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SEX AND GENDER IDENTIFICATIONS IN THE VIEW OF ISLAM AND WESTERN THOUGHT: A COMPARATIVE NARRATIVE ON GENDER AMBIGUITY DEBATES

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ABSTRACT

Contemporary debates on gender identity reveal a fundamental divergence between Islamic and Western perspectives, creating significant theoretical and practical tensions in addressing gender ambiguity. Islam upholds a binary framework where biological sex determines gender identity, while Western thought increasingly separates sex from gender, recognizing gender as a social construct independent of biological markers. This ideological divide raises critical issues regarding gender dysphoria management, gender transition legitimacy, and accommodation of gender-variant individuals within different societal frameworks. This study conducts a comparative analysis of Islamic jurisprudence and Western gender theory through qualitative content analysis of religious texts, scholarly works, medical literature, and policy documents to examine how each tradition addresses gender identification conflicts. The research investigates theoretical foundations and practical applications of both approaches to gender-related disorders and identity crises. Key findings reveal that while Islam maintains consistent binary classifications rooted in biological determinism since the Quranic era, it demonstrates flexibility in addressing intersex conditions through established jurisprudential mechanisms. Despite fundamental philosophical differences, the study concludes that potential convergence areas exist between Islamic principles and certain medical interventions, suggesting possibilities for nuanced dialogue rather than absolute opposition in addressing contemporary gender identity challenges and fostering cross-cultural understanding.

Keywords: *Sex, gender, identification, gender dysphoria, Malaysia.*

1. INTRODUCTION

The conceptualization of sex and gender represents a fundamental area of divergence between Islamic jurisprudential frameworks and contemporary Western scholarly discourse. These differing paradigms reflect distinct epistemological foundations and carry significant implications for understanding human identity and social organization.

Within Islamic theological and legal traditions, sex and gender constitute an integrated construct where biological characteristics correspond directly to prescribed social roles and responsibilities. In Islam, the normative requirement for human classification regarding sex permits only a binary system of male and female genders. Consequently, jurists assign a person with both male and female genitals to either male or female gender, depending on the potency or functionality of one of the organs (Haneef & Zahir, 2016). Additionally, the Islamic perspective conceptualizes human sexual differentiation as encompassing both shared universal characteristics and distinctive gender-specific attributes, creating a complementary rather than hierarchical understanding of male and female roles (Abdulsalam, 2006). This framework demonstrates remarkable consistency in its approach to biological ambiguity: when individuals present with intersex conditions involving both male and female anatomical features, Islamic jurists employ functional criteria to determine gender assignment, typically based on the predominant or more viable reproductive organ system.

Traditionally, Western cultures have ascribed to the sex and gender binary (Morgenroth et al., 2021). However, in this modern day, sex and gender are viewed as complex, complicated and non-binary. Contemporary Western scholarship has increasingly emphasized the analytical separation between biological sex and socially constructed gender. Sex, according to them, refers to a person's biological makeup, while gender is more focused on social roles. At one level, they view sex as a natural function, growing out of biological, evolutionary or species-needs imperatives (Gagnon & Simon, 2017). Based on this view, biology determines an individual's classification as male or female but does not dictate the traits of masculinity and femininity, which are regarded as cultural products (Entwistle, 1998).

The disaggregation of sex and gender categories in Western societies has generated complex psychological and sociological phenomena. Gender orientation is no longer fixed for individuals, even though they were born with specific genitalia (i.e.: penis, vagina). This phenomenon has led society to be glued to gender dysphoria conflicts, creating identity conflicts that hinder individuals from identifying the gender roles they could play within social

settings (Cooper et al., 2020). Additionally, the emergence of gender dysphoria as a recognized clinical condition reflects the tension between biological assignment and subjective gender identity, creating situations where individuals experience significant distress regarding their assigned gender roles despite clear biological indicators.

Gender dysphoria traces its conceptual origins to John Money's pioneering work in the 1950s, which sought to optimize social adjustment for intersex children through medical intervention (Gill-Peterson, 2018). The formal recognition of these conditions gained institutional legitimacy with the American Psychiatric Association's inclusion of "gender identity disorder of childhood and transsexualism" in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders.

Islam, on the other hand, stands with its own unique approaches in dealing with gender dysphoria, with the standards proclaimed by its scholars. Gender dysphoria is an age-old phenomenon discussed since the Prophet's time and later extended by the Muslim jurists' discourses. Significantly, Haneef and Zahir (2016) suggest that despite apparent methodological differences, Islamic and contemporary scientific approaches to sex and gender identification possess potential for harmonization. This perspective acknowledges the distinct philosophical foundations of each tradition while identifying areas of practical convergence in addressing human sexual variation.

2. LITERATURE REVIEW

2.1 *Gender and Sex Orientation: A Western Perspective*

Human sexual differentiation operates through a biological system fundamentally governed by chromosomal composition. Humans are born as either male or female, determined by their sex chromosomes specifically, whether they have XX (female) or XY (male) chromosomes (Mohd Zainudin, 2024). The human genome is organised into 23 pairs of chromosomes (22 pairs of autosomes and one pair of sex chromosomes), with each parent contributing one chromosome per pair. The X and Y chromosomes, also known as the sex chromosomes, determine the biological sex of an individual: females inherit an X chromosome from the father for a XX genotype, while males inherit a Y chromosome from the father for a XY genotype (mothers only pass on X chromosomes). The presence or absence of the Y chromosome is critical because it contains the genes necessary to override the biological default female development and cause the development of the male reproductive system. A difference between XX and XY cells arises from imprinting, a differential expression of either the maternal or the paternal allele of a given gene. Males

exclusively inherit X genes with a maternal genomic imprint, whereas females have cells containing both the maternal and paternal imprint on X genes (Arnold, 2004). As such, the development of a person's sex phenotype is influenced by the presence of specific sex chromosomes, which in turn determines the production of certain hormones during prenatal development (Mohd Zainudin, 2024).

The clinical understanding of gender-related distress has evolved significantly within contemporary psychiatric classification systems. Individuals experiencing gender dysphoria often report profound disconnection from their physical form and discomfort with behaviors and attitudes typically associated with their biological sex. This psychological phenomenon has generated considerable scholarly debate and clinical attention within contemporary discourse (Zucker et al., 2016). In this regard, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines gender dysphoria as a condition characterized by marked incongruence between an individual's experienced or expressed gender identity and their assigned biological sex at birth (Kaltiala-Heino, 2018). This clinical framework recognizes the psychological distress that may arise when personal gender identity conflicts with biological sex characteristics.

From the Western perspective, Francoeur et al. (1995) deliberate the meaning of gender as "one's personal, social, and/or legal status as a male or a female or as a person of mixed gender". It encompasses internal perceptions such as one's identity or external expectations of masculinity and femininity. Meanwhile, "sex" refers to biological characteristics like chromosomes and physical traits. (American Psychological Association, 2015). Gender identity concerns the individual's core sense of being "female", "male" or another gender (Heino, 2018). The narrative creates a new phenomenon, and the term gender dysphoria is widely used, referring to those experiencing conflicts in gender assignation in which some believe the orientation of their sexual organs does not reflect gender identity anymore. This perspective is certainly different from the gender spectrum clarified by Islam, where its corpus stresses the interconnection between gender and sex orientation as both should be inherently aligned from birth.

2.2 *Gender Dysphoria: A Theoretical Foundation*

The idea of gender originated in the 1950s in a clinical environment, when the New Zealand psychologist, Money, adopted the term from linguistics and used it as an analytical tool to help him study the manliness and womanliness in children born with anatomical features that were not fully ascribable to the male or female sex (Germon, 2009). The first mode of ordering

identified was the ordering of Gender Dysphoria as a matter of diversity. Understanding gender identities as a matter of diversity was endorsed by the *Standards of Care 7*, which explicitly states in its opening chapter that 'being transsexual, transgender, or gender-nonconforming is a matter of diversity, not pathology' (Coleman et al., 2012).

Gender Dysphoria denotes the situation of partial or complete incongruence between the ascribed sex, determined by external genitalia, and the gender perceived by the brain. Consequently, it is defined by anguish, discomfort, and tension. This existential condition possesses an inherent complexity that permits equal attention and management as the associated medical concerns (Lavorato et al., 2022). According to Capetillo-Ventura et al. (2015), gender identity disorder is defined as the inconsistency between the physical phenotype and gender, in other words, self-identification as a man or a woman. Experiencing this inconsistency is known as gender dysphoria. Gender dysphoria is distress due to a discrepancy between one's assigned gender and gender identity, according to Cooper et al. (2020). Similarly, Karamanis (2023) describes it as significant distress or impairment caused by the discrepancy between an individual's experienced gender and the sex assigned at birth. Others stated that gender dysphoria was subjective distress with one's gender identity and described it as a continuum with two poles, namely (unproblematic) gender identity and gender dysphoria, based on a bigender system (Schneider et al., 2016). Capetillo-Ventura et al. (2015) also added that the most extreme form, where people adapt their phenotype to make it consistent with their gender identity, using hormones and by undergoing surgery, is called transsexualism.

Zucker et al. (2016) stressed that gender dysphoria occurs at every age level. Initial symptoms of gender dysphoria may manifest as early as 2 to 3 years. Research on childhood indicates that gender dysphoria persists until adulthood for 6–23% of males and 12–27% of females. In other words, less than a third of children, in whom gender dysphoria has been diagnosed, will maintain this condition even during adolescence. However, when gender dysphoria persists in the early stage of sexual development (puberty), it rarely disappears over time, and nearly all adolescents with gender dysphoria maintain this condition well into adulthood.

For children, a marked incongruence between their experienced or expressed gender and assigned gender of at least six months duration, is manifested by at least six of the following criteria (Zucker et al., 2016):

1. A strong desire to be 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; 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 a 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

For adolescents and adults, gender dysphoria criteria are perceived through an incongruence between an individual's experienced or expressed gender and their assigned gender, lasting for a minimum of six months. The criteria are evidenced by at least two of the following (Zucker et al., 2016):

1. A significant incongruence or disparity between an individual's experienced or expressed gender and their primary or secondary sex traits (or, in young teenagers, the secondary sex characteristics that is anticipated)
2. An intense drive to eradicate the main and/or secondary sex traits due to a disparity with one's perceived or expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
3. An intense drive of an individual for the main and/or secondary sex traits of the other gender
4. An intense drive of an individual to assume the other gender (or an alternate gender identity)
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)

Some studies urged that gender identity and sexual orientation are shaped by biological factors, such as genes, hormones, gene expression, and

environmental influences, including parents, peers, partners, and social models (Altinay & Anand, 2020). Studies indicate that both nature and nurture play key roles in the development of gender identity and sexual orientation (Hines, 2004). While biology contributes significantly to these aspects, the environment and experiences also play essential roles (Roselli, 2018). One key brain structure involved in sexuality is the hypothalamus, which serves as a control centre for many crucial bodily functions, including sexual behaviour. Within the hypothalamus, specific nuclei, such as the preoptic area and the ventromedial nucleus, are critical in orchestrating sexual responses. These areas receive input from sensory organs and higher brain regions, integrating information to initiate and regulate sexual arousal, desire, and performance (Mohd Zainudin, 2024).

Biological factors, including prenatal hormone exposure and brain structure variations, contribute to gender identity and sexual orientation development. According to Mohd Zainudin (2024), these biological aspects are important and may interact with social and environmental factors such as upbringing, life events, societal expectations and cultural norms in the formation of gender identity and sexual orientation. Cultural influence may impact the acceptance or rejection of the ascribed genders in individuals with disorders of sex development (DSDs) and their families, as well as the psychosexual development of the patient and the medical therapy involved. Reports from numerous countries such as Turkey (Özbey et al., 2004), Egypt (Dessouky, 2001) and Saudi Arabia (Taha, 1994), indicate a growing inclination to designate male gender regardless of karyotype, gonadal composition, and fertility potential rendering it the preferred sex.

Studies also indicate that hormones play a role in shaping sexual orientation, particularly during critical stages of early development. Hormones also influence various psychological and behavioural traits often associated with gender roles. These traits can include patterns of sexuality, cognitive styles, emotional tendencies, interests, and mental well-being, all of which are influenced to some extent by hormonal factors during early life, according to Hines (2004). Wu et al. (2014) assert that Disorder 46, XX male syndrome is an uncommon sex reversal syndrome marked by a female karyotype that is inconsistent with a male phenotype. Their study indicates that 90% of 46, XX testicular DSD typically present with expected male phenotypic heterogeneity at birth and are diagnosed as post-puberty due to genital infertility or ambiguity. In this context, they may exhibit normal external genitalia and masculinisation yet demonstrated azoospermia.

Some research claims that gender dysphoria in not a mental health issue (Cooper et al., 2016). However, it could not deny the psychological

complication experienced by gender dysphoria. Several studies have found that certain psychological disorders, such as trauma or personality disorder, can lead to gender dysphoria, which can then exacerbate other psychological issues, such as depression, anxiety and substance abuse (Said et al., 2023). Research reveals significant mental health challenges among adolescents with gender dysphoria, with 30% of these youth affected by depression. In comparison, anxiety rates range from 16% to 25%, 2% to 15.8% experiencing eating disorders, 13.1% to 53% have tried to harm self, and 9.3% to 30% have attempted suicide (Bonifacio et al., 2019). Hanna et al. (2019) stated that the diagnosis of psychiatric disorders was a twofold increase among the transgender population, with over a third of people in the group having at least one mental health disorder.

3. METHODOLOGY

To complete the research objectives, this study employs a qualitative research approach. Johnson et al. (2006) affirm that qualitative research provides a profundity of knowledge that could not be attained through any quantification method, and it makes the study centres on text, words, feelings, and viewpoints (Levy, 2006). Based on the nature of the study, this approach is significant to highlight issues concerning gender assignation from both Western and Islamic perspectives, driving to the clarification on debates regarding gender dysphoria. A narrative research design has been adopted, incorporating in depth-review as the main data collection method alongside other qualitative forms of observations (Butina, 2015). For the data collection, library research is the key component of the study. The derivation of research data is based on diverse sources that have been analysed using a thematic analysis, drawing from classical and recent discourses with regard to gender studies, from both Western and Islamic scholarship, covering revisions of books, journals, and international and national policies to ensure the data gained for the study of the gender dysphoria.

4. RESULTS & DISCUSSION

4.1 *Islamic Jurisprudential Perspectives on Gender Ambiguity*

Scholars discussing Islamic jurisprudence have specifically addressed the definition of gender, especially in situations where a man is unsure of his gender identification. It is clear from their discussion that confusion may arise when a person is born with two different types of genital parts, making it difficult to determine which gender best fits that person.

The traditional scholars in this case have discussed the problem in terms of *khunsa*. The terminology of *khunsa* is medically established by the experts of this field and they also include *khunsa* as part of gender dysphoria issues. Zainuddin and Abdullah Mahdi (2016) subliminally reveal, according to Islamic traditions, that individuals with somatic sex ambiguity due to a disorder of sex development (DSD), such as 46, XX congenital adrenal hyperplasia or 46, XY androgen insensitivity are acknowledged as *khunsa*.

According to Rahman (2022), *khunsa* is an organism with both male and female reproductive systems. According to Yama and Dehis (2018), professional medicine believes that there are four potential states of intersex:

1. 46, XX intersex: When a person has male outward sexual organs but feminine internal sex organs.
2. 46, XY intersex: A person with male chromosomes but a female appearance.
3. True Gonadal Intersex: A person with testicular tissue and ovaries who may be classified as single *khunsa*.
4. Complex problems or Sexual Development Servers (Unspecified Sexual problems Development): Based on sexual conditions that are not yet characterized or on variants of the aforementioned disorders.

According to Rahman (2022), *khunsa* comes in two varieties. Both of them are simultaneous and sequential. Their sexual activity determines this because other reproductive organs go dormant when one of the two sexes activates. Intersex disorder occurs due to chromosomal imbalances. Genotype 10 is the primary genetic code in humans that represents DNA (deoxyribonucleic acid), whereas an organism's characteristics and physical traits are known as phenotypes. Everyone in this world has different DNA, which is the basic concept of cloning. By taking the DNA of an individual, ditto copies can be created. Usually, the chromosomal genotype of the sexual phenotype in males is XY, whereas, in females, it is XX. In Intersex, genotypes alter due to which sexual phenotypes also alter, which causes genital ambiguity due to which sustenance of another inside their bodies is impossible. The altered form of chromosomes is XXY, X, XXXY, XXX, divided into four categories. This condition is also called a Disorder of Sexual Development (DSD).

In Islamic jurisprudence, individuals classified as *khunsa* are divided into two categories: *khunsa mushkil*, where the individual's sex is ambiguous and cannot be determined clearly, and *khunsa ghair mushkil*, which applies to individuals whose sex can be definitively identified (Al-Babarti, n.d). *Khunsa mushkil* is a *khunsa* whose gender cannot be directly determined because they are born without any genitalia and only have a device to urinate (Al-'Aini, 2000). *Khunsa*

mushkil is a person who urinates from both genitalia at the same time and is one in whom it is difficult to ascertain the correct gender because there is no dominant male or female characteristic. In the instance of *khunsa mushkil*, it is imperative to observe and monitor for changes in puberty to determine the true gender. A potential indicator of an individual's dominant sex is the exclusive urination from one of the two genitalia, a predominance of the urine discharge from one genital as compared to the other, or cessation of the urine from one genital rather than the other. *Khunsa ghair mushkil* on the other hand, it can be ascertained that their skills are either geared towards women or men through physical signs (Ibn Nujaym, n.d), or confirmed gender clinically (Davis et al., 2016).

Additional changes may include the onset of menstruation, breast development or the emergence of sexual attraction to men or pregnancy. In such cases, the individual is undoubtedly female. The other changes include the development of a deep voice, facial hair growth, or the emergence of a sexual attraction to women; these changes designate the individuals to be male. Further characteristics that may define gender, but Muslim scholars disagree include the number of ribs a person has and the position or structure of the orifice from which a person ejaculates.

Another terminology of gender dysphoria written in Islamic scholarly works is *mukhannath*. Zakaria et al. (2021) defined *mukhannath* as a genuine man whose instincts are towards women. In other words, it is referred to as transgender, which is the act of resembling a woman in terms of behavior, conversation, dress, including sexual activity.

Scholars define *mukhannath* in two categories. The first kind refers to individuals who naturally exhibit physical characteristics similar to those of women. Since these traits are considered innate, scholars opted that there is no harm if they have certain features similar to women since they are born with such features. The second kid, however, consists of individuals who are biologically male but deliberately altered because of their propensity for women. In this scenario, Muslim scholars include them as those who are cursed by the Prophet Muhammad PBUH as narrated in authentic hadith narrated by al-Bukhari (2009), "*Allah's Messenger cursed those men who are in the similitude (assume the manners) of women and those women who are in the similitude (assume the manners) of men*."

This verse stresses on the restriction of *mukhannath* through their presence and expression as a lesbian, gay, bisexual and transgender as these practices are prohibited by the major religions in the world as it is not only a sheer violation of marriage institution but also disrespect for human being as it contradicts the

very nature of man's creation. While many countries have legalized LGBT rights as part of human rights protections, numerous governments continue to reject their legitimacy. No Muslim-majority country currently supports LGBT rights; Malaysia and Nigeria exemplify this position, as these governments view LGBT practices as incompatible with Islamic principles, culture, and tradition.

4.2 *Methods to Assign Intersex Identity in Islam*

The office of the Mufti of the Federal Territory states that beyond physical appearance and genitalia, several additional factors are used to determine the gender of intersex individuals, including gonads (testes and ovaries) and chromosomes. Islamic jurists (*fuqaha*) have established criteria for classifying intersex individuals that extend beyond genitalia and physical appearance. These criteria include secondary sexual characteristics such as body hair distribution, facial hair, beard growth, and voice depth, which the *fuqaha* classify as masculine traits. Individuals displaying the opposite characteristics are categorized as female (Ibn 'Abidin, 1990; al-Sarakhsi, 1993).

Another method for determining gender identity in intersex cases involves assessing romantic or sexual attraction. According to this framework, an intersex person who is attracted to men is classified as female, while one attracted to women is classified as male. In summary, Muslim scholars have established multiple criteria to determine intersex gender classification, which can be understood through several approaches.

Islamic jurisprudence establishes six primary methods for determining gender in intersex cases. The first method relies on urination patterns, where gender is determined based on urogenital anatomy and function. Males urinate exclusively through the penis, while females urinate solely through the vagina. For individuals with both structures, gender classification depends on which anatomical route is used during the first urination.

The second approach focuses on ejaculation and menstruation patterns. Gender classification relies on reproductive fluid patterns and cyclical processes. Male designation requires seminal ejaculation through the penis, while female classification is based on either vaginal seminal discharge or menstrual cycles. Accurate determination requires long-term observation to confirm consistent physiological patterns.

Pregnancy and giving birth serve as the third method, where childbirth (*wiladah* in Islamic terminology) provides definitive proof of female classification. This criterion takes precedence over all other contradictory indicators that may have

been previously applied. The fourth method examines the absence of menstruation after puberty, where the lack of menstrual cycles after reaching puberty indicates male classification. This approach parallels the urogenital assessment method for gender categorization.

The fifth method considers feelings of attraction, where sexual orientation determines gender for intersex individuals when biological indicators are unclear. Attraction to male's results in female classification, while attraction to females results in male classification. This method is used only when other physical or physiological markers are insufficient for definitive assignment.

Finally, the emergence of certain characteristics serves as the sixth method. Specific behavioral traits including courage, combat resilience, and physical strength indicate masculine characteristics in intersex individuals. Physical markers include androgenic features such as facial hair (mustache and beard) as well as breast development and lactation ability. For secondary intersex cases (lacking both penile and vaginal structures), behavioural indicators are insufficient, making sexual attraction patterns the only remaining classification criterion.

4.3 *Medical and Psychological Approaches to Treatment*

The intersection of modern medical advances and Islamic jurisprudence has created complex debates regarding gender reassignment procedures. As medical technology has evolved to offer surgical interventions for gender dysphoria, Islamic scholars have grappled with determining the permissibility of such procedures within religious frameworks. This discourse has led to nuanced distinctions between different types of gender-related medical interventions and their theological implications.

Muslim scholars disagree on sex reassignment surgery (SRS) for non-intersex individuals experiencing gender dysphoria. Advanced medical research has identified that certain organs within the human body, including hearts, lungs, carry gender-specific characteristics (Rasheed, 2022), together with gonads, chromosomes, and hormones. Neuroimaging studies have revealed structural differences in the brains of cisgender individuals compared to transgender individuals without intersex conditions (Frigerio et al., 2021; Guillamon et al., 2016). These findings have enabled Muslim jurists to distinguish between psychological disorders and biological necessities in cases of gender dysphoria.

Most scholars reject SRS for non-intersex individuals with gender dysphoria, arguing that it constitutes an alteration of Allah's creation and causes significant harm (Haneef, 2011). They support this position by citing the

Quranic verse: "The laws of nature ordained by Allah cannot be changed" (Al-Rum 30). Additionally, they reference Surah Al-Nisa' 119, which describes altering Allah's creation as a satanic act. Scholarly interpretations of these verses vary: some view them as referring to changes in religious practices (Al-Tabari, 2012), others see them as addressing physical transformations, while still others believe they encompass both religious and physical alterations (Al-Suyuti, 2011). Islam maintains a firm position against changing Allah's creation, supported by prophetic traditions, including one where "the Prophet cursed women who practice tattooing and those who seek to be tattooed, and women who remove facial hair, as they seek beautification by changing Allah's creation" (Al-Bukhari, 2009: 2782).

Islam also prohibits causing harm, as evidenced throughout Quranic verses and hadiths. One relevant hadith state: "No harm shall be inflicted nor reciprocated" (Malik, 1954: 2171). Some Muslim jurists include this principle among the five universal legal maxims (*qawāʿid fiqhiyyah*), arguing that SRS for non-intersex individuals with gender dysphoria causes serious religious, physical, and psychological harm.

A minority of Muslim jurists present a counterargument supporting SRS for non-intersex individuals with gender dysphoria, claiming that such procedures help alleviate frustration and depression, allowing individuals to align with their inherent nature. However, the majority responds that if imitating the opposite gender through clothing, behavior, and speech is forbidden, then SRS should be even more strictly prohibited as it involves more fundamental alterations to gender identity.

Some scholars apply the maxim "Harm should not be replaced with another harm or with the same harm" as a guiding principle in Islamic jurisprudence. This principle emphasizes caution when considering medical or surgical procedures, particularly when outcomes are uncertain or when unforeseen physical or psychological consequences are possible. While not entirely dismissing medical interventions, they argue that such procedures must be undertaken carefully, ensuring that potential benefits outweigh associated risks.

For non-intersex individuals, gender-affirming surgery is classified as *taghyīr al-jins* (sex change) or *taḥwīl al-jins* (sex conversion) and is forbidden primarily for religious reasons, as it alters Allah's creation. From a medical perspective, it damages healthy organs. However, for intersex individuals, gender-affirming surgery falls under *taṣḥīḥ al-jins* (sex realignment/correction) and is permitted because it corrects a deformity.

4.4 *Psychological Considerations*

The mental health implications of gender dysphoria present significant challenges that extend beyond theological debates into the realm of human welfare and medical necessity. Understanding these psychological dimensions is crucial for developing comprehensive approaches to addressing gender dysphoria within religious communities.

Individuals with gender dysphoria undeniably face significant psychological challenges that affect their entire lives. Those dissatisfied with their physical appearance may suffer from mental illness severe enough to threaten their lives. Research from the United States shows that individuals with gender dysphoria experience higher rates of depression, anxiety, and suicidal thoughts compared to the general population (Zahra et al., 2024). Data from Iran reveals that gender dysphoria sufferers experience substantial psychological distress due to stress, feelings of unforgivable sin, persistent abuse, self-blame, feeling trapped, excessive shame, and feeling like family outcasts (Zahra et al., 2024).

Studies published by Ecare in 2024 highlight major mental health challenges among individuals with gender dysphoria, including feelings of sadness, hopelessness, and isolation. Social anxiety—fear of exclusion, bullying, or misunderstanding can heighten these individuals' distress. To escape these mental struggles, individuals with gender dysphoria may turn to self-harm and suicide. These studies also discuss post-traumatic stress disorder (PTSD), noting that many individuals who experience discrimination, violence, or abuse face high PTSD risk. Those living with gender dysphoria may suffer long-term psychological consequences from traumatic experiences.

The methodology for determining gender identity raises important questions about the reliability and appropriateness of different assessment criteria. Contemporary debates in both medical and religious contexts have highlighted the need to establish clear, consistent standards for gender assignment that balance scientific understanding with theological principles.

Individual feelings and attractions cannot be considered primary or relevant methods for social/legal gender assignment until physical examination becomes impossible. Advanced biomedical understanding shows that sexual ambiguity can be identified through internal organ examination. Therefore, transgender individuals can be assigned social/legal gender based on physical attributes. Feelings cannot serve as benchmarks for social/legal gender assignment because they are neither static nor reliable, whereas technical and empirical solutions are available. If someone currently identifies or feels female, this decision may change over time. Research by Littman (2019) on gender

dysphoria suggests that misalignment between social/legal gender assignment and biological sex has emerged as "social contagion" and a trend, particularly among teenagers, termed "peer contagion." In such circumstances, the solution involves thorough diagnosis of the individual's emotions and using psychological data for subsequent psychiatric evaluation.

5. CONCLUSION

This study concludes that Muslim and Western thoughts have approached gender dysphoria through several key frameworks. Muslim scholars have worked to understand gender dysphoria through both Islamic bioethical principles and contemporary medical research. Meanwhile, Western approaches the issue of gender dysphoria by focusing on the narrative of separating between sex and gender roles. Muslim scholars inclined to oversee the issue as a disease that must be treated by the patients. Some scholars have engaged with scientific research on the biological and psychological aspects of gender identity, working to contextualize new findings within Islamic scriptural and legal traditions. Theologically, some scholars explore the distinction between biological sex and gender identity, examining whether Islamic tradition provides space for understanding conditions beyond the binary male-female framework. Muslim scholars acknowledge that gender dysphoria is a recognized psychological condition rather than merely a social construct. Many emphasize counseling and therapy that align with Islamic values, focusing on spiritual well-being alongside medical treatment. While some advocate for gender-affirming care, others emphasize therapy to help individuals reconcile with their biological sex.

The permissibility of sex reassignment surgery (SRS) remains debated; classical scholars permitted SRS for intersex individuals, but whether this extends to transgender individuals varies across different Islamic legal traditions. Some contemporary scholars have issued fatwas allowing SRS for individuals diagnosed with severe gender dysphoria, considering it a medical necessity rather than an alteration of Allah's creation (*taghyīr khalq Allāh*).

Islamic jurisprudence (fiqh) continues to grapple with the legal and ethical dimensions of gender dysphoria. Some scholars argue that if the condition causes severe distress, Islamic principles of removing hardship (raf' al-ḥaraj) could allow for medical interventions. Others, however, maintain that Islamic law is fundamentally based on biological sex and that gender identity alone cannot override legal classifications concerning prayer, inheritance, and marriage.

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Beyond legal and medical debates, there are growing efforts to support individuals experiencing gender dysphoria within an Islamic framework. Institutions such as The Deparment of Islamic Development of Malaysia (JAKIM), and the State Religious Islamic Councils (SRICs) engage in discussions aimed at fostering a more compassionate and nuanced approach to the issue. Many scholars and community leaders seek to de-stigmatize conversations about gender identity, ensuring that individuals struggling with these issues receive care, dignity, and spiritual guidance while upholding Islamic teachings. While the reconciliation between Islamic tradition and modern science remains an evolving discussion, ongoing academic and theological discourse reflects a broader effort to balance religious principles, medical advancements, and ethical considerations in addressing gender dysphoria.

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7. REFERENCES

Abdulssalam, A. S. (2006). Gender and sexuality: An Islamic perspective. *SARI: Jurnal Alam dan Tamadun Melayu*, *24*, 34-48.

Al-Ayni, M. A. M. A. H. (2000). *Al-Binayah Sharh Al-Hidaya*. Dar Al-Kutub Al-Ilmiyya.

Al-Babarti, M. M. M. (n.d.). *Al-'Inayah Sharh Al-Hidaya*. Dar Al-Fikr.

Al-Bukhari, M. I. I. (2009). *Sahih al-Bukhari*. Dar al-Salam.

Al-Sarakhsi, M. I. A. (1993). *Al-Mabsut*. Dar al-Ma'rifah.

Al-Sayyid Salam, A. M. K. (2010). *Sahih Fiqh al-Sunnah*. Dar al-Tawfiqiah li al-Turath.

Al-Tabari, M. I. J. (2012). *Jami' al-Bayan fi Ta'wil ay al-Qur'an*. Dar al-Qalam.

Altinay, M., & Anand, A. (2020). Neuroimaging gender dysphoria: A novel psychobiological model. *Brain Imaging and Behavior*, *14*(4), 1281-1297.

Al-Zuhayli, W. (2013). *Mawsu'ah al-Fiqh al-Islami wa al-Qadaya al-Mu'asirah*. Dar al-Fikr.

Arnold, A. P. (2004). Sex chromosomes and brain gender. *Nature Reviews Neuroscience*, *5*, 1-8.

Bonifacio, J. H., Maser, C., Stadelman, K., & Palmert, M. (2019). Management of gender dysphoria in adolescents in primary care. *CMAJ*, *191*(3), E69-E75.

Butina, M. (2015). A narrative approach to qualitative inquiry. *Clinical Laboratory Science*, *28*(3), 190-196.

Capetillo-Ventura, N. C., Jalil-Pérez, S. I., & Motilla-Negrete, K. (2015). Gender dysphoria: An overview. *Medicina Universitaria*, *17*(66), 53-58.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, *13*(4), 165-232.

Cooper, K., Russell, A., Mandy, W., & Butler, C. (2020). The phenomenology of gender dysphoria in adults: A systematic review and meta-synthesis. *Clinical Psychology Review*, *80*, Article 101875.

Davis, G., Dewey, J. M., & Murphy, E. L. (2016). Giving sex: Deconstructing intersex and trans medicalization practices. *Gender & Society*, *30*(3), 490-514.

Dessouky, N. (2001). Gender assignment for children with intersex problems: An Egyptian perspective. *Egyptian Journal of Surgery*, *20*, 499-515.

Eagly, A. H. (1987). *Sex differences in social behavior: A social-role interpretation*. Psychology Press.

Ecare. (2024). Gender dysphoria: Understanding the condition and its mental health treatments.

Entwistle, J. (1998). Sex/gender. In *Core sociological dichotomies* (pp. 151-165).

Francoeur, R. T., & Hendrixson, L. L. (1999). Human sexuality. In *Handbook of marriage and the family* (pp. 743-766). Springer.

Gagnon, J. H., & Simon, W. (2017). *Sexual conduct: The social sources of human sexuality*. Routledge.

Germon, J. (2009). *Gender: A genealogy of an idea*. Springer.

Gill-Peterson, J. (2018). *Histories of the transgender child*. University of Minnesota Press.

Haneef, S. S. S., & Zahir, A. A. (2016). Gender categorization between Islam and science: The problem of integration from Islamic jurisprudence perspective. *Revelation and Science*, *6*(1).

Hanna, B., Desai, R., Parekh, T., Guirguis, E., Kumar, G., & Sachdeva, R. (2019). Psychiatric disorders in the US transgender population. *Annals of Epidemiology*, *39*, 1-7.

Hines, M. (2020). Human gender development. *Neuroscience & Biobehavioral Reviews*, *118*, 89-96.

Ibn Nujaym, Z. I. M. (n.d.). *Al-Bahr Al-Ra'iq Sharh Kanz Al-Daqa'iq* (2nd ed.). Dar Al-Kitab Al-Islami.

Ibn Qudamah, M. I. A. I. A. (2004). *Al-Mughni*. Dar al-Hadith.

Ibn Qudamah, M. I. A. I. A. (2010). *Al-Kāfī fī Fiqh al-Imām Aḥmad bin Ḥanbal*. Dar Ibn Hazm.

Jacobs, M. D. (2011). Western history: What's gender got to do with it? *Faculty Publications, Department of History*, *114*.

Jamneankal, T., Kiatrungrit, K., & Arunakul, J. (2023). Validity and reliability of the Thai version of the Utrecht Gender Dysphoria Scale-Gender Spectrum (UGDS-GS) in Thai youths and young adults with gender dysphoria. *General Psychiatry*, *36*, Article e100980.

Kaltiala-Heino, R., Bergman, H., Työläjärvi, M., & Frisén, L. (2018). Gender dysphoria in adolescence: Current perspectives. *Adolescent Health, Medicine and Therapeutics*, *9*, 31-41.

Lavorato, E., Rampino, A., & Giorgelli, V. (2022). Gender dysphoria: Overview and psychological interventions. *Practical Clinical Andrology*, 263-272.

Levy, D. (2006). Qualitative methodology and grounded theory in property research. *Pacific Rim Property Research Journal*, *12*(4), 369-388.

Mohd Zainudin, M. (2024). Gender dysphoria. In *Centris* (Chapter 3).

Morgenroth, T., Sendén, M. G., Lindqvist, A., Renström, E. A., Ryan, M. K., & Morton, T. A. (2021). Defending the sex/gender binary: The role of gender identification and need for closure. *Social Psychological and Personality Science*, *12*(5), 731-740.

Özbey, H., Darendeliler, F., Kayserili, H., Korkmazlar, Ü., & Salman, T. (2004). Gender assignment in female congenital adrenal hyperplasia: A difficult experience. *BJU International*, *94*(3), 388-391.

Rey, R., Josso, N., & Racine, C. (2020). Sexual differentiation. In K. R. Feingold, B. Anawalt, & M. R. Blackman (Eds.), *Endotext*. MDText.com.

Roselli, C. E. (2018). Neurobiology of gender identity and sexual orientation. *Journal of Neuroendocrinology*, *30*(7), Article e12562.

Said, A. H., Abd Rahim, I. S., Zaini, N. N. B. M., & Nizam, N. I. B. S. (2023). Factors affecting adherence to lipid-lowering drugs: A scoping review. *Oman Medical Journal*, *38*(4), Article e523.

Schneider, C., Cerwenka, S., Nieder, T. O., Briken, P., Cohen-Kettenis, P. T., De Cuypere, G., Haraldsen, I. R., Kreukels, B. P., & Richter-Appelt, H. (2016). Measuring gender dysphoria: A multicenter examination and comparison of the Utrecht Gender Dysphoria Scale and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults. *Archives of Sexual Behavior*, *45*(3), 551-558.

Simon, W. (2017). *Sexual conduct: The social sources of human sexuality* (2nd ed.). Routledge.

Taha, S. A. (1994). Male pseudohermaphroditism: Factors determining the gender of rearing in Saudi Arabia. *Urology*, *43*, 370-374.

Wilhelm, D., & Pask, A. J. (2018). Gametogenesis, fertilization and early development. In *Encyclopedia of reproduction* (2nd ed.).

Wu, Q., Li, N., Li, W., Li, T., Zhang, C., Cui, Y., & Zhai, J. (2014). Clinical, molecular and cytogenetic analysis of 46, XX testicular disorder of sex development with SRY-positive. *BMC Urology*, *14*, Article 70.

Yama, P., & Dehis, N. H. B. (2018). Perbezaan Khunsa dan Mukhannath menurut Perspektif Al-Quran dan Al-Sunnah. In *Proceeding of The International Conference On Contemporary Issues In Al-Quran And Hadith* (pp. 72-77).

Zakaria, P. Y., Omar, S. A. C., & Dehis, N. H. (2021). Khunsa dan Mukhannath Menurut Perspektif Hadith dan Pengaruhnya di Media Sosial. *Sains Insani*, *6*(2), 9-15.

Zucker, K. J., Lawrence, A. A., & Kreukels, B. P. (2016). Gender dysphoria in adults. *Annual Review of Clinical Psychology*, *12*(1), 217-247.