: It is permissible to perform the operation in order to reveal what was hidden of male or female organs. Indeed, it is obligatory to do so on the grounds that it must be considered a treatment, when a trustworthy doctor advises it. It is, however, not permissible to do it at the mere wish to change sex from woman to man, or vice versa (2017, p. 97)".

Both Tantawi and Khomeini, in issuing the fatwa, have explained the Islamic jurisprudence principle "necessity overrides prohibition", in which a gender transition through gender affirming medical intervention(s) can be accepted as it becomes permissible given the desperate need of transgender individuals as part of a medical remedy (Alipour, 2017; Barmania&Aljunid, 2017). In recent times, this has been extended to include social welfare to support freedom, human dignity and human fraternity (Al-Qaradawi, 1999), fundamental rights and liberties, economic development, as well as research and development in science and technology (Kamali, 1989). One view point for surgical treatment for gender dysphoria as stated by Sarcheshmehpour et al. (2018) in their conclusion: "they should not be prohibited according to Islamic ethics and their surgical treatment should not be considered as a manipulation of Allah's creation".

On the other hand, the Fiqh Council of North America (FCNA) has addressed the topic of transgender individuals in a comprehensive fatwa authored by Dr.YasirQadhi. The fatwa emphasizes the Quranic perspective that humanity is created from a male and a female, underscoring a fundamental gender binary. It acknowledges that while feelings of gender dysphoria might be beyond one's control and are not sinful if not acted upon, Islam distinguishes between feelings, actions, and identity. The fatwa explicitly prohibits cross-dressing and any deliberate attempt to appear as the opposite gender. Regarding gender reassignment, the FCNA deems it impermissible to actively attempt to change one's biological sex or gender through medical interventions, except in cases involving intersex individuals which has a clearer ruling.

Conclusion

The intersection of gender dysphoria and Islamic perspectives presents a complex and evolving discourse that requires careful consideration of medical, psychological, theological, and social factors. While gender dysphoria is now well-documented in medical literature and recognized as a legitimate condition requiring compassionate care, its acceptance and management within Islamic jurisprudence remain a subject of ongoing debate.

Islamic teachings uphold the binary framework of gender, which forms the basis for religious obligations, inheritance laws, and social roles. However, classical Islamic scholarship has historically acknowledged intersex individuals (khuntha) and effeminate males (mukhannathun), offering specific legal rulings for their inclusion in society. The more recent discourse on transgender identity has led to divergent fatwas, with some scholars permitting gender-affirming medical interventions as a form of treatment, while others strictly prohibit elective transitions as an alteration of God's creation.

Across the Muslim world, transgender individuals continue to face social stigma, discrimination, and legal restrictions, leading to mental health struggles, economic hardships, and societal exclusion. Some countries, like Iran and Pakistan, recognize transgender rights to varying degrees, while others, like Saudi Arabia and the UAE, impose legal and religious barriers against gender transition. The lack of open discussion and safe spaces further exacerbates the challenges faced by those experiencing gender dysphoria within Islamic communities.

From a medical perspective, gender-affirming treatments such as hormone therapy and surgery have been shown to improve the mental health and well-being of transgender individuals. However, recent shifts in Western medical policies, particularly the increasing scrutiny of hormone therapy for minors, indicate that the field is still evolving. Islamic medical ethics must engage with these developments to ensure that any intervention aligns with both scientific evidence and religious considerations.

Moving forward, it is crucial for Islamic scholars, healthcare professionals, and policymakers to engage in compassionate, evidence-based discussions on gender dysphoria. A more nuanced, interdisciplinary approach, one that integrates faith, science, and mental health awareness, can help foster greater understanding, reduce

stigma, and provide practical guidance for those navigating gender dysphoria within the framework of Islamic beliefs.

Ultimately, as society continues to evolve, there is an opportunity for Islamic perspectives on gender identity to be revisited with greater emphasis on human dignity, justice, and compassion- principles that are deeply rooted in Islamic tradition

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Appendix

Fatwa From Saudi Arabia

Al Jurayyan (2011), a Professor of Paediatrics from King Saud University, Saudi Arabia, presented a set of guidelines or recommendations on this issue based on the current Islamic fatwas put forward by the senior ulama council in Saudi Arabia and the experiences of medical practitioners in Saudi Arabia (Abdullah et al., 1991; Al Herbish et al., 1996; Al Jurayyan, 2011; Couch, 1987). These fatwas are translated as follows:

1. A sex change operation [in a non-DSD individual] is totally prohibited and considered to be criminal in accordance with the Holy Quran and the Prophet PBUH's sayings.
2. Those who have both male and female organs require further investigation and, if the evidence is more suggestive of a male gender, then it is permissible to treat the individual medically (i.e., with hormones or surgery) in order to eliminate the ambiguity and to raise him as a male and vice versa.
3. Physicians are required to explain to the child's guardians the results of the medical investigations and whether the evidence indicates that the child is male or female in order to keep the guardians well informed.

Al Jurayyan (2011) stated that the dominant role of the male gender in the Muslim community should not overrule Islamic laws, and he emphasized that these laws should not be ignored and be given due consideration.

Fatwa From Malaysia

There have been several fatwas produced by the Fatwa Committee of the National Council of Islamic Religious Affairs Malaysia regarding the permissibility of genital reconstruction surgery in patients with DSD.16 The most recent one from November 2006 is formulated as follows:

1. For those with 46,XX CAH reared male, gender reassignment surgery to get back to the previous gender that is female is permitted in Islam because it can be treated by hormone treatment and surgery.
2. For those with 46,XY AIS reared female, getting back to the male gender through surgery or hormone treatment is quite difficult. If the patient intends to undergo surgery, it is permitted, provided that the surgery does not harm the patient psychologically or biologically.
3. For those with 46,XY AIS reared female, but diagnosed only after the person has already grown up, the person can continue a normal life and the gender is recognized from his/her [body build] and the [appearance] of the genitalia. Surgery to remove the testes (if any) is permissible to prevent the risk of cancer. The marriage of a man with a female spouse who suffers from 46,XY AIS does not need to be dissolved.
4. Medical specialists should provide explanation and advice to Muslim individuals who are affected by CAH and AIS and their parents to undergo treatment in a way that avoids any difficulties with religious regulations.

Fatwa From Egypt

As Dessouky (2001), a pediatric surgeon from Egypt, states, "All juristic religious opinions (fatwas) concerning the change of sex in a totally feminine or masculine human being with no physical abnormalities in his body (only due to the refusal of the person to accept his natal sex, i.e., in a transsexual) state that it is a religious doctrinal crime, as it changes 'what God has created'." He continues that these fatwas decreed that if both masculine and feminine characters are detected in a person (such as in a person with a DSD), the doctors should determine which characteristics are dominant and remove any other characteristic that may cause "suspicion" to achieve the best outcome for the person. Dessouky points out additional important issues in the management of Muslim patients with DSDs that still require decisions from the religious authorities, including the following:

1. which characteristic, i.e., chromosomes, gonads, phenotype, or appearance and function of the external genitalia, is the best criterion to determine whether a person is male or female;
2. the legality of performing gonadectomies or hysterectomies in patients with partial AIS and wrongly assigned males with 46,XX CAH, especially after late diagnoses