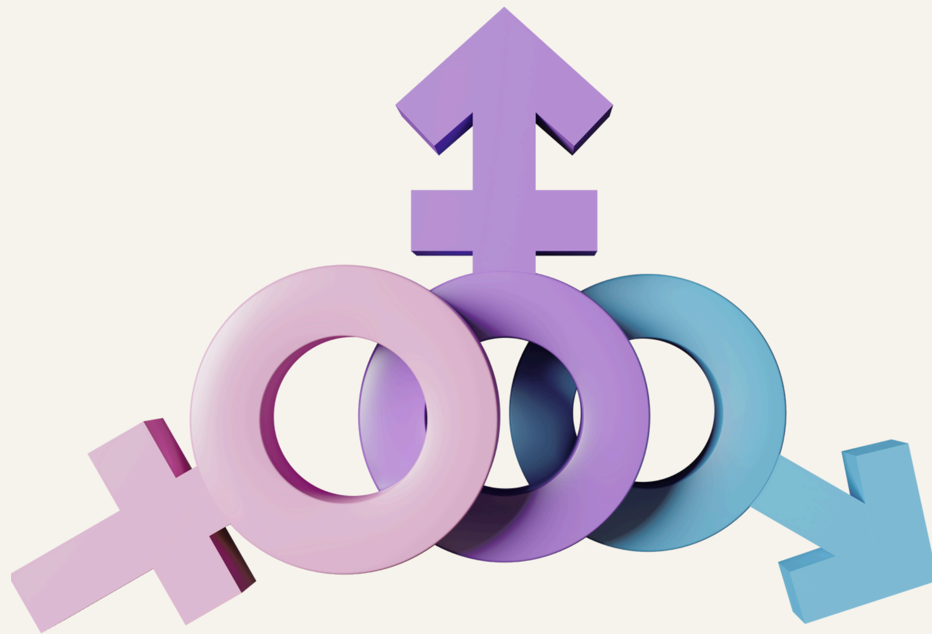
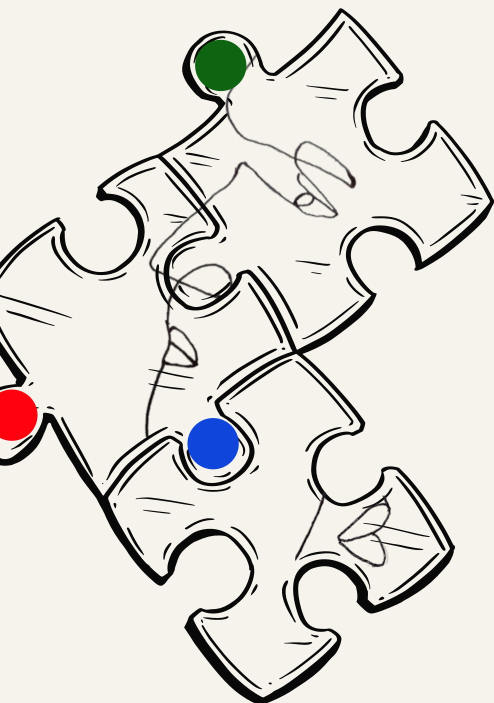
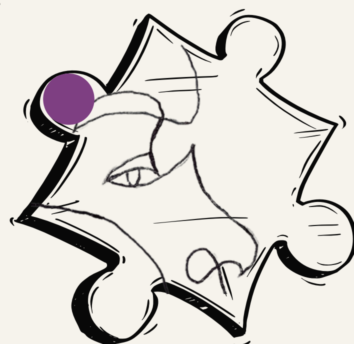
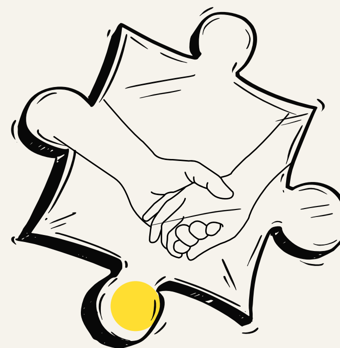


GENDER DYSPHORIA

MEDICAL, ISLAMIC REVEALED KNOWLEDGE AND HUMAN SCIENCES PERSPECTIVES







Editors

Samsul Draman

Abdul Hadi Said

Zahid Zamri

GENDER DYSPHORIA

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Editors

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EDITORS' INTRODUCTION

This book aims to address issues related to gender dysphoria from an Islamic perspective. The issues were discussed from religious, medical and human sciences points of view. This is because in Islam, there is no separation between science and religion. Therefore, the authors in this first volume of the book are from medical, human sciences as well as the Islamic revealed knowledge fields. The views from Islamic revealed knowledge and human sciences are necessary to balance the perspectives made by the medical experts, as we believe it is not enough to address the issue only from modern medical science alone (it is worth to mention that some of the research findings from the medical science have been presented in "Gender Dysphoria, Issues and Solutions").[1] To solve the issue, we need a more comprehensive view of the matter. Hence, we bring authors not only from medicine but also from sociology, psychiatry, and Islamic legal codes to discuss gender dysphoria academically as a response to the secular non-Islamic arguments on the problem. We are very concerned about the social ills involving lesbian, gay, bisexual, and transgender groups (LGBT). With continuous support from Professor Emeritus Tan Sri Dato' Dzulkifli Abdul Razak (the 6th IIUM rector), it is hoped that the act of normalising the LGBT lifestyle will be curbed, not only in the IIUM campus but even throughout Malaysia and the whole world.

1 Said, A. H. et al. (Eds.). (2023). *Gender Dysphoria, Issues and Solutions*. Kulliyyah of Medicine, International Islamic University Malaysia.

ABOUT THE EDITORS

Abdul Hadi Said is a is an assistant professor in the Department of Family Medicine at the Kulliyyah of Medicine, International Islamic University Malaysia. He earned his Medical Doctor (MD) degree from Universiti Sains Malaysia and Master in Medicine (Family Medicine) from the same university. Since then, he has been actively involved in the field of family medicine as an academician/ researcher. His professional interests focus on non-communicable disease such as bronchial asthma. He has been involved as one of the team members of IIUM's Gender Dysphoria Flagship Project since 2019.

Samsul Draman is a professor in the Department of Family Medicine, International Islamic University Malaysia. He earned his Medical Doctor (MD) degree from Universiti Sains Malaysia. He furthered his studies by pursuing Master in Medicine (Family Medicine) at the same institution. His area of interest is in men's health particularly on Gay Bisexual Transgender. Since 2011, he is the advisor of Persatuan Insaf Pahang which focuses on transsexual women in Kuantan, Pahang. He also involved in developing a module entitled "*Garis Panduan Pengendalian Masalah Kesihatan Gender di Klinik Kesihatan*" (Kementerian Kesihatan Malaysia, 2017) for the Ministry of Health, Malaysia.

Zahid Zamri is the Head of Research and Publication at the Centre for Islamisation (CENTRIS), International Islamic University Malaysia (IIUM). He is also an assistant professor in the Department of Political Science, AbdulHamid AbuSulayman Kulliyyah of Islamic Revealed Knowledge and Human Sciences, IIUM and was the Coordinator of Islamisation of Human Knowledge at the Kulliyyah. He holds a PhD in International and Strategic Studies, University of Malaya; Master of Human Science in Political Science; and Bachelor of Human Science in Political Science (Honours with Islamic Revealed Knowledge Minor) from IIUM. He also holds a Diploma in Computer Science from Universiti Putra Malaysia.

01

SHARING THE PERSONAL EXPERIENCE OF TRANSGENDER WOMEN IN MALAYSIA

Abdul Hadi Said
Kulliyyah of Medicine, IIUM

ABSTRACT

This chapter explores the individual experiences of transgender women in Malaysia, emphasizing the societal obstacles and health concerns of these individuals. The definition of essential words pertaining to the lesbian, gay, bisexual, and transgender (LGBT) community is covered at the outset, giving readers a basis of understanding about this chapter. The chapter also provides insight into the experiences of transgender women as they deal with discrimination and stigma within their cultural environment. The difficulties they encounter are examined, including their financial necessity and marginalization driving their involvement in sex work. The health risks connected to these behaviors are also discussed. The document highlights the need for societal support and action to improve the quality of life and lessen their involvement in sex trafficking.

Introduction

The term "LGBT" is a short form that stands for Lesbian, Gay, Bisexual, and Transgender. It is a common term used nowadays when discussing issues related to this group, especially health-related issues. This chapter aims to briefly introduce the readers to the terms used to describe the LGBT group. Beyond that, this chapter will also share with the readers the personal experiences of transgender women in Malaysia based on their own stories.

Definition of terms

1. Lesbian/Gay: This term refers to people who are attracted to the same sex or gender romantically, emotionally, or sexually. Gay is the commonly used term when discussing issues related to Men who have Sex with Men (MSM).

2. Bisexual: This refers to individuals who are attracted to multiple sexes or genders romantically, emotionally, or sexually.

3. Transgender and cisgender: While cisgender refers to a person whose gender identity or expression corresponds to their assigned birth sex, transgender is an umbrella word that includes people whose gender identity differs from their original assigned birth sex. In addition, there are three main subcategories of the term transgender: transgender women, transgender men, and nonbinary. Transgender men are those who were given the gender of a woman at birth but who now identify as a man, and transgender women are those who were given the gender of a man at birth but who now identify as a woman. Non-binary refers to additional specific genders like genderqueer, agender, bigender, and genderfluid if a person does not identify with both binary genders

4. Gender dysphoria; A term/concept used in the DSM-5-TR (American Psychiatric Association, 2022) as a significant impairment or distress clinically, related to gender incongruence, which may include a desire to change primary and/or secondary sex characteristics.

Transgender women in Malaysia

Tasyabbuh, which in Arabic means "resembling something," is the word for transgender. The Fiqh jurists' definition of transgender from an Islamic perspective is that it refers to men who resemble women or vice versa through their clothes, decoration, voice, gait and mannerisms, as well as to changing their physical appearance. This is prohibited in Islam.

In Malaysia, terminology like "trans woman," "*mak nyah*," "transsexual," and "*thirunagai*" are frequently used to refer to transgender women. Some of the terminology used, such as "*bapok*," "*pondan*," and "*sotong*," among others, may be derogatory to transsexual women.

Although the total number of transgender women worldwide is unknown, it is estimated that between 0.5% and 1.3% of babies who are born males identify as transgender women. In Malaysia, transgender advocates pegged the number of transgender women at between 20,000 and 30,000 in the year of 2018 (Draman et al., 2020). Sixty percent of these are Malay. Meanwhile, local studies found an increase from 10,000 to 50,000 transgender women between 2001 and 2016. Despite this population's tremendous rise, it is still not widely accepted in Malaysia. Transgender women often encountered stigmatisation and prejudice in various contexts, which made their lives difficult. The health problems that the transgender community experiences have an impact on both their physical and mental well-being (Said et al., 2023).

Exploring the personal life of transgender women in Malaysia

Desire to become a transgender woman

> “I have loved playing “*pondok-pondok*” with girls ever since I was in elementary school. From elementary to secondary school, all of my buddies were female. I had only two or three guy friends” (male participant, 29 years of age).
>
> “I have had “*maknyah*” experiences since I was a young child. My sister and I switched clothes. She wore my things, and I did too. Since I was a little child, maybe 5 or 6, I have enjoyed dressing in feminine clothes” (male participant, 48 years of age).
>
> “I have always been identified as a woman. I liked being female. When I was 13 years old, I began using my mother's cosmetics in secret, including her lipstick” (male participant, 44 years of age).

"Perhaps it was my own desire to become a transgender woman. During my school days, I dressed like a typical boy. However, I didn't have feelings for girls. I once tried to date girls, but it felt awkward and uncomfortable as if I was deceiving myself. From then on, I began thinking about how to attract men's attention, so I started to wear makeup, women's clothing, and wigs" (male participant, 34 years of age).

For most of them, the urge to transition into a woman has been present since a young age. This was evident in their lifestyle, friends, and clothing. Hence, both parents and teachers have a duty to watch over these kids from a young age. Even if they were unable to control their desire to transition, they should nonetheless get adequate sexual and Islamic education. With proper guidance, they should be able to lead a better life in the future.

Contributing elements to becoming a transgender woman

"I was the one who took care of our house because my mother was too busy involved in politics. I also looked after my deceased grandmother... . In the kitchen, I was entirely responsible. So, having to perform all of the household chores, I have a propensity to be a woman" (male participant, 40 years of age).

"When my mother was pregnant with me, my gender was revealed by the ultrasound as a girl. But then I was born a boy. But my parents only had girls' clothing ready when I was born, so I wore girls' clothing. I did not have my first haircut until I entered kindergarten. I would wear a "b*aju kurung*' during Hari Raya, just like my sister" (male participant, 30 years of age).

"My siblings could be a contributing element as well. Since they were all female, I became accustomed to females. After I left school, I became more interested in being a "*maknyah*" (male participant, 20 years of age).

"In my family, all my siblings are boys. Back then, when my mother and father were working, I was the one who managed all the household chores. Because of that, I started to lean towards femininity. As I grew older, I often saw my friends putting on makeup, and I remember they once taught me how to put on makeup and invited me to go out with them" (male participant, 45 years of age).

"I've been living alone since I was young; even during school, I was on my own. My parents had divorced, and there were family issues. All my siblings are girls, so I'm used to being around women. After I dropped out of school, I started to delve deeper into learning how to become a transgender woman, especially after spending a lot of time socialising with them" (male participant, 20 years of age).

"My mother indeed wanted a daughter and she had already prepared a girl's name for me. Some of my neighbours and friends have known my girl's name since childhood, and they call me by that name" (male participant, 30 years of age).

"After my mother passed away, I lived with my father. At that time, he always asked me to do household chores like cooking and cleaning. My sister continued her studies abroad, and when she returned, she asked me to dance to entertain her. But I do not blame anyone because I enjoy and am content with my life like this" (male participant, 30 years of age).

The main factors that led them to transition into a transgender woman were their own desires and the influence of their families and friends. Despite being boys, some of them had been treated like girls since they were young. They finally stopped living as men and started living as women as a result. With the correct guidance and support from their surroundings, individuals might still be able to avoid engaging in sex work. Every child should be treated by their family according to their gender, and they should not be allowed to participate in activities or wear clothing that is inappropriate for their gender.

Engaging with the first sexual intercourse

"My uncle taught me about sex. I was feminine in primary school, but it became more apparent in secondary school. He first started having sex with me at a "*kenduri*." When I first did it, I was 14 years old" (male participant, 40 years of age).

"When I was 17 years old, right before SPM, I began having sex. During that time, I often met my teacher preparing for SPM. I had my first sexual encounter with him. The teacher did not make me do anything, yet I was the one who desired it. I did it right before turning 17 years old" (male participant, 44 years of age).

"When I first had sex, it was purely for fun. We are called the Divas" in my village. The boys would follow my group and me as we rode on our motorcycles after school. I first had sex at that time. They are secondary school seniors. At the time, I was a Form 3 student" (male participant, 30 years of age).

"The first time I did it was with a classmate during high school. My school often organised overnight religious programs (*qiamullail*) where we would sleep at the school together. During one of these occasions, he invited me because I was known to be gentle and soft-spoken" (male participant, 45 years of age).

"I had sex for the first time when I was 15 years old after I finished school. I thought of a way to get money because I was living alone without my family. I asked my friends who were working as sex workers at the time. They share a little about their experiences. At first, I was a bit scared but the first time I did it was with my client at home" (male participant, 20 years of age).

"I did it with my neighbour who was the same age as me. During the day, we don't seem to know each other but at night, he always looks for me. I was in 2nd grade at the time, around 14 years old. I did it because of pleasure and lust" (male participant, 29 years of age).

"My first sexual relationship was with my cousin when I was in form 1. My cousin was older than me in his 20s, maybe that's why he was more lustful than me. He invited me to do it and at that time, I just obeyed" (male participant, 48 years of age).

Most of them started to engage in sexual activity during adolescent age. Sadly, for most of them, their first sex partner comes from their own family members, teachers, and friends. Surprisingly, they frequently have their first sex encounter with the closest and most trustworthy adult. Since sodomy is a sensual act outside nature's order and some of them were under the legal age of 16, it is illegal and punishable by law. Parents should keep track of where their children are and teach them about healthy sexual behaviour, especially throughout the adolescent years.

The process of gender transformation

"So far, I have only taken hormone injections, pills, and implants. I got the implant done abroad, but I tried the pill because many friends bought it from pharmacies. The injectable hormones are also from abroad, and if there's no stock, then I take the pills" (male participant, 29 years of age).

"I initially tried hormone pills, and gradually, I began trying hormone injections. I had contacts from abroad, making it easy to get supplies. I also tried breast implants there" (male participant, 30 years of age).

"I obtained pills and hormone injections from abroad. I also underwent nose surgery, but I had it removed at UIA Hospital. I removed it because I felt it didn't suit my face as it was too long" (male participant, 40 years of age).

"I have been taking hormones until I turned 40 because the doctor advised me to stop due to my diabetes. Now, I only use hormone patches, which I buy from the pharmacy once a week".(male participant, 44 years of age).

"We have access to buying hormone pills from the pharmacy, especially if they recognise us as frequent customers. I've had an experience of overdosing on hormones, which led to diabetes and kidney damage according to the doctor. This overdose was a result of taking too many hormone pills—about six a day —which likely contributed to my kidney issues. For the past 13 years, I've been relying on insulin injections. Besides that, I've also undergone nose surgery and breast implants" (male participant, 30 years of age).

Hormonal pills, hormone injection, implant insertion and surgical procedures were the four main methods used by them for their gender transformation process. With the exception of hormonal pills, all other three methods (hormonal injection, implant insertion and surgical procedure) required them to go out of the country in order to obtain it. It is interesting to note that some of them brought up medical problems associated with all four of these techniques. As healthcare providers, one of our objectives is to use medical issues to educate patients against the use of harmful methods and procedures. Proper health education may help prevent them from using any gender alteration techniques.

Experience as a sex worker

"I began working as a sex worker when I was 19 years old, just after SPM. I initially went to "*lorong*" with my pals, and by that time I had already started dressing like a woman and applying cosmetics. At that time, I also had feelings for guys. I went and began learning about "*lorong.*" My very first sexual encounter was with a client. My own lust was the reason. I am not worried about money yet. However, when my lust was satisfied and I received the cash, my urge to perform sex acts grew" (male participant, 34 years of age).

"When I started working at a resort, I became a sex worker. There, I was a showgirl. I would take a customer after my night shift ends. I was 19 years old when that happened. The visitors to the resort were my clients. It eventually turns out enjoyable" (male participant, 48 years of age).

"Since I moved to Kuala Lumpur (KL), I started working as a sexual worker. I performed massages and other services for cash. I moved to KL after finishing my studies (when I was 18 to 19), and I work alone" (male participant, 29 years of age).

"Before this, I was employed, but my boss treated me unfairly. I consequently connected with the "*maknyah*" community and began to learn about the "*lorong*" sex industry. I started working as a sex worker at "*lorong*" only after experiencing discrimination from my boss. I did it for money because I had quit my permanent work at that time" (male participant, 40 years of age).

"I am looking for alternatives to get money. I see that sex workers have a lot of money and it is easy to get it. At that time, I had no education, no certificate, nothing. So, I started working as a sex worker" (male participant, 20 years of age).

> "When I was in form 5, normal school hours ended at 2pm and I went straight to my friend's house to get ready for work in his night hallway. At that time, I learned a lot from my "*mak ayam*" (male participant, 30 years of age).

Some of them worked as sexual prostitutes out of passion and for fun, but the majority were forced to do so for financial reasons. Sadly, some of them had to abandon their previous industry due to discrimination and mockery, forcing them to turn to sexual work in order to survive. Government or nongovernmental organisations should look into this issue as many of them engage in sex work due to financial necessity and low educational attainment. More strategies are needed to reduce the number of transgender sex workers in our country.

Desire to repent/stop from 'sex work'

> "To be frank, there was a time when I seriously contemplated leaving the sex work industry. I openly admitted that I had intentions to quit before reaching the age of 40. I pondered the longevity of my career in this field, recognising that while there may be ample demand when one is young, the prospects of finding clients as one ages become increasingly uncertain" (male participant, 34 years of age).

> "I often think about why there are fewer customers nowadays in the alleys. Sometimes, the thought of quitting crosses my mind, especially now that I am nearing 40. I have cooking skills and used to work as a cook in school, but in my current situation, it is still uncertain. Many shops have closed, so I am not sure when I can quit because I am afraid of not having a steady job after this" (male participant, 40 years of age).

> "It is not that I don't want to quit; I've already decided that by age 40, I want to leave this (sex work) behind. But we are forced to do it because of our current economy, whether we like it or not. Deep down, we don't want to work as sex workers anymore, but we're compelled to because of financial needs. We have to pay for housing, expenses, and help our families. Even though we have tried our best to stop, at the moment it is unavoidable. That's what I can say (male participant, 44 years of age).

> "It's probably time that I start feeling a bit inclined to quit. But we're compelled to continue doing this (sex work) due to financial circumstances and the need for money. But if you ask me if there is a good job opportunity, I would definitely consider it. Because I know I am not getting any younger. Everyone has their perspective, their rights" (male participant, 20 years of age).

"I feel like even if I were to quit, it is not because of health issues or anything like that. It is more about the customer's factor. If a person feels they are still in demand, they might continue. If they feel they are not, they might stop. I think if someone is still in demand, they'll continue doing this work even as they get older. That may be the difficult part because the money from sex work is a lot and quick. It is easy and enjoyable work. It's easy money. Compared to other jobs where you have to exert physical effort and get tired" (male participant, 30 years of age).

"I have tried to quit many times. I stopped taking hormone pills, cut my hair, and considered seeing a doctor to remove the implants. Recently, I made an appointment with a doctor to remove the implants, but because I have diabetes, it makes me afraid of surgery. So now, I haven't quit yet, but I've started to slow down. I still do sex work because when I stop, I see my savings dwindling. Meanwhile, my friends have more fun buying all sorts of things. Instead of sitting idly, I might as well work too. Eventually, it's difficult to quit when it becomes harder to make money. It's hard to leave this job. I feel like I've committed many sins; I sit alone and cry, thinking about all this. Many of my young friends also have diseases, HIV, or something. I'm not exempt from that; I can't escape it. I'm scared; death feels like it's looming over me; I feel like it's getting closer and closer" (male participant, 30 years of age).

"I do have the desire to stop, but instincts often overpower that intention. For me, money is not the main reason. My urges and desires that surface make it difficult to stop. Presently, these desires have a strong hold over us. Perhaps with time and effort to quit, divine intervention may assist in regaining control over our urges" (male participant, 48 years of age).

"I can not predict (when to stop sex work) yet because I am still young. But if I have an opportunity to earn a lot of money through other means, then I would definitely leave this sex work behind. So, I would pursue other avenues to earn money aside from sex work. For now, there doesn't seem to be any indication of quitting yet. But if the opportunity arises, I would definitely leave. Because if I could, I would want to move on" (male participant, 20 years of age).

Many of them express a desire to leave sex work, particularly as they approach the age of 40, citing concerns about aging and the diminishing demand for their services. Financial necessity often compels them to continue despite their intentions to find alternative employment. Most of them mentioned the ease and quick financial rewards of sex work compared to other jobs but also acknowledged the emotional toll and health risks associated with it. They express a mix of hope for future opportunities and fear of instability in the job market, revealing a complex interplay between the desire for change and economic pressures.

Take home messages

In Malaysia, transgender women have experienced numerous difficulties since their young age. Family is crucial in helping to raise children correctly and gender-appropriately during their formative years. In addition, everyone must play a part in preventing transgender women from becoming sex workers, including teachers, family members, and the community. To enable this population to live a better life free from risky sex and other unhealthy behaviours, social issues such as discrimination against them must be resolved. In order to lessen discrimination against transgender people, we need to assist them in bettering themselves and encourage them to give up sex trafficking. The government, non-governmental organisations and the community must all play a part in resolving these issues.

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02

CANCER: ARE TRANSGENDER WOMEN AT RISK?

Nurulhasanah Mustapar
Kulliyyah of Medicine, IIUM

ABSTRACT

This chapter explores the cancer risks faced by transgender women, focusing on the potential effects of hormone therapy, surgical procedures, and other modifiable factors such as smoking and obesity. The chapter highlights the scarcity of research on cancer in transgender populations, emphasising the need for more studies to understand the prevalence and prognosis of various cancers. Specific risks related to breast cancer, prostate cancer, HPV-related cancers, and other conditions like meningiomas and prolactinomas are discussed. The importance of developing transgender-specific cancer screening guidelines and addressing healthcare disparities is underscored to improve health outcomes in this vulnerable population.

Cancer in Transgender People

Transgender individuals are people whose gender identity or expression differs from the gender assigned to them at birth. Gender affirmation refers to the process of aligning one's gender identity with their physical body. For some transgender individuals, this process may involve undergoing medical procedures such as gender reassignment surgery and hormone therapy. However, it's important to note that not all transgender individuals choose to pursue these options. Some may choose to express their gender identity through non-medical means, such as changes to their name, pronouns, clothing, and appearance. Ultimately, the decision to pursue gender affirmation is a personal one that should be made with the support of qualified healthcare professionals.

Given that cross-sex hormones used for gender affirmation can be administered at high doses and for extended periods, the carcinogenicity of hormonal therapy for transgender individuals is a serious concern. Furthermore, concerns regarding cancer risk in transgender patients have been linked to Sexually Transmitted Infections (STDs), increased exposure to established risk factors such as alcohol and tobacco use, and limited access to screening.

Cancer risks in the transgender population

Transgender individuals are more likely to suffer from negative health outcomes as per the current literature. While there has been a surge in research on transgender health issues, the majority of studies have focused on substance abuse, sexual health, STDs, and to a lesser extent, mental health problems (MacCarthy et al., 2015). However, little information is available on the prevalence of age-related chronic diseases like cancer.

Prioritising research on cancer in transgender individuals is crucial. However, current concerns regarding the occurrence and prognosis of malignant tumours in this population are primarily based on anecdotal evidence or general analyses of potential disease processes. Unfortunately, due to the limited number of comprehensive prospective studies, there is insufficient high-quality empirical data available to accurately evaluate cancer incidence and mortality rates among transgender individuals. In this chapter, we will explore the potential risk factors that may differentially impact cancer risk in this population, while also acknowledging the unique challenges associated with studying this group.

Risk factors of cancer in transgender women

Possible effects of cross-sex hormones

Typical hormonal treatment for transwomen aims to decrease blood testosterone to physiological female concentrations (30–100 ng/dL) through antiandrogens (or surgical castration) and to achieve normal female but not supraphysiological levels (<400 pg/mL) of estradiol through estrogen therapy (Gardner & Safer, 2013).

There have been studies suggesting that transwomen who undergo medical or surgical gender affirmation may have an increased risk of hormone-related cancers such as breast and prostate cancer, prolactinomas, and meningiomas (Braun et al., 2017). In the following sections, we will discuss some common types of cancer that transgender patients may experience after undergoing hormonal or surgical gender affirmation.

Breast augmentation using silicone and breast implants

Breast augmentation is a surgery used for both cosmetic and reconstructive purposes. It involves the use of breast implants, such as silicone gel prosthesis, which were first introduced by Cronin and Gerow in 1962.

Implants used in medical devices are designed to be chemically inert, temperature-stable, and resistant to oxidation, microorganisms, mechanical strain, and body fluids. Additionally, they should not cause inflammation or hypersensitivity, must maintain their shape, be easy to sterilize, and not be carcinogenic. Currently, there is a wide range of medical devices that use silicone implants, including breast and larynx implants, hydrocephalus shunts, implantable infusion pumps and ports, intraocular lenses, pacemaker and defibrillation devices, and penile and testicular prostheses.

The impact of silicone on chronic inflammation must be analysed, taking into consideration the multiple factors suggested to promote autoimmune disease development, tolerance breakdown in females, and genetic and epigenetic vulnerability (de Boer et al., 2018).

Implants, especially older ones, can lead to chronic activation of the immune system against the prosthetic material. This is more likely to happen in genetically susceptible individuals. Studies indicate that this polyclonal activation can result in monoclonality in at-risk individuals, which can ultimately lead to lymphoma (Bizjak et al., 2015).

Human papillomavirus infections

There is a strong correlation between Human Papillomavirus (HPV) and various types of cancer in the transgender population. Out of more than 40 types of HPV, at least 13 are considered high-risk due to their potential to cause cancer (Supindham et al., 2015). Numerous studies have found that there is a significant association between the incidence of HPV-related lesions and individuals infected with the human immunodeficiency virus (HIV).

Other cancer risk factors

While there is no large-scale nationally representative data, evidence suggests that transgender individuals are at a higher risk for cancer due to modifiable factors such as smoking, obesity, and inadequate screening (Braun et al., 2017).

Common types of Cancer among transgender women

Human papillomavirus-related cancer

Various studies have revealed that HPV has a strong link with anal, oropharyngeal, and penile cancers in non-transgender men, and cervical, anal, vulvar, and vaginal cancers in non-transgender women (Gillison et al., 2008). There have been several reports of potential or presumably HPV-associated cancers in transgender individuals who have undergone gender affirmation therapy, including neovaginal and anal cancers in transwomen and cervical and vaginal cancers in transmen (Braun et al., 2017). It is noteworthy that the use of heterotopic penile skin in neovaginas may increase the risk of HPV-induced squamous cell carcinoma.

In a recent study conducted at a clinic in Amsterdam, neovaginal swabs were taken from 54 transwomen who had undergone vaginoplasty. The swabs were tested for the presence of high-risk HPV DNA. Out of the 28 sexually active individuals included in the study, 6 (20%) tested positive for neovaginal high-risk HPV (van der Sluis et al., 2016). It has been suggested that complications from vaginoplasty, such as chronic laceration and inflammation, may increase the risk of cancer in this population (Harder et al., 2002).

Studies have shown that people infected with HIV are more prone to developing HPV and HPV-related anal squamous intraepithelial lesions. This holds for both transgender and non-transgender individuals (Braun et al., 2017). Transgender people, particularly transwomen, have a higher likelihood of contracting HIV infections, which has led to some of the highest laboratory-confirmed prevalence rates in the world (Poteat et al., 2016). Due to these factors, HPV-related cancers are expected to occur more frequently among transgender individuals than in the general population (Quinn et al., 2015).

Prostate cancer in transwomen

It is important to consider the role of exogenous estrogen and its effect on estrogen receptors during gender confirmation surgery, as the prostate is not removed. It was previously believed that androgen deprivation by using antiandrogens or orchiectomy would protect against prostate cancer, but recent studies have shown that this may not be the case. Different estrogen receptor isoforms may have contradictory modes of action, with estrogen receptors accelerating prostate cancer while estrogen receptor appears to exert antineoplastic effects (McPherson et al., 2010). It has also been observed that 17-estradiol, with the help of coactivators or androgen receptor mutations that cause 17-estradiol hypersensitivity, can bind to androgen receptors. Additionally, estrogen acts on more than just estrogen receptors (Thin et al., 2003; Yeh et al., 1998). Transwomen with prostate cancer may have more aggressive forms of the disease despite having low testosterone and high estrogen levels (Turo et al., 2013).

It has been reported that all cases of prostate cancer among transwomen who have undergone gender affirmation had orchidectomy, and were receiving hormonal therapy. In almost all reported cases, hormonal therapy was administered for at least ten years before diagnosis, except for one case (Braun et al., 2017). Although high PSA levels, which are indicative of an aggressive disease, were found in most cases of prostate cancer in transwomen, it should be noted that these individuals were either symptomatic or had a palpable prostate lesion at the time of diagnosis. Thus, it is expected that PSA levels in these cases would be higher than the levels typically observed in the general population of prostate cancer patients (Holz & Goodman, 2015).

Breast cancer in transwomen

When high doses of exogenous cross-sex estrogens and androgen antagonists are administered, breast lobules, ducts, and acini that are histologically identical to those of biological females are stimulated to form. Exogenous estrogen binds to the estrogen receptor in the breast tissue and is thought to promote the development of cancer by promoting cell growth, reducing apoptosis, and upregulating the synthesis of oxidative metabolites that cause DNA damage (Maglione et al., 2014; Yager & Davidson, 2006). Studies suggest that transwomen may have an increased risk of breast cancer due to hormone therapy. This is supported by the finding that higher serum levels of endogenous estradiol are linked to a higher risk of breast cancer (Yue et al., 2013).

It has been found through various studies that the use of progesterone in hormone replacement therapy for postmenopausal women may increase the risk of breast cancer. It is important to pay close attention to the risks associated with progesterone use when considering hormone replacement therapy (Braun et al., 2017).

Transwomen may be exposed to hormonal therapy from an earlier age and for longer periods than non-transgender women receiving hormone replacement therapy for menopause, which may increase their cumulative risk. One study of 2,307 transgender women and 3,541 transgender men found that the risk of breast cancer in transgender women is higher compared to transgender men (de Blok et al., 2019).

This suggests that hormone therapy and other factors related to gender identity and transition may play a role in the increased risk of breast cancer for transgender women. The study also found that breast cancer in transgender women has been observed after approximately ten years of cross-sex hormonal therapy. Interestingly, the cases were reported at a younger age (49 years) compared to the median age of diagnosis for non-transgender men (72 years) and non-transgender women (61 years). This finding suggests that hormone therapy may increase the risk of developing breast cancer at a younger age for transgender women.

Breast-implant associated Anaplastic Large Cell Lymphoma (ALCL)

Studies on the association between breast implants and breast cancer have generally found no link between the two. However, there have been some reports of an increase in a specific type of non-Hodgkin's T-cell lymphoma called Breast Implant-Associated Anaplastic Large-Cell Lymphoma (BIA-ALCL) among patients with certain types of implants. It is important to note that the number of reported cases of BIA-ALCL is still relatively small and the exact number of cases worldwide has not been established (de Boer et al., 2018). Nevertheless, these findings remain a topic of debate.

Breast implant-associated Anaplastic Large Cell Lymphoma (ALCL) is a specific type of T-cell lymphoma that is linked to breast implants. This type of lymphoma occurs more frequently in women with textured breast implants. Although the risk of developing breast implant-associated ALCL in women with textured implants is low, the current incidence rate in the US is significantly higher than that of primary ALCL of the breast in the general population (Santanelli di Pompeo et al., 2023).

It has been suggested that silicone implants can cause a local inflammatory response, which may be triggered by silicone-derived products or bacterial species present on the surface of the prosthesis in the form of biofilm. This response can lead to scarring of the surrounding tissue, and eventually to the formation of a capsule around the implant. In some rare cases, inflammation can persist and activate lymphocytic cells, both polyclonal and monoclonal. Studies have shown that there may be local and systemic immunological reactions to silicone (Bizjak et al., 2015).

Toxic substances that are involved in the production of breast implants have been linked to genetic mutations. It is unclear whether certain groups of women have a higher risk of developing lymphoma due to exposure to breast implants. These groups may have a genetically determined altered or exaggerated local immune response, but this remains a hypothetical theory (de Boer et al., 2018).

Meningioma in transwomen

There is a possibility that female sex hormones could be involved in the development of meningiomas. This theory is based on several observations, such as the fact that women are more likely to develop meningiomas than men, the size of the tumours can change during the menstrual cycle and pregnancy, meningiomas are often associated with the use of birth control pills and hormone replacement therapy, and they tend to occur alongside breast cancer (Claus et al., 2013; Wiemels et al., 2010). Most meningiomas contain progesterone receptors, while only around one-third of tumours contain estrogen receptors. Therefore, it is believed that progesterone, especially when taken in high amounts, may play a role in the development of meningiomas in transgender women (Gazzeri et al., 2007). The use of cyproterone acetate, a chemical that acts as both a progesterone agonist and an antiandrogen, is of particular interest in these cases (Cebula et al., 2010).

Prolactinoma in transwomen

Prolactinomas are the most common type of pituitary tumour. They are usually small and slow-growing and are more commonly diagnosed in women. Studies have shown that estrogens can lead to the production and release of prolactin, thereby increasing the risk of hyperprolactinemia and prolactinoma development (García-Malpartida et al., 2010). There is also evidence to suggest that progesterone may play a role in the development of prolactinomas, as these tumours have been found to express both estrogen and progesterone receptors. However, this pathway is not yet fully understood (Chen et al., 2020).

Cancer Screening and awareness among the transgender Community

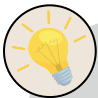
Transgender individuals face unique challenges when it comes to healthcare due to discrimination and specific health needs. This group is at increased risk for cancers of the reproductive systems that do not necessarily correspond to their gender identity. For example, transgender women might not be aware of their risk for prostate cancer. Additionally, those who have undergone sex reassignment surgery may not be aware of the ongoing risk of reproductive malignancies due to remaining tissue. Unfortunately, many transgender individuals avoid cancer screenings and exams due to emotional or physical distress related to their gender identity and genitalia. Medical personnel who lack knowledge about transgender health conditions can also be a barrier to receiving proper medical care. Disengagement from gender-specific healthcare can lead to missed opportunities for cancer screening and diagnosis, contributing to the higher incidence of cancer in this population.

Cancer risk is a top priority area for research in the transgender community. There are several uncertain areas, including the risk of breast cancer and the need for breast cancer screening in transwomen who receive estrogens. Additionally, it is crucial to determine optimal screening protocols for breast cancer in individuals who are exposed to estrogens, as well as the incidence and progression of estrogen-related prolactinoma, PSA levels, and both the risk and prognosis of prostate cancer after estrogen exposure and/or orchiectomy.

Transgender-Specific Cancer Screening Guidelines

Due to a lack of studies and standard guidelines, specific cancer screening guidelines for transgender individuals have yet to be established. Medical societies should establish guidelines for the early detection of cancers in this population, as it is an area of unmet medical need. It has been suggested that clinicians should recommend prostate cancer screening for transgender women based on guidelines for non-transgender men, with screening intervals tailored to each individual case. Additionally, physicians should consider screening transgender women for breast cancer if they have used hormone therapy for more than five years. Routine screening for HPV should be implemented in transgender women who have undergone vaginoplasty (Jackson et al., 2024).

As a medical professional, how do you approach patients from the LGBTQ community?

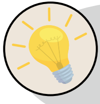


As a medical professional, it is essential to approach patients from the LGBTQ+ community with sensitivity, respect, and a commitment to providing equitable and inclusive care. Here are some key principles to follow:

1. Create a Welcoming Environment: Ensure that your practice or clinic is welcoming to all patients.
2. Use Inclusive Language: Always use the patient's chosen name and pronouns. Avoid making assumptions about a patient's gender identity, sexual orientation, or relationships to create rapport and avoid feeling of discomfort.
3. Maintain Confidentiality: Protect the privacy of LGBTQ+ patients just as you would with any other patient. Be mindful of the sensitivity of information related to their sexual orientation or gender identity.
4. Educate Yourself: Stay informed about the specific health needs and disparities faced by the LGBTQ+ community. This includes understanding the impact of minority stress, the prevalence of certain health conditions, and appropriate screenings and preventive care.
5. Provide Comprehensive Care: Address both physical and mental health needs, recognizing that LGBTQ+ patients may have unique health concerns or may be at higher risk for certain conditions. This includes being aware of the effects of hormone therapy, understanding the importance of HIV/STI prevention and treatment, and providing mental health support.

By following these principles, medical professionals can help ensure that LGBTQ+ patients receive the compassionate, competent, and respectful care they deserve.

Do you think this community struggles with social acceptance?



Yes, the LGBTQ+ community often struggles with social acceptance. This lack of acceptance can be attributed to various factors:

Reasons for Social Acceptance Struggles

1. Cultural and Religious Beliefs: Many cultures and religions have traditional views on gender and sexuality that do not align with LGBTQ+ identities. This can lead to social rejection, discrimination, and even hostility towards LGBTQ+ individuals.

2. Lack of Education and Awareness: Misunderstanding and lack of knowledge about LGBTQ+ issues can foster prejudice and fear. Stereotypes and misinformation contribute to negative attitudes and discrimination.

3. Legal and Policy Discrimination: In many places, laws and policies do not protect LGBTQ+ individuals from discrimination. This legal discrimination can reinforce social stigma and exclusion.

Addressing the Challenges

Efforts to address these challenges include:

- Education and Advocacy: Increasing awareness and understanding through Islamic education and advocacy can help reduce stigma and discrimination.
- Healthcare Training: Ensuring healthcare providers receive training on LGBTQ+ health issues.
- Mental Health Support: Providing accessible mental health services tailored to the needs of the LGBTQ+ community.
- Community Building: Creating safe spaces and supportive networks for LGBTQ+ individuals to keep in touch with them and bring them towards the right path.

Addressing these issues requires a multifaceted approach involving individuals, communities, institutions, and governments to help bring back LGBTQ+ individuals to the right path of Islam.

Conclusion

In summary, transgender individuals face unique health challenges, including an increased risk of certain types of cancer. We must recognise and address these risks to improve the health outcomes of the transgender population. By raising awareness, advocating for better access to healthcare, and supporting research, we can work towards reducing the cancer burden in this vulnerable community.

Everyone deserves to be treated with dignity and kindness, and being a supportive ally is important in helping create a more inclusive and understanding society. As a member of the community, I would ensure that they feel safe, valued, and loved, and would stand by them against any discrimination or prejudice they might face and slowly bring them back to the right path of Islam.

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03

MAPPING THE BIOLOGICAL LANDSCAPE: UNDERSTANDING THE PHYSIOLOGY OF GENDER DYSPHORIA

Maizura Mohd Zainudin
Kulliyyah of Medicine, IIUM

ABSTRACT

This chapter delves into the intricate neurobiological and physiological underpinnings of gender dysphoria and gender identity. The exploration begins with an examination of the neurobiology of gender identity, emphasizing the role of brain structures and their influence on human sexuality. The chapter also addresses the physiology of brain structures, highlighting how differences in brain morphology and connectivity can contribute to variations in gender identity. Additionally, the chapter explores the critical role of the endocrine system and hormonal influences in shaping sexuality, focusing on how hormonal fluctuations during critical periods of development can impact gender identity and sexual orientation. The chapter concludes with an in-depth discussion on Hormone Replacement Therapy (HRT) in transgender individuals, providing insights into the physiological effects of HRT and its implications for gender-affirming care. Through this comprehensive examination, the chapter aims to provide a holistic understanding of the physiological factors contributing to gender dysphoria, offering a foundation for future research and clinical practices.

Neurobiology of Gender Identity

Human sexuality is a complex system with various aspects, described differently depending on the context. While "sex" refers to biological characteristics like chromosomes and physical traits, "gender" encompasses both internal perceptions (gender identity) and external societal expectations of masculinity and femininity (gender roles) (American Psychological Association, 2015). "Sexual orientation" relates to whom a person is attracted to (sexual preference) (Meyer, 2013).

Humans are born as either male or female, determined by their sex chromosomes specifically, whether they have XX (female) or XY (male) chromosomes (Figure 1). The development of a person's sex phenotype is influenced by the presence of specific sex chromosomes, which in turn determine the production of certain hormones during prenatal development.

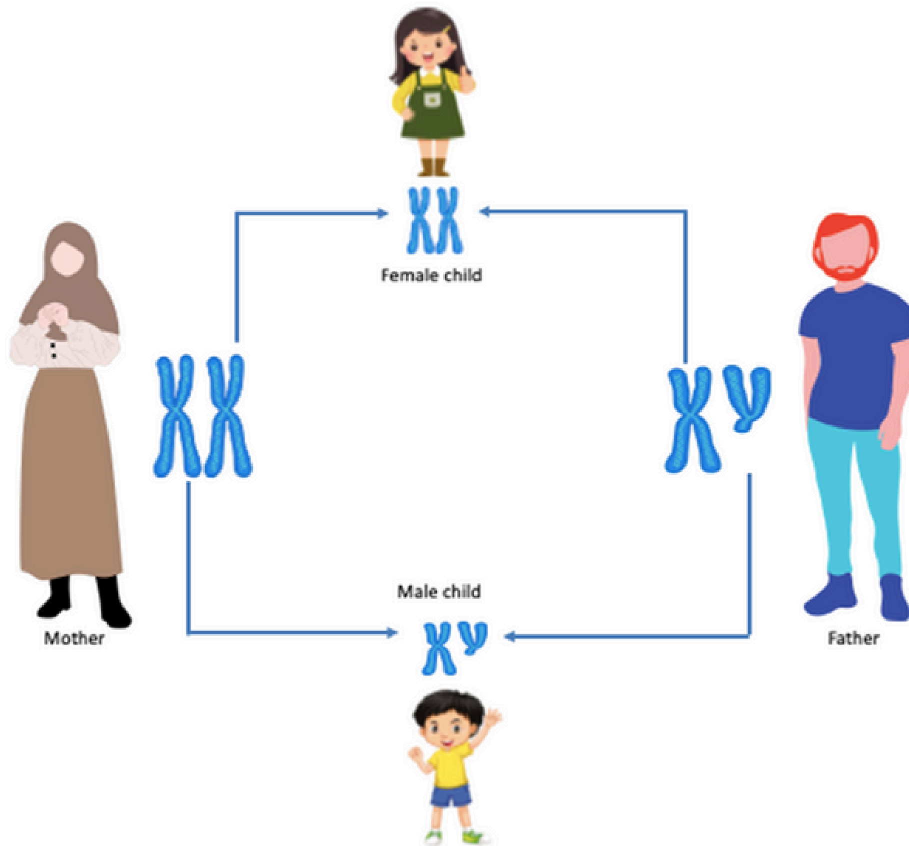


Figure 3.1: X and Y sex chromosomes determine the gender of the offspring

During foetal development, the presence of the SRY gene on the Y chromosome in XY individuals triggers the development of testes, which produce testosterone hormone. Testosterone then leads to the development of male sex characteristics such as the formation of the penis, scrotum, and other male reproductive structures. This process highlights the critical role of chromosomes in initiating the development of primary and secondary sex characteristics that define an individual's sex phenotype (Figure 2).

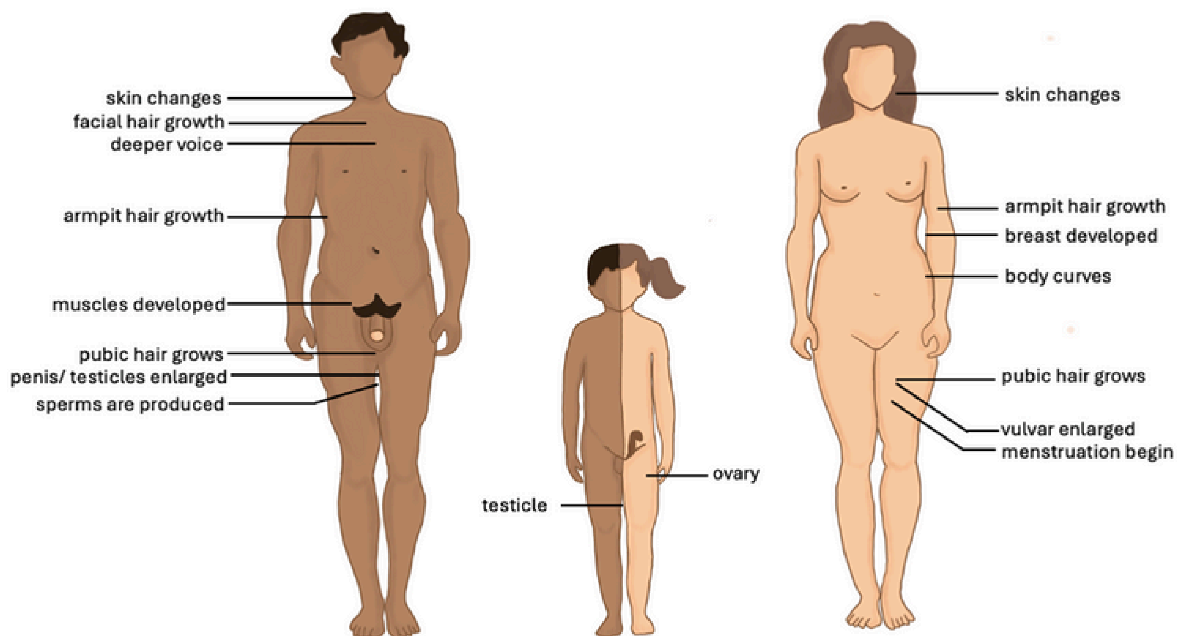


Figure 2: Secondary Sexual Characteristics

In individuals with XX chromosomes, the default pathway leads to the development of female sex characteristics. The development of the female sex phenotype begins during embryonic development. At around six weeks of gestation, in the absence of the Y chromosome, the gonads in XX individuals develop into ovaries. The ovaries then start producing oestrogen and progesterone, which are key hormones in the development of female sex characteristics. These hormones play roles in various aspects of female characteristic development including the external genitalia, internal reproductive organs, breast development, and secondary sexual characteristics (Figure 2).

Oestrogen promotes the development of the labia majora, labia minora, clitoris, and vaginal opening. These structures contribute to the external appearance of the female genitalia. Additionally, oestrogen and progesterone stimulate the development of the fallopian tubes, uterus, and vagina. These organs are essential for reproduction and menstruation. Oestrogen, along with other hormones like prolactin, contributes to the growth and development of the breasts during puberty and pregnancy. Oestrogen also influences the development of secondary sexual characteristics such as the distribution of body fat, growth of pubic and axillary hair, and changes in voice pitch.

Throughout puberty and adulthood, the balance of hormones, particularly oestrogen and progesterone, continues to regulate menstrual cycles, reproductive function, and other aspects of female physiology. These hormonal processes collectively contribute to the development and maintenance of the female sex phenotype.

The "born that way theory" suggests that gender identity and sexual orientation are inherent and unchangeable characteristics (Savic et al., 2010; Swaab, 2007, 2008). However, studies have proposed that differences in brain development can affect how transgender people perceive their bodies or how homosexual individuals experience sexual arousal. Some researchers also suggest that our sense of gender identity and sexual preferences might be "programmed" early in the brain, separate from how our genitals develop before birth (Savic et al., 2010; Swaab, 2007, 2008). This idea suggests that who we are attracted to or how we see ourselves might not always match our physical features at birth.

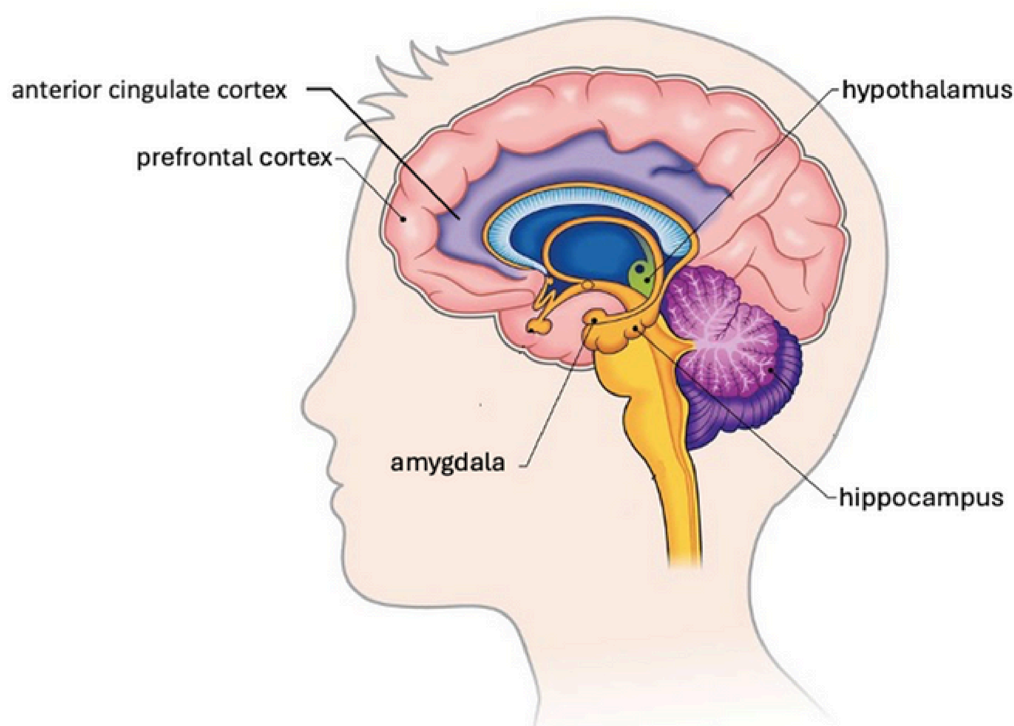
In this view, the brain's sexual differentiation occurs at a distinct stage and may be influenced by genetic, hormonal, and environmental factors. These factors can potentially lead to variations in the development of brain structures related to gender identity and sexual arousal. For instance, in transgender individuals, it's proposed that differences in brain structure and function related to body perception may contribute to the experience of gender dysphoria (Savic et al., 2010).

Similarly, in individuals who are homosexual, there may be alterations in brain areas associated with sexual arousal and attraction. This idea of decoupling genital and brain differentiation challenges traditional assumptions that gender identity and sexual orientation are solely determined by biological sex or genitalia, highlighting the complex interplay of biological and environmental influences on human sexuality (Roselli, 2018).

Gender identity and sexual orientation are shaped by both biological factors, such as genes, hormones, and gene expression, and environmental influences, including parents, peers, partners, and social models (Altinay & Anand, 2020; Balthazar, 2016; Jorge, 2010). 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 important roles (Roselli, 2018).

The Physiology Of Brain Structure Affecting Human Sexuality

The physiology of brain structure and its connection to human sexuality is a fascinating area of study. The brain plays a central role in regulating sexual behaviour, desires, and responses through a complex interplay of neural networks and chemical messengers. Several brain structures are intricately involved in human sexuality. The structures include the hypothalamus, amygdala, hippocampus, and frontal cortex (Figure 3). Together, these brain structures form a complex network that governs various aspects of human sexuality, including desire, arousal, behaviour, emotions, and memory.



According Figure 3: Brain Structure

One key brain structure involved in sexuality is the hypothalamus, which serves as a control centre for many basic bodily functions, including sexual behaviour. Within the hypothalamus, specific nuclei such as the preoptic area and the ventromedial nucleus are crucial 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.

Moreover, the limbic system, particularly the amygdala and the hippocampus, contributes to emotional aspects of sexuality, including attraction, bonding, and memory formation related to sexual experiences. These regions help form associations between stimuli and emotional responses, shaping an individual's sexual preferences and behaviours over time.

The physiology of brain structure involved in sexuality is intricate and multifaceted, encompassing neural circuits, neurotransmitters, hormones, and emotional processing. Understanding these mechanisms not only sheds light on the complexities of human sexuality but also has implications for addressing sexual health issues and developing interventions for sexual disorders.

Neurotransmitters are naturally occurring chemicals that facilitate communication between neurons throughout the body, enabling the brain to perform a wide range of functions, including those related to sexual activity. For instance, dopamine, a neurotransmitter associated with pleasure and reward, is released during sexual activity, contributing to feelings of arousal and satisfaction. Additionally, hormones such as testosterone, oestrogen, and progesterone influence sexual development, desire, and behaviour through their interactions with various brain regions. These intricate processes underscore the crucial role neurotransmitters and hormones play in regulating sexual function and overall well-being.

How much do biological factors contribute to shaping gender and sexual orientation, compared to the influence of personal experiences and cultural norms? The contribution of biological factors versus personal experiences and cultural norms in shaping gender and sexual orientation is a complex and debated topic. Biological factors, such as genetics, hormones, and brain structure, play a role in influencing gender identity and sexual orientation. However, the exact extent of their contribution compared to personal experiences and cultural norms is not definitively established and can vary widely among individuals.

Biological factors can influence the development of gender identity through processes like hormone exposure during critical periods of foetal development. Similarly, variations in brain structure and function have been linked to differences in sexual orientation. These biological aspects are important components but may interact with social and environmental factors.

Personal experiences, such as upbringing, social interactions, and life events, also play a significant role in shaping gender identity and sexual orientation. Cultural norms and societal expectations can strongly influence how individuals perceive and express their gender and sexuality. Family, peer relationships, media representation, and cultural attitudes toward gender and sexuality all contribute to the formation of an individual's identity.

It's essential to recognise that gender identity and sexual orientation are multifaceted and can be influenced by a combination of biological, personal, and cultural factors. The relative importance of these factors may vary for different individuals and may not be easily separated or quantified in absolute terms. Understanding and respecting the complexity of these influences is crucial in promoting inclusivity and supporting individuals in their journey of self-discovery and acceptance

Endocrine System and Hormonal Influences on Sexuality

The Brain Organisation Theory proposes that steroid hormones experienced during foetal development organise the brain in a lasting way regarding gender-related traits. These traits encompass patterns of sexuality, thinking styles, emotional tendencies, hobbies, and mental well-being that are traditionally labelled as either "masculine" or "feminine." (Hines, 2004 & Pinker, 2005).

Hormones play a crucial role in shaping sexual and gender-related traits from early life by organizing the brain, influencing sexual differentiation, contributing to gender identity formation, and influencing psychological and behavioural characteristics associated with gender roles. These hormonal influences contribute to the rich diversity of human sexuality and gender experiences.

Steroid hormones such as testosterone and oestrogen play a crucial role in shaping the structure and function of the brain during foetal development. Testosterone, for instance, is associated with the development of male-typical brain structures, while oestrogen is linked to female-typical brain development. These hormonal influences help lay the foundation for later sexual and gender-related characteristics (Bao & Swaab, 2011; McCarthy, 2008).

Hormones are instrumental in the process of sexual differentiation, which occurs early in gestation. The presence or absence of specific hormones during critical periods of development determines the differentiation of male or female reproductive organs, as well as the development of secondary sexual characteristics during puberty.

Hormones may also play a role in shaping gender identity, which is a person's internal sense of their own gender. While the exact mechanisms are complex and not fully understood, hormonal influences during foetal and early childhood development are believed to contribute to the formation of gender identity.

Hormonal influences may also extend to sexual orientation, although it's important to note that sexual orientation is multifactorial and not solely determined by hormones. However, hormonal factors during critical periods of development may contribute to aspects of sexual attraction and orientation.

Beyond sexual and gender identity, 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 (Hines, 2004; Peper & Dahl, 2013).

Hormone Replacement Therapy in Transgender Individuals

In a distinct context from natural development, hormone therapy or hormone replacement therapy is an essential component of medical transition for numerous transgender individuals, as it aids in aligning their physical attributes with their gender identity. The effects of hormone therapy can vary based on the individual's assigned sex at birth, the type of hormones used, dosage, and duration of treatment. Additionally, the degree and speed of changes occurring depend on various factors, including genetic makeup, the age at which hormone therapy begins, and the overall health status of the individual. The anticipated changes as hormone therapy progresses are expected in four key areas, namely physical, sexual, reproductive, mental, and emotional aspects.

Male to Female Transgender Hormonal Therapy

Hormone therapy for Male-to-Female (MtF) transgender individuals, also known as feminizing hormone therapy, uses oestrogen and sometimes anti-androgen medications. These hormones cause physical changes that help align a person's appearance with their gender identity. The therapy affects physical features, genitalia, and emotional well-being.

Physical changes

One of the most noticeable physical changes is breast development, as oestrogen promotes the growth of breast tissue over time. In fact, the sole lasting effect of long-term oestrogen use is the development of breast tissue (Figure 4). This process begins within the initial three months, marked by the formation of "breast buds," and progresses over the following two to three years.

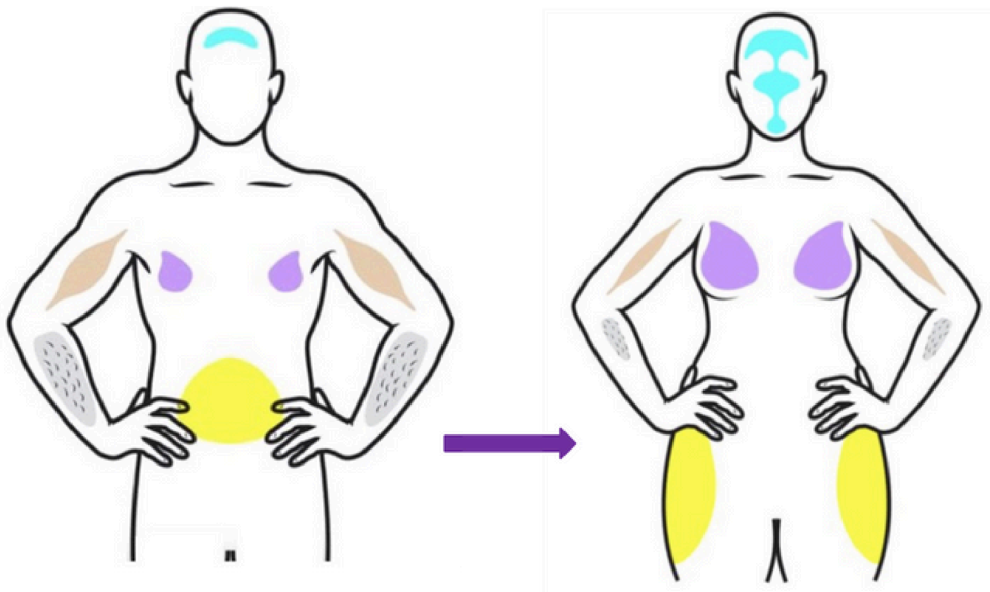


Figure 4: Male to female effects of oestrogen hormone replacement therapy.

Alongside this, there is typically a reduction in body hair growth, especially on the face, chest, and back, due to oestrogen therapy. Additionally, skin may become softer and smoother, and there is a redistribution of body fat from the abdomen and upper body to the hips, thighs, and buttocks, creating a more feminine body shape. Anti-androgens contribute to this process by reducing muscle mass and strength, leading to a less masculine physique (Figure 4).

Sexual and Reproductive Changes

In terms of genital changes, feminising hormone therapy can lead to a decrease in libido (sexual desire) and changes in sexual function. Prolonged oestrogen therapy may also result in genital atrophy, involving a reduction in the size of the testicles and penis, although the extent of these changes can vary among individuals (Hembree et al., 2017). Despite these physical changes, it's important to note that hormone therapy does not typically alter the internal reproductive organs (Wylie et al., 2016). Figure 5 shows the timeline of the expected changes experienced while on oestrogen.

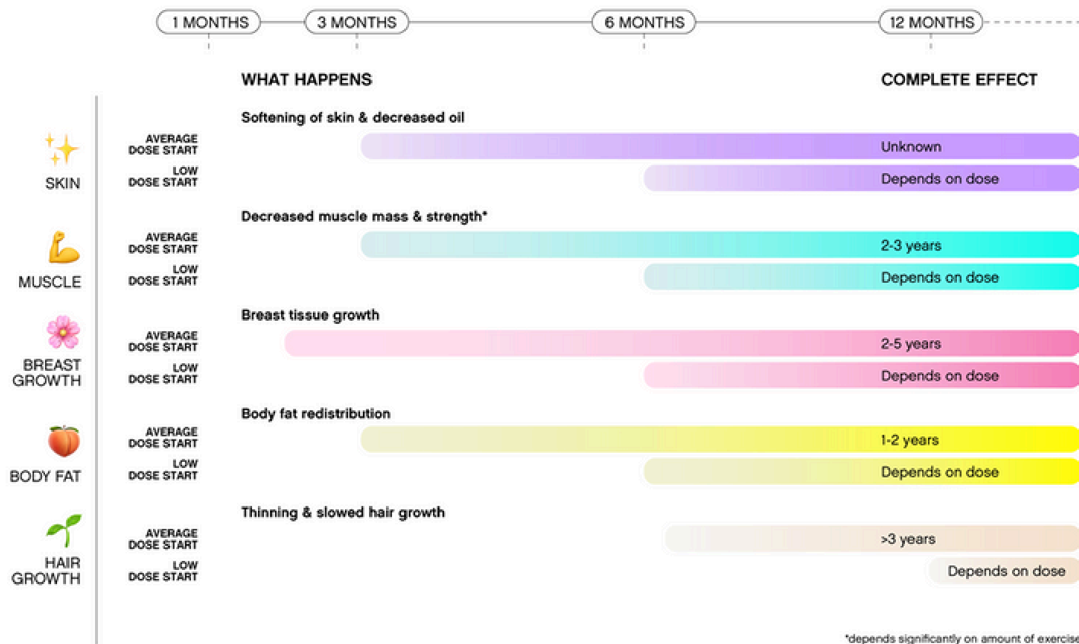


Figure 5: Timeline for expected physical changes on oestrogen hormone replacement therapy (Folx, 2022).

Mental and emotional Changes

Beyond the physical effects, feminising hormone therapy is reported to have positive impacts on emotional and mental health. Many MtF individuals experience reduced gender dysphoria as their physical appearance becomes more aligned with their gender identity. This reduction in gender dysphoria contributes to improved mental well-being, self-esteem, and overall satisfaction with one's body image (Wierckx et al., 2014).

Hormonal influences shape emotional and physical experiences, impacting how individuals perceive the world and themselves. Gender-affirming hormones typically enhance mood, fostering a sense of well-being in one's mind, emotions, and physical state (Gorin-Lazard et al., 2013).

For many transgender women and individuals with diverse gender identities, the introduction of oestrogen allows for a deeper connection with their emotions in a body that resonates more authentically with their sense of self, particularly within the initial year (Fisher et al., 2016). This may be reflected in heightened emotional states or a sense of expansiveness in mood. Moreover, changes in mood due to oestrogen can contribute to improved emotional and mental health, as gender-affirming hormone therapy plays a significant role in alleviating gender dysphoria, validating gender identity, and enhancing overall quality of life (Colizzi et al., 2013).

For individuals undergoing testosterone hormone replacement therapy, such as trans men and other gender-variant people, a lower-pitched voice with a deepened tone is a common outcome. However, the opposite effect of voice changes is not feasible for those on oestradiol/oestrogen hormone therapy. To clarify, oestrogen does not have the ability to alter one's voice.

If someone was assigned male at birth and did not undergo hormone blockers during adolescence, testosterone would have naturally thickened their vocal cords, resulting in a deeper voice. If altering one's voice is a goal, voice feminization techniques can be pursued through methods like voice therapy and/or surgical interventions. The field of transgender voice therapy, dedicated to assisting individuals in achieving a more feminine voice, is rapidly expanding, with a growing number of experts knowledgeable about transgender-specific needs.

However, it's essential for individuals to undergo hormone therapy under the supervision of knowledgeable healthcare providers, as there are potential side effects and risks associated with oestrogen and anti-androgen use. Some of the potential risks include a slight increase in the risk of blood clots, especially in individuals with other risk factors like smoking or a history of blood clots. Oestrogen therapy can also impact cardiovascular health and lipid levels, necessitating monitoring by healthcare providers. Long-term use of oestrogen may also affect bone density, highlighting the importance of regular monitoring and potential supplementation with calcium and vitamin D.

Additionally, certain effects of hormone therapy, such as breast development and voice changes, are permanent and irreversible. Individuals interested in preserving fertility should discuss options like sperm banking before starting hormone therapy. Overall, while feminizing hormone therapy can lead to significant physical, emotional, and psychological changes, it's crucial for individuals to work closely with healthcare providers to manage risks, monitor for potential side effects, and ensure overall health and well-being throughout the transition process.

Potential Risk and Complications of Oestrogen Replacement Therapy in Transgender Individual

Oestrogen hormone replacement therapy (HRT) can be an essential component of gender-affirming care for transgender individuals seeking feminization. While HRT can have numerous benefits, it's important to be aware of potential risks and complications associated with oestrogen therapy in this context including increased risk of blood clots formation (thrombus), problems with breast development, endometrial health, emotional and mental health, and bone health.

One significant risk associated with oestrogen therapy is an increased likelihood of developing blood clots, such as Deep Vein Thrombosis (DVT) (Figure 6) or pulmonary embolism (PE) (Figure 6). Deep vein thrombosis is a condition where a blood clot forms in a deep vein, typically in the legs. This can cause swelling, pain, and redness in the affected leg. If a piece of the blood clot breaks off and travels to the lungs, it can block blood flow in the pulmonary arteries (the artery that carries blood from the heart to the lungs for oxygenation) leading to a PE. A PE can cause chest pain, shortness of breath, and in severe cases, can be life-threatening cardiovascular complications.

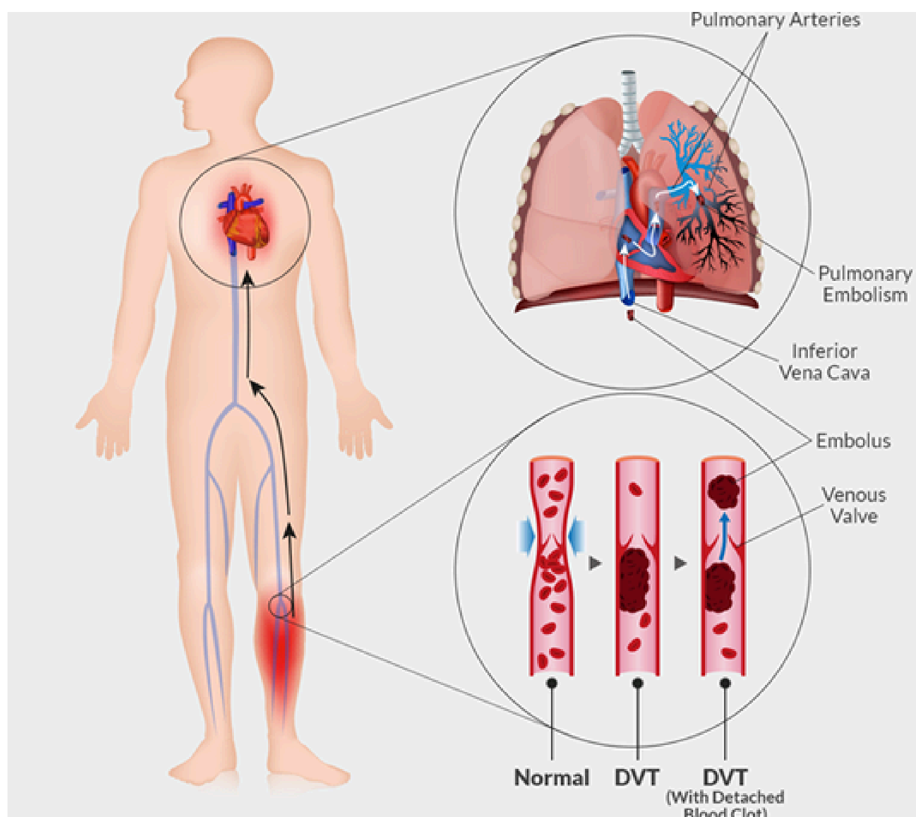


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Figure 6: Deep Vein Thrombosis and Pulmonary Embolism

Breast development is a desired effect of oestrogen therapy for many transgender women. However, this process may also bring about complications such as breast tenderness, discomfort, or changes in breast tissue that necessitate medical attention.

For transgender women who have not undergone hysterectomy (removal of the uterus), long-term oestrogen therapy without progesterone can elevate the risk of endometrial hyperplasia or cancer. Regular monitoring and discussions with healthcare providers are crucial to addressing and managing this risk.

Emotional and mental health considerations are also essential. Oestrogen therapy can influence mood, emotional well-being, and mental health. Mood swings, emotional changes, or mental health concerns like depression or anxiety may arise, highlighting the need for open communication with healthcare providers and access to mental health support.

Maintaining bone health is another important aspect, as oestrogen plays a role in bone density. Regular monitoring and screening for osteoporosis or other bone-related issues are recommended for transgender women on long-term oestrogen therapy.

Additionally, transgender women should be mindful of potential interactions between oestrogen therapy and other medications they may be taking, including anti-androgens or medications for other health conditions. It's vital to inform healthcare providers about all medications to avoid potential complications or drug interactions.

Overall, while oestrogen HRT is a crucial component of gender-affirming care, individuals and healthcare providers must work together to navigate potential risks, undergo regular monitoring and screenings, and maintain open communication to optimize health outcomes and minimize complications.

Female to Male Transgender Hormonal Therapy

Female-to-male (FtM) transgender hormonal therapy, also known as masculinizing hormone therapy, involves the use of testosterone to help female individuals align their physical characteristics with their desired gender identity, promoting a sense of congruence and well-being. FtM transgender individuals typically continue testosterone therapy long-term to maintain physical changes and hormone levels consistent with their gender identity.

Testosterone is typically administered through intramuscular injections, transdermal patches, gels, or pellets implanted under the skin. The dosage and frequency of testosterone administration are determined based on individual needs, hormone levels, and response to treatment.

Hormone therapy induces numerous physical changes over a variable timeline, typically spanning around two years. The physiological responses to hormone therapy exhibit considerable variability, making it impossible to precisely anticipate the changes each patient will experience. Notably, the fundamental body structure remains unaltered by hormones. For transgender men, the existing body and facial bone structure remain unchanged, and hormonal treatment does not affect one's height.

Potential changes encompass a deepened voice, clitoral enlargement, increased facial and body hair growth, cessation of menstrual cycles, breast tissue atrophy, heightened libido, and a shift in body composition favouring muscle mass over fat percentage. These changes range from reversible to irreversible (Figure 7).

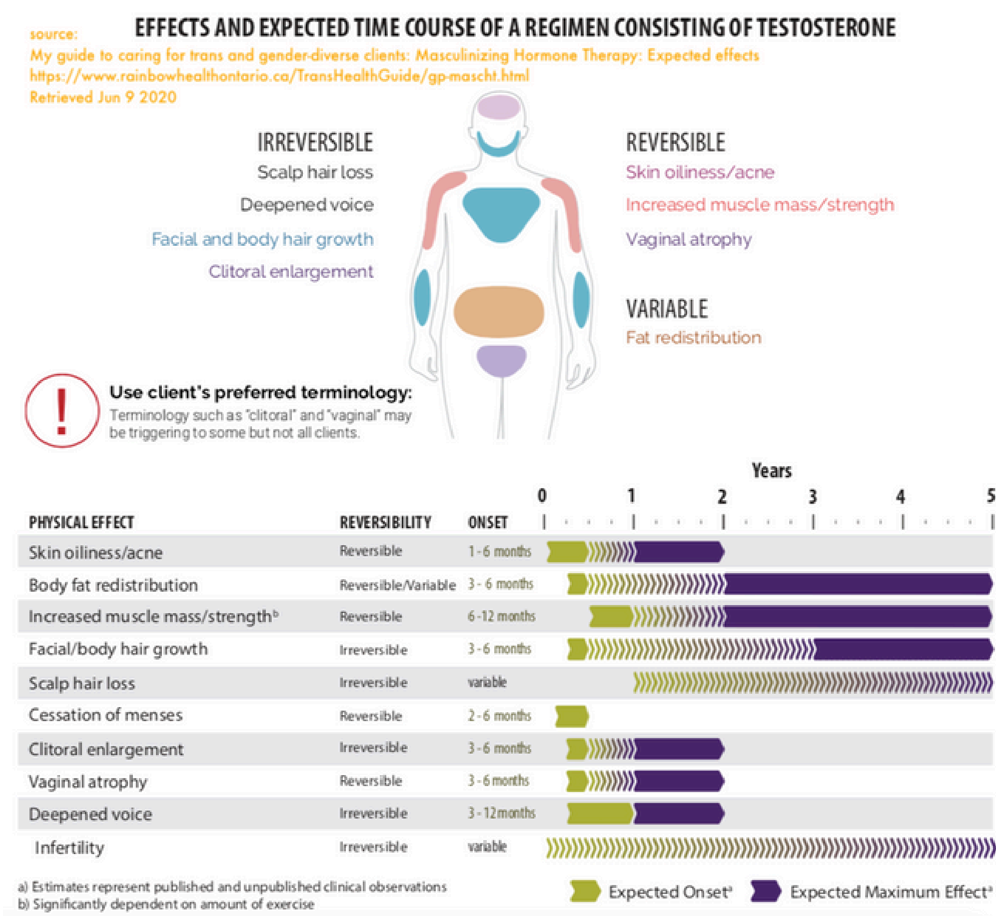

Figure 7: Effect and Expected Time Course of Testosterone Hormone Replacement Therapy (Trans Primary care, 2020)

Physical changes

Throughout testosterone therapy, several notable physical changes often manifest: skin becomes thicker and oilier, there's an increase in oil production leading to larger pores and alterations in sweat and urine odours, and acne may develop, typically manageable with skincare and treatments. Chest appearance tends to remain relatively consistent, yet it's advisable to postpone considering top surgery initially. Weight distribution shifts occur, resulting in reduced fat around hips and thighs alongside increased muscle definition in arms and legs (Figure 8).

Additionally, the facial fat diminishes, creating a more angular appearance, though significant bone structure changes are uncommon. Muscle mass and strength typically increase, influencing weight fluctuations based on factors such as diet, exercise habits, and genetics. Voice deepening occurs, leading to a more masculine tone, while body hair thickens and darkens. Scalp hair loss may occur, managed similarly to cisgender men, and facial hair growth can vary considerably. Additionally, sensory changes may arise, affecting touch perception, taste preferences, and scent recognition.

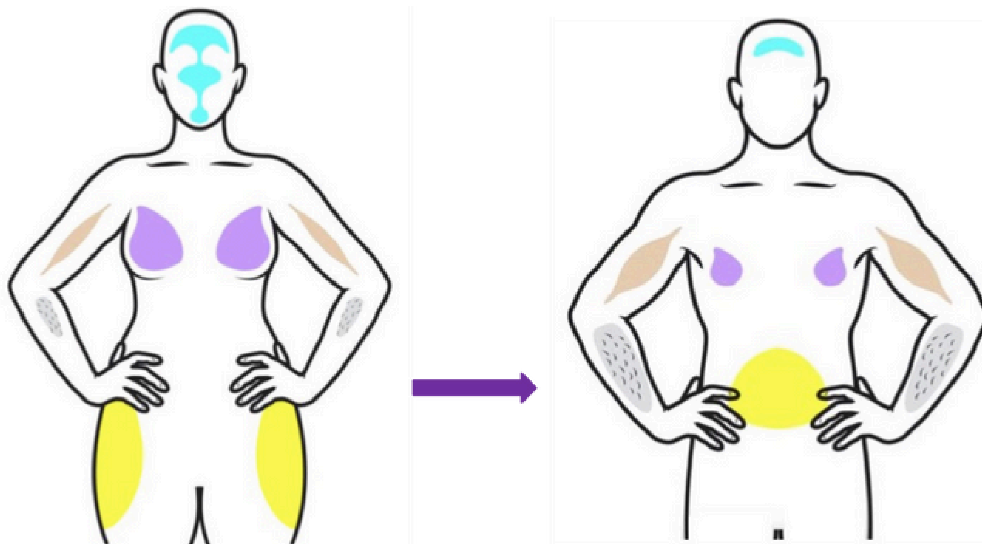

Figure 8: Female to male effects of testosterone hormone therapy

Reproductive System Changes

Hormone therapy's impact on the reproductive system is significant. Initially, changes in menstrual cycles may occur, with periods becoming lighter, delayed, shorter, or occasionally heavier before stopping completely. Testosterone use may lower the chances of pregnancy but doesn't eliminate the risk entirely; transgender men can still become pregnant while on testosterone and should use contraception consistently if sexually active with a partner who can produce sperm. In cases of suspected pregnancy while on testosterone, immediate medical consultation is crucial as testosterone can pose risks to the foetus. To pursue pregnancy, testosterone treatment must be paused under medical guidance.

Prolonged testosterone use may impact fertility, requiring specialized fertility treatments like in vitro fertilization, which can be costly and may not be covered by insurance. In rare instances, testosterone therapy might lead to complete infertility.

Reproductive System Changes

Shortly after starting testosterone treatment, changes in libido are common. Genital growth, particularly in the clitoris, occurs quickly and may expand further during arousal. New sources of erotic pleasure might be discovered, and orgasms may feel more intense with a focus on genital stimulation. While undergoing testosterone treatment, sexual interests, attractions, or orientation may undergo changes. These changes may lead to shifts in how individuals perceive themselves and their identities.

Changes in sexual orientation can affect self-esteem and self-acceptance. They can also influence existing relationships, especially romantic or sexual partnerships. Additionally, individuals may encounter challenges related to social acceptance and support. These changes can lead to emotional impacts like stress, confusion, or anxiety.

Mental and Emotional Changes

When undergoing testosterone hormone therapy, individuals may notice shifts in their emotional experiences, interests, tastes, hobbies, and interactions in relationships. These changes can manifest as a narrower range of emotions or feelings, different preferences or pastimes, and altered behaviour when interacting with others (Gorin-Lazard et al., 2012). However, these adjustments may be temporary and tend to stabilize over time as individuals adapt to their new experiences and circumstances (Slabbekoorn et al., 2001).

For some people, the transition may bring about minimal or no changes in their emotional state or behavioural patterns. They may continue to feel and behave much as they did before starting hormone therapy or undergoing other transitions. This variability in emotional and behavioural responses is natural and reflects the diversity of individual experiences and coping mechanisms (Budge et al., 2013).

Overall, while some individuals may initially experience shifts in their emotional landscape or behaviour, these changes are often part of the adjustment process and tend to normalize over time, leading to a greater sense of stability and well-being. Individuals undergoing transitions needs time and space to adapt and to seek support from healthcare providers or mental health professionals if needed.

Risk and Complications of Testosterone Hormone Replacement Therapy

Masculinizing testosterone therapy has been linked to potential risks such as an increased likelihood of conditions like diabetes or obesity, although there is limited research supporting these assertions (Irwig, 2017). One known risk is the thickening of the blood, termed high haematocrit count, which can lead to serious medical issues such as strokes or heart attacks, especially if the dosage exceeds the body's metabolic capacity (Gooren et al., 2014).

Another concern is the potential development of breast cancer in residual breast tissue, although screening for this can be challenging and may yield false positive results (Reisner et al., 2016). Changes in dosage or missed doses can sometimes lead to a recurrence of vaginal bleeding or spotting, which may occur even after months or years of testosterone treatment. This can be attributed to metabolic shifts, altering the body's energy processing and utilization mechanisms due to hormonal fluctuation (Seal et al., 2012).

Acne is a common side effect experienced by most individuals undergoing masculinising testosterone therapy. Additionally, some may encounter mood swings or exacerbation of existing mental health conditions like anxiety or depression, particularly during the adjustment phase resembling a second puberty.

For those who have undergone ovary removal, maintaining a low dose of hormones post-surgery until at least age 50 is crucial to prevent osteoporosis, which can lead to severe and debilitating bone fractures.

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04

UNDERSTANDING THE HEALTH ISSUES AFFECTING TRANSGENDER WOMEN

Mohd Zhafri Mohd Razib
Kulliyyah of Medicine, IIUM

ABSTRACT

Mak Nyahs often received hormone treatment and surgeries to change the way their bodies look - to be more feminine. It is believed that these therapies will lessen the discomfort related to their gender identification. This chapter explores the complex challenges encountered by transgender women, including the potential adverse effects of hormonal treatments, psychosocial issues, and the difficulties in ensuring equitable healthcare services for this community.

Introduction

Mak Nyah is a term used in Malaysia that refers to someone who is assigned male at birth but has transitioned to present themselves outwardly as women (transgender women). Within the medical context, they are recognized to experience gender dysphoria, a condition where there is a misaligned between one's assigned gender at birth and their gender identity. In the Western community, they are often advised to undergo Gender Affirmation Treatment (GAT), which involves hormonal treatment to change their body's hormone levels to transform the appearance resembling a woman. Some transgender women choose to undergo Gender-Affirming Surgery (GAS), which involves procedures such as genitalia change and breast enlargement. These interventions are thought to ease or comfort the distress associated with their gender identity. Many of them receive psychotherapy sessions in order to help them feel comfortable and confident in gender expression. This chapter explores the complex challenges encountered by transgender women, including the potential adverse effects of hormonal treatments, psychosocial issues and the difficulties in ensuring equitable healthcare services for this community.

Hormone Consumption Among Transgender Women

Transgender women not only modify their external appearances, such as their hair and clothes but also modify their body shape to align with their desired gender identity like a typical woman. Despite there are international guidelines available for the treatment of gender dysphoria, such as 'Gender Affirming Treatment (GAT)' and 'Cross-Sex Hormonal Treatment (CHT)', it is known that these practices are not widely accepted or implemented in Malaysia's healthcare system due to general local community rejection of transgender and Lesbian, Gay, Bisexual and Transgender (LGBT) culture. Nevertheless, transgender women in Malaysia are still able to acquire and consume hormones even without proper monitoring by medical professionals.

According to research by Rashid et al. (2022), a dosage of 2 to 4 milligrams of oestrogen (estradiol) commonly taken by transgender women, is found to be sufficient to induce physical changes. The main desired outcome is breast enlargement, a key marker of femininity resulting from effective hormone therapy. Other than that, hormone level changes can lead to redistribution of body fat, with more fat accumulating in the hips while decreasing overall muscle mass. Moreover, it contributes to skin softening and reduces the skin oiliness.

In addition to oestrogen, anti-androgen hormones such as spironolactone (100-300 mg per day) and cyproterone acetate (25-50 mg per day) are commonly used together to enhance the effects of physical changes in transgender women. These particular hormones act by suppressing the production and simultaneously weaken the effect of testosterone hormone (an important hormone for men), resulting in diminished secondary male physical characteristics such as facial hair growth like moustaches and beards. Another type of hormone, progestin often taken with oestrogen and anti-androgen hormones, as it is believed to contribute to further rapid and noticeable transformation in transgender women.

In Malaysia, pharmaceutical companies often market oestrogen drugs in the form of oral contraceptive pills (known as oral contraceptive pills) and menopausal hormone replacement pills (menopausal hormone therapy). According to a previous study, transgender women commonly prefer the combination form of oestrogen and progesterone, known as the Combined Oral Contraceptive Pill (COCP). They find it more effective than drugs containing one type of hormone. COCPs are also affordable and readily available for purchase, making them the most frequently used hormonal drugs by transgender women in Malaysia (Rashid et al., 2022).

Apart from taking daily pills, some transgender women choose injections of intramuscular estradiol (5 to 30 mg every two weeks). Unfortunately, there have been reports of administering the hormone above the recommended dosage, leading to more adverse effects due to a drastic elevation of the body's hormone level. Alternatively, some transgender women may choose to use a transdermal hormone patch method (oestradiol patch 0.0025 to 0.2 mg per day or oestradiol gel 2 to 4 mg per day), which requires constant patching. After initiating the hormonal therapy, some will experience the effects of transformation immediately, while others take more time because it is influenced by the individual's physiological factors.

Hormone Therapy Adverse Effect

The purchase of hormonal drugs ideally should occur through a clinic or pharmacy under medical supervision. However, many transgender women consume hormones without consulting first a medical doctor or licensed pharmacist. They often acquire hormones online, from herbal and traditional drug stores, or through acquaintances who reside in neighbouring countries (Rashid et al., 2022). While those methods of purchase can be more convenient and faster, they carry the risk of consuming medications from questionable sources and containing dubious ingredients.

Opting for the non-prescriber method poses a significant health risk as there will be no pre-medication consultation, screening or continuous follow-up by a medical professional. They need to take responsibility for their health by always seeking accurate information about the medicine they consume. An observational study reported that the mortality risk of transgender women using hormone treatment was higher than that of cisgender men in the general population (C. J. de Blok et al., 2021). Blood vessel blockage or occlusion is a significant observed complication in transgender women taking hormones, often associated with excess intake of the oestrogen hormone, particularly Ethinyl Oestradiol (EE). According to a study conducted in the Netherlands, they have a 20-fold increased risk of developing Venous Thromboembolism (VTE) and a higher risk of dying from heart disease and other causes of mortality compared to other men who do not consume hormones (Asscheman et al., 2014). Due to EE having more harmful side effects than other forms of oestrogen, the current international practice of GAT does not recommend Ethinyl Oestradiol (EE) in treatment.

Consuming oestrogen and progesterone pills is associated with an increased risk of weight gain and obesity, hence, raising the likelihood of developing thromboembolic and arterial disease in the future. Compared to cisgender people, transgender women have a higher prevalence of obesity. Research by Kyinn et al. (2021) found an average weight increment of more than five kilograms after 11 to 21 months of hormonal therapy initiation. The initial obesity prevalence of 25% rose to 30% during the study period. In general, having excessive body fat not only shortens life expectancy but also increases the risk of comorbidities such as hypertension, diabetes, dyslipidemia, stroke, sleep apnea, fatty liver disease, gallbladder disease, osteoarthritis, and slipped discs.

Transgender women need to take hormones in a long-term period to maintain their feminine physical appearance. According to a report, transgender people who use oestrogen for longer than six years are more likely to get an ischemic stroke than a man who does not take the hormone (Getahun et al., 2018). This is attributed to the fact that oestrogen-containing drugs can increase the level of triglyceride fat in the body, while commonly associated with low HDLs and high LDL-C, increases the risk of blood vessel occlusion. Other than that, elevated blood cholesterol and triglyceride levels may induce acute pancreatitis, resulting in hospitalisation for the patient.

Apart from the potential risk of cardiovascular disease, taking these hormonal drugs increases the risk of developing cancers linked to hormone changes, namely breast cancer and prostate cancer. Unfortunately, there is still a lack of research and knowledge about breast cancer in transgender women. Studies conducted in the Netherlands, indicate that they are more likely to get breast cancer, and their risk may increase with continued hormonal exposure. Thus, any signs such as lumps and discharge from the breast should be considered serious and medical consultation should be sought. The international guideline has specified that those who have used hormone therapy for at least five years and are over 50 years old should be screened for breast cancer.

Another potential side effect that the users may experience is skin dryness and itching as a result of hormonal changes. Therefore, they are advised to apply moisturising cream to provide comfort and itch relief. There are also studies associating the use of these hormones with anaemia (low haemoglobin), insulin resistance or diabetes and liver damage.

Before starting oestrogen hormone therapy, it is generally recommended that they undergo an initial assessment by a medical professional. During the consultation, they can be advised about possible side effects and contraindications, such as a history of liver disease, stroke, heart disease, and thromboembolism. Periodic Cardiovascular Disease (CVD) risk assessment such as measurements of blood pressure, body mass index, blood glucose and cholesterol level should be conducted for those who take long-term hormone therapy. In addition, because tobacco smoking addiction is common among transgender women and is a significant risk factor for cardiovascular disease, it is important to encourage those who smoke to quit. Smoking, along with hypertension, dyslipidemia, and obesity, significantly increases the risk of thromboembolism in transgender women.

They should also be educated about the potential side effects of specific hormones, such as spironolactone, which can deteriorate kidney function and raise potassium salt levels to dangerous levels in the body. This situation may lead to symptoms like muscle weakness, and palpitation or cause serious heart problems. The risk is more likely to occur in elderly persons and those with high blood pressure on ACE-inhibitor drugs (e.g.: perindopril). Whereas, for those who take cyproterone acetate, it is recommended to have periodic blood tests for prolactin levels, which can increase rapidly. This type of hormone is not suitable for those with liver problems.

The complications and their severity can vary based on hormone dosages and the opted mode of administration. Generally, transdermal oestrogen patches are considered safer than oral and injection medications due to their lower cardiovascular risk. This method of hormone administration is often preferred by the practice of GAT protocols abroad, especially for persons over 40 years old. Conversely, oral and injection methods are more favoured by many transgender women here because they are affordable and readily available. These methods also give flexibility in adjusting the dosage to a higher level, aiming to achieve the desired result earlier. There are reports that some of them consume higher doses of oral oestrogen (more than 6 to 10 mg) to fully suppress testosterone hormone production. Additionally, many of them practice a combination of injections and pills methods, which further increases the risks associated with their hormone therapy.

Psychological Health and Social Issues of Transgender Women

Transgender individuals often face stigmatization, oppression, and rejection from various sources such as family members, friends, and colleagues, all of which significantly contribute to poor mental health such as suicidal thoughts, depression and anxiety disorder. The marginalization of transgender women within the local community, often due to their small numbers and involvement in prostitution, exacerbates these challenges. According to studies conducted in the United States, Canada and Australia, there are more than 38% to 61% of transgender women are at risk of suicide, depression, and extreme anxiety (Abdul Hadi Said et al., 2021). Despite limited research on this topic in Malaysia, it is believed that the numbers of this group are very well significant.

Even though they are known for their susceptibility to mental illness, the mental health issues among transgender individuals in Malaysia are often inadequately addressed, and the level of healthcare provision frequently appears insufficient. Reports stated that discrimination happens in healthcare clinics in the form of suboptimal management, unfair services and rudeness towards them. One contributing factor is the lack of expertise among medical professionals knowledgeable about transgender health-related issues. Consequently, many transgender individuals adopt avoidant behaviours towards the current healthcare system, worsening their feelings of marginalisation and rejection. This highlights the need for more health professionals skilled in providing counselling and psychotherapy tailored to transgender individuals. Stigma and discrimination also impede their access to education, employment and quality healthcare, leading to homelessness, while others have become victims of sexual violence and crimes. They also face financial constraints, forcing them to engage in prostitution.

Although the exact number of transgender women in Malaysia is not known, it is estimated that there are 32,000 of them are engaged in prostitution to earn a living. Such circumstances have had detrimental effects, including an increase in cases of sexually transmitted diseases and HIV infections, with an estimated HIV infection rate of 10% among transgender women. However, many do not attend a clinic for health screening due to stigma and discrimination. Consequently, addressing these complex challenges requires the health ministry to allocate additional resources to track those who are infected near their housing area (*lorong*) for medical screening. Moreover, the government is required to allocate substantial funding to provide HIV prevention and treatment programmes as well. These measures are essential to improve the overall health and well-being of the community and to combat the stigma and discrimination they face.

Children and adolescents who struggle with gender identity and sexual orientation gender might develop gender dysphoria. Transgender youth are observed to have a higher prevalence of comorbid psychiatric conditions compared to their peers. Factors like physical and verbal abuse, discrimination, social isolation, bad peer relationships, low self-esteem, and body weight dissatisfaction contribute to their negative mental health outcomes. Consequently, they are at increased risk of developing depression, anxiety disorder, eating disorders, suicidal ideation, and engaging in self-harm (Connolly et al., 2016).

A weak familial bond is often identified as the root cause, compounded by issues such as poverty, parental divorce or death, and parent's busy work schedule that hinder quality time with children. In some cases, parents even dress their sons in girls' clothes. Additionally, a lack of parental supervision and monitoring may lead to issues like pornography addiction. Reports indicate that some of them engage in sexual activities at a young age while some of them become victims of sexual abuse. Young individuals are often victimised because they lack an understanding of what is happening, while the lack of parental support and protection leads them to conceal their problems.

These repeated traumatic events can be classified as Adverse Childhood Experiences (ACE), where repeated stressful or traumatic events experiences are remembered and can lead to a significant impact on the children's physical and mental health throughout their lives. Even though the number of cases may be small, it is found to be important to raise educational awareness and conduct early screening in primary and secondary schools. Students identified as at risk must receive appropriate support, therapy and ongoing monitoring by both teachers and healthcare professionals. Early intervention starting at the school age is crucial, as evidence suggests that prompt treatment and adequate social support are key elements in promoting children's healthy development into adulthood.

Understanding the psychosocial problems and issues faced by transgender women is necessary to find effective solutions. To enhance the situation in Malaysia, we must strengthen the collaboration among stakeholders such as medical sectors, educational centres, researchers, and Islamic scholars. The health-care services can be improved by increasing awareness and training among medical practitioners regarding transgender-related illnesses. A holistic strategy to support this marginalised group may involve fostering an enabling environment to reduce stigma, particularly within healthcare services, integrating medical and religious professional to deliver high-quality consultation and psychotherapy sessions, and providing social support to increase their overall quality of life.

Transgender Women's Sexual Health

The word "Man-sex-Man" refers to the sexual practice of transgender women having sex with cisgender men, usually involving anal intercourse. Those who do not undergo Gender Affirming Surgery (GAS) still retain male genitalia which is the penis and testis. It is important to note that while they may experience changes in their physical appearance and gender identity through hormone therapy and surgical procedures, these interventions typically do not enable reproductive capabilities to the extent of those with female reproductive anatomy.

Sexual desire, also known as libido, is a natural aspect of human needs, and transgender women experience it like everyone else. Despite claims that hormonal drugs are used to support and enhance sexual function in the transgender community, some of them may have low libido due to hormone change or other challenges throughout their transition. For instance, hormone treatment can suppress the production of testosterone, leading to a decrease in libido. In addition, they might feel discomfort about their genitalia, which further reduces their desire and satisfaction during sexual activity.

Transgender women commonly experience feelings of low self-esteem, often due to dissatisfaction with their appearance, which can affect their confidence during sexual intercourse. While hormonal drugs may provide outward appearance changes and alleviate distress related to gender dysphoria, they may not address problems with sexual satisfaction. Research has shown that the prevalence of Hypoactive Sexual Desire Disorder (HSDD) among transgender individuals using hormonal drugs is comparable to that of cis-gender males (Kerckhof M.E. et al., 2019). To address these concerns, regular consultation with therapists and ongoing monitoring of their condition is recommended. These measures can help manage issues related to self-confidence and overall mental and emotional well-being among transgender women.

Conclusion

Regular educational awareness programs are crucial for addressing important topics within the transgender women community in Malaysia. These programs should cover sexually transmitted illnesses, the risks associated with unsupervised hormonal drug use, and mental health issues related to transgender women individuals. These initiatives play a vital role in ensuring they are well-informed and take responsibility for their health. This includes regularly seeking health screenings and adopting healthy lifestyle practices such as maintaining an exercise routine, managing their diet to control obesity and quitting smoking. Every consultation with the community should be conducted in a non-judgmental manner, while also respecting the cultural norms of the local community. This approach is needed to ensure that all transgender individuals receive adequate and fair healthcare services, promoting inclusivity and well-being within the community.

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05

MANAGEMENT OF GENDER DYSPHORIA

Ramli Musa & Aida Farihah Amir Haszuwanni
Kulliyyah of Medicine, IIUM

ABSTRACT

This chapters explores the management of gender dysphoria including biological, psychotherapy, and spiritual management. It also provides insights about the psychotherapy treatment on the problem. The research findings suggest that for transgender individuals in a Muslim country, a multifaceted approach is needed. This includes medical treatments,, spiritual guidance to instill positive religious practices, and social support from families and the broader community. At the same time avoiding judgment and providing understanding to help them navigate their situation.

Introduction

Gender identity refers to an individual's strong internal perception in regard to their own gender and identification as a male, female, a combination of the two, or neither male nor female. Meanwhile, gender dysphoria is a disorder in which a person's gender identity contradicts their biological sex. Based on the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders: DSM-5 (American Psychiatric Association, 2013), gender dysphoria can be defined as marked incongruence between an individual's gender identity and assigned gender with associated distress or impairment in functioning. Further criteria include a marked incongruence between one’s gender and sex characteristics, strong desire to be rid of one’s sex characteristics and desire for the sex characteristics of the other gender, strong desire to be of the other gender and be treated as the other gender and belief that one shares the same sentiments and responses as the opposite gender. An individual that fulfils at least 2 of these criteria in at least 6 months period and may be diagnosed with gender dysphoria.

Globally, the prevalence of gender dysphoria is estimated to be approximately about 0.005 to 0.014% of the population for biological males and 0.002–0.003% for biological females. We can conclude that most of the incidents occur among male. However, both Japan and Poland discovered that the prevalence of gender dysphoria is higher in biological females. Aside from that, a sexual health study by Zucker reported that the prevalence of self-reported transgender identity in children, adolescents, and adults ranges from 0.5% to 1.3% (Zucker, 2017; Garg et al, 2023). Based on these statistics, it is reasonable to assume that the numbers have increased during the last few decades.

In Malaysia, the exact incidence cannot be ascertained due to a lack of resources as research in this area is considered very sensitive to cultural and religious customs. In the past, individuals with gender incongruence, especially Muslims and Malays would face huge humiliation and negative stigma from society whenever they tried to open up about their thoughts regarding gender. Thus, they would stay hidden and uncovered. However, in this modern age, we can observe that they have become bolder in exposing themselves and expressing their thoughts by organizing movements such as associations, parties, and the media, as well as disputing the legality of any law restrictions deemed to limit their freedom (Akilah et. al, 2020). It demonstrated that the number of people with gender incongruence is rising.

Various factors possibly lead a person to have gender identity disorder which include prenatal stress, parental sexual relations, genetic disorders, hormone structure, neuroanatomical problems, and psychological factors (Hruz, 2019; Vetri et al., 2021; Karamanis, 2023). Aside from that, studies found that patients with gender identity disorder are closely related to psychological issues such as depression, anxiety, phobias, adjustment disorder and personality disorder (Giulio, 2021; Hruz, 2019; Yazdanpanahi et al., 2022).

Literature Review

Biological Management

In gender dysphoria, the issues are mostly related to psychological problems. 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 (Abdul Hadi Said et al, 2023). As a consequence, these mental health issues may lead the person into self-harm, and suicidal ideation and eventually commit suicide.

Depression is a commonly observed psychiatric disorder that contributes significantly to the worldwide disease burden that has been associated with high rates of suicidal attempts and mortality (Karrouri et al., 2021). In another study, they found that about 30% of adolescents with gender dysphoria experience depression, dysthymia or symptoms of depression, anxiety affects 16%–25%, 2%–15.8% have eating disorders, 13.1%–53% have self-harmed and 9.3%–30% have attempted suicide (Bonifacio et al., 2019). Besides, 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.

In order to deal with the concerns, the person should start on pharmacotherapy in order to relieve the symptoms of depression and anxiety. In general, antidepressants are the most routinely prescribed with Selective Serotonin Reuptake Inhibitors (SSRIs) being the most frequently prescribed type of antidepressant (Tiefenthaler & Lee, 2023). Karrouri et al., 2021, stated that SSRI has been the gold standard treatment for depression. Luo et al., 2020 pointed out that additional psychotropic medications, such as bupropion, mirtazapine, Second-Generation Antipsychotics (SGAs), buspirone, lithium, and thyroid supplementation, may be added to antidepressant medications especially if patient had other features or comorbid.

On the other hand, in Western countries, cross-sex Hormone Replacement Therapy (HRT) has been one of the treatments in which it consists of masculinization for trans males and feminization for trans females. In masculinisation, a trans man (female becoming a male) will take testosterone, cyproterone acetate, and spironolactone, meanwhile in feminization, a trans woman (male becoming a female) will take oestrogen and progesterone (Venkataramu & Banerjee, 2021).

Aside from that, for adolescents, puberty suppression has been suggested in teenagers with gender dysphoria. According to the Dutch protocol, this treatment uses Gonadotropin-Releasing Hormone analogues (GnRHa) to postpone the physical changes of endogenous puberty. Therefore, it allows these teenagers more time to explore their gender identification (Karamanis, 2023). However, due to insufficient evidence in determining long-term safety, the US Food and Drug Administration has denied approval for this class of drug. GnRHa could increase the risk of osteopenia, altered adult height, and impaired special memory (Hruz, 2019; Karamanis, 2023; Biggs, 2022).

On the other hand, another study also suggested surgical treatments such as Chest Reconstructive Surgery (CRS) and Gender Affirming Genital Surgeries (GAGSs) (Nobili et al., 2018). Nevertheless, owing to the permanent alteration in fertility and the risks corresponding to surgery in general, genital surgery tends to be the last recommended treatment for gender dysphoria. Also, the World Professional Association for Transgender Health (WPATH) suggests that patients must go through some type of social transition using psychotherapy and HRT before pursuing surgical intervention (Anderson et al., 2022).

Psychotherapy Management

Aside from medical intervention, psychotherapy has been one of the definitive treatments for gender dysphoria such as cognitive behavioural therapy, interpersonal psychotherapy, brief psychodynamic therapy and supportive therapy. Taslim et al. (2021), agreed that counselling and psychotherapy-based conversion therapies are more appropriate for gender dysphoria patients as they help align their feelings to their natal sex. The WPATH also acknowledges that psychotherapy can help people with their gender identity without the need for hormones or gender affirmation surgery (Anderson et al., 2022).

Cognitive behavioural therapy in particular may have significant benefits to this patient population by reducing social anxiety as it focuses on being aware of and changing patterns of thought to change behaviours and emotions (Busa et al., 2018). Nevertheless, the 'Guidelines for Psychological Practice with Transgender and Gender Nonconforming People' issued by the American Psychological Association endorsed trans-affirmative therapy in which the practitioner should acknowledge, appreciate, embrace and validate patient's identities and their preferred gender (Busa et al., 2018). In addition, gender-affirming therapy is believed able to provide greater improvement towards patient condition as it would be lifelong support that could maintain the positive outcome towards the patient's feelings and condition (Anderson et al., 2022).

Aside from that, Clayton (2022) stated that adolescents with gender incongruent are at high risk of suicide. Hence, patients could opt for dialectical behavioural therapy as studies found that dialectical behavioural therapy was superior in reducing suicidal behaviour, self-injury and dissociation or psychoticism (Johnson et al., 2018; Oud et al., 2018).

Social Approach

Patients with gender incongruent are exposed towards stigma and discrimination. Statistics from the National Transgender Discrimination Survey showed that 90.0% of respondents complained of workplace discrimination, 47.0% stated that they were fired, not hired, or denied a promotion and 19% reported being turned down for a home or shelter (Schulman & Erickson-Schroth, 2019). Instead of being judgmental towards this group, family and society should give positivity towards them. Family therapy and support provide lifelong support towards patients which may maintain a positive outcome (Anderson et al., 2022). McCann et al. (2020) agreed that sufficient encouragement and psychosocial support from parents, teachers, and mental health practitioners aid in establishing higher resilience and coping strategies.

In addition, society may assist and guide people who are experiencing gender dysphoria. Taslim et al. (2021) mentioned that transgender people deserve to be given the choice to make decisions about their lives, meanwhile, society should reevaluate their attitudes towards trans persons and reconsider how we might embrace and support them on their journey to treatment.

Spiritual Approach

Transgender people's religious-spiritual lives must be meticulously assessed to ensure their individual and social well-being. Spirituality can be illustrated as acceptance and 'loving compassion' which can entail deep interpersonal relationships, a profound connection to nature, and a respect for all forms of life. It is about love, understanding, compassion and a connection to a higher being or "god" that may exist (McCann et al., 2020).

A study conducted by Mohammadi et al. (2021) proved that spiritual psychotherapy interventions for clients with gender dysphoria assisted the patient in changing irrelevant cognitions, emotions, behaviours, and circumstances to match her given sex, as well as adjusting her gender identification to match her biological sex.

Aside from that, an approach to organising a spiritual program with transgender also could help instil positivity and good moral values. For instance, International Islamic University Malaysia (IIUM) conducted an *Ibadah* camp which involved transgender with the hope they would become a better person after receiving "*Hidayah"* (Draman, 2022).

Discussion

Gender dysphoria is one of the mental health issues in which a person expresses dissatisfaction with their real anatomic gender, and longs to change their physical appearance. It is a relatively rare condition which may occur in both children and adults. In Malaysia, based on Department of Islamic Development Malaysia (JAKIM), the gay community recorded an increase of 310,000 in 2018 compared to 173,000 in the past five years. which is almost 100% increments. Meanwhile, the transgender group recorded an increase to 30 000 individuals in 2018 compared to 10 000 in 1988 (Akilah et. al., 2020). Many studies believe the etiology could be due to biological factors such as genetic correlation, hormone influences, genes and chromosomal alterations and psychological factors such as abandonment, sexual abuse and traumatic events.

In general, the World Professional Association for Transgender Health (WPATH) stated that the approach to gender dysphoria has evolved to include a more individualised, multidisciplinary approach while still keeping to standardised standards such as those established by the (Karamanis, 2023). If Gender Dysphoria fails to be identified and treated, the person's desire to be one of the other sex will grow stronger and subsequently will reject their biological sex of body.

The approach of management can be classified into biological, psychological, social and spiritual components with the goal of alleviating dysphoria or distress while also treating comorbid conditions such as depression and anxiety. In the biological aspect, pharmacotherapy should be given towards patients with symptoms of depression and anxiety. As mentioned above, patients with gender dysphoria are usually associated with various psychiatric comorbidities which include depression, anxiety, and insomnia. Thus, the psychiatrist can prescribe medication accordingly. For example, patients with comorbid depression and anxiety should be prescribed antidepressants and if a patient had a panic attack or insomnia, they should be prescribed benzodiazepines, which act as sedatives and anxiolytics.

On the other hand, a new guideline from WPATH introduced clinical criteria for hormone therapy and surgical therapies for gender dysphoria which facilitate the individuals to change themselves. This includes estrogen hormone therapy for trans women, testosterone hormone therapy for trans men, breast reconstructive surgery and genital surgeries. This practice has been widely practiced in Western countries especially. However, in Malaysia as a Muslim-majority country, this practice is prohibited as it is contrary to the practice and belief of a Muslim. Muslims are prohibited from making changes towards their bodies as everything that we have is owned by Allah including our body.

A hadith narrated by Narrated Ibn 'Abbas:

"The Messenger of Allah (ﷺ) cursed the women who imitate men and the men who imitate women."

Based on this hadith, it proved that even the act of resembling another gender is disliked by the Prophet Muhammad S.A.W. In addition, in accordance with both the penal codes and *shari'ah* law, homosexuality is considered to be illegal in Malaysia and the people could be punished.

Thus, Malaysian transgender usually undergo these treatments by travelling abroad such as in Thailand, Korea and the United States. Even so, surgical intervention is not recommended as it is a permanent and irreversible procedure. If someone regrets their choice, there is nothing they can do and this could lead to another episode of depression or anxiety. A study by Bizic et al. (2018) found that some patients would have definite regret in when they wish to return to their birth gender after the genital surgery procedure.

Next, psychotherapy would be the most definite treatment for patients with gender incongruent. Examples of psychotherapy include cognitive behavioural therapy, dialectical behavioural therapy, interpersonal therapy and deep breathing therapy. Cognitive behavioural therapy aids in improving mental health, quality of life, and self-esteem. It is not intended to change gender identity; rather, this therapy can help to explore gender difficulties and find solutions to minimise gender dysphoria. The goal is to facilitate people to feel comfortable with their gender identity so that they can flourish in relationships, education, and work. At times, people tend to be gender incongruent due to their personality. For instance, society always views a girl who is tough and does a heavy workload as masculine. As a result, they occasionally confuse their own gender. Other mental health disorders such as depression and anxiety also can benefit from therapy as well.

Even though the Western country believes that gender-affirming therapy is a successful therapy in reducing psychiatric problems in people with gender dysphoria, it is not a practice in Malaysia. As mentioned above, altering our own identity based on our desire is like trying to challenge the power of Allah as our Creator. As a Muslim, we believe that Allah has created everything perfectly. Thus, we are forbidden to change it despite the fact that we really wish to.

Aside from that, dialectical behavioural therapy can be applied to patients with self-harm and suicidal ideation. Typically, when a patient is distressed about their biological sex and feels excluded by others, they will injure themselves as a coping method to relieve their stress. As has been mentioned, most patients have borderline personality traits and this could lead them to have unstable relationships with family and friends. Thereby, interpersonal therapy would be helpful in patients who have interpersonal issues with relationships.

As with the social method, it required collaboration from the patient's family, friends, and society. In some situations, patients are abandoned by their families as a result of their actions and decisions, which can lead to further psychological issues. Therefore, it is critical to provide family therapy to family members. Family members will be informed about the patient's illness and will learn how to deal with the patient during family therapy. Furthermore, owing to the negative stigma, society has a bad attitude towards them and treats them poorly. They are not to be judgmental and must treat patients with respect. This approach is not about supporting transgender people, but simply becoming close to them so that we may gradually offer guidance on something they can alter.

Lastly, spiritual approaches are important to instil good religious practice among patients. Spirituals are mainly related to the inner character of a person and religion focuses on the spiritual side of life. The government and NGO can organise a religious program with the transgender to instil positivity and general Islamic knowledge. For example, IIUM conducted a yearly program called *Nusantara Ibadah* Camp' in which the participants are 100% "*Mak Nyah"* (trans woman). Through this program, they did a lot of activities created bonding and also shared input from an Islamic perspective with the transgender.

Conclusion

The number of cases of gender dysphoria has been rising. Even now, we can see the trend increasing through social media. However, treatment options for gender dysphoria are still not widely discussed. As a consequence, the person will be untreated and mentally suffer due to negative stigma and discrimination from the community. As discussed, the intervention in treating the patient is not only by psychiatrist and psychologist but it involves the community in handling the issue. If these people keep being neglected and abandoned, it will make them become wilder and involved in high-risk behaviour such as sexual activity. Later, this could lead to another serious issue which is the spreading diseases like HIV.

In the medical aspect, many treatments can be offered to these patients. As in the community, the public should be wise towards these people at the same time helping them escape from these situations. As a Muslim country, gender dysphoria is one of the most sensitive issues as the nature of it is against the law in Islam.

A hadith narrated from Ibn`Abbas that the Messenger of Allah (ﷺ) said:

"Whoever you find doing the action of the people of Lut, kill the one who does it, and the one to whom it is done."

The people of Lut were the first to encounter or conduct homosexuality. They indulged in these immoral activities in the open, talked bluntly about it, and were incredibly proud of their behaviour. The Prophet Lut (A.S) was sent as a messenger. However, they rejected Prophet Lut (A.S), ignored his prophethood, and continued with their immorality, even though Prophet Lut (A.S) had warned them to stop and delivered Allah's warning to them. Still, people turned a deaf ear to Allah's message. Due to this, they were punished by Allah S.W.T with a terrible earthquake strong winds and hail until it was destroyed. Eventually, they were buried under the rubble of their own house.

This proved that the act of homosexuality is a serious sin and haram in Islam. Thus, early intervention should be done properly in order to avoid the rising number of gender dysphoria which leads to an increase in homosexuality. It is important to note that Lesbian, Gay, Bisexual, Transgender, Queer, and others (LGBTQ+) and gender dysphoria are not completely similar however, patients with untreated gender dysphoria tend to be involved with LGBTQ+.

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06

UNDERSTANDING THE DISCOURSE OF GENDER DYSPHORIA IN THE REALM OF ISLAMIC SCHOLARLY DISCUSSION

Ahmad Akram Mahmad Robbi
AbdulHamid AbuSulayman Kulliyyah of Islamic Revealed Knowledge and Human Sciences, IIUM

ABSTRACT

This study explores the discourse surrounding gender dysphoria within Islamic scholarly discussions, aiming to understand how contemporary Islamic thought navigates the complexities of gender identity issues. Utilising qualitative research field, this study is examining classical and modern Islamic jurisprudence, as well as theological perspectives, delving into the ways Islamic scholars address the nuances of gender dysphoria, considering the implications of both traditional interpretations and evolving contemporary views. Ultimately, this research seeks to contribute to a deeper understanding of how Islamic scholarship engages with the challenges posed by gender dysphoria in the modern context.

Introduction

According to American Psychiatrist Association, gender dysphoria refers to a person whose sex assigned at birth (i.e: the sex assigned at birth, usually based on external genitalia) does not align their gender identity (American Psychiatrist Association, 2022). The term refers to the uncertainty in identifying the specific gender of an individual when their genitalia do not align with their internal sense of gender identity. Put simply, it describes when a person feels that their inner sense of self contradicts their physical anatomy, such as a man feeling a strong inclination to identify as a woman, and vice versa.

While gender dysphoria encompasses more than just transgender experiences, it does highlight the connection between the two. Transgender individuals may perceive their transgender identity in diverse ways and may recognise it at any stage of life. Some can recall feeling different from their assigned gender from a young age, experiencing a sense of not belonging or desiring to be another gender

Furthermore, others become aware of their transgender identities or begin to explore and experience gender-nonconforming attitudes and behaviours during adolescence or much later in life. Some embrace their transgender feelings, while others struggle with feelings of shame or confusion. Those who transition later in life may have struggled to fit in adequately as their assigned sex only to later face dissatisfaction with their lives. Some transgender people, transsexuals in particular, experience intense dissatisfaction with their sex assigned at birth, physical sex characteristics, or the gender role associated with that sex. These individuals often seek gender-affirming treatments (American Psychological Association).

In the realm of Islamic scholarly discussions, it is observed that Muslim scholars made efforts to address uncertainty regarding gender identification when an individual displayed confusion. In such instances, these scholars would evaluate the functioning genital organs of the person to discern which parts were operational and which were not. The functional genital part would then be utilized as a basis to ascertain the individual's gender. In addition, some scholars claim that a person's gender identity can be changed even after they have reached puberty or after the identification process is finished. Furthermore, scholarly discourse revolves around the implications of gender dysphoria for *shari'ah* rulings.

It is clear from the aforementioned statement that both Islamic and contemporary medicine address the problem of gender dysphoria. To address this topic academically, Muslim academics have conducted literature reviews, which are displayed in this paper.

The Conceptual Framework of Gender Dysphoria

Sexual orientation is an often enduring pattern of emotional, romantic, or sexual attraction to men, women, or both. It also refers to an individual's sense of personal and social identity based on those attractions, related behaviours, and membership in a community of others who share those attractions and behaviours according to the American Psychological Association. Gender, a psychosocial identity rooted in masculinity and/or femininity, is frequently confused with sex assigned at birth, or the appearance of male versus female reproductive organs defined by chromosomal makeup. Instead, society (and healthcare) frequently assumes that the sex assigned at birth is the same as gender identity (Uma and Preetha, 2022).

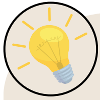
According to Ventura et al. (2015), gender identity disorder is defined as the inconsistency between physical phenotype and gender. In other words, self-identification as a man or a woman. Experiencing this inconsistency is known as gender dysphoria. Gender dysphoria is distress due to a discrepancy between one's assigned gender and gender identity according to Cooper et al. (2020). It is significant distress or impairment caused by the discrepancy between an individual's experienced gender and the sex assigned at birth according to Karamanis (2023).

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, 2016). Ventura et al. (2015) also added, that the most extreme form, where people adapt their phenotype to make it consistent with their gender identity, through the use of hormones and by undergoing surgery, is called transsexualism.

Traditionally, gender dysphoric people were classified as male to female and female to male as well as homosexual versus non-homosexual. In recent times, another differentiation was made between persons with an early onset of gender dysphoria, which means an onset in childhood, and individuals with a late onset, which stands for an onset in or after puberty (Nieder et al., 2011).

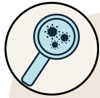
Characteristics of Gender Dysphoria

ICD-10 defines transsexualism as the desire to live and be accepted as a member of the opposite sex, which is usually accompanied by feelings of discomfort or disagreement with their own anatomic sex, as well as the desire to undergo surgical or hormone treatment so that their bodies match as much as possible with the preferred sex. In order to diagnose it, transsexual identity must have been present constantly for at least two years and not be a symptom of another mental disorder, like schizophrenia, or secondary to any intersexual, genetic or sexual chromosome anomalies.



Gender dysphoria in children is defined as a strong inconsistency between the sex one feels or expresses and the one assigned, with duration of at least six months, which manifest in at least six of the following characteristics:

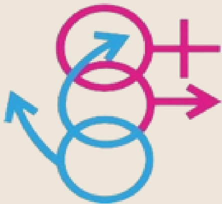
1. A strong desire to belong to the opposite sex or an insistence that he or she belongs to the opposite sex (or from an alternative sex different from the one assigned).
2. In boys (assigned sex), a strong preference for transvestism, or for simulating feminine attire; in girls (assigned sex) a strong preference for dressing only in typically masculine clothes and a strong resistance to wearing typically feminine clothes.
3. A strong and persistence preference to play the opposite sex's role or fantasies about belonging to the opposite sex.
4. A strong preference for the toys, games and activities customarily used or practiced by the opposite sex.
5. A strong preference for playmates of the opposite sex.
6. In boys (assigned sex), a strong rejection to typically masculine toys, games and activities, as well as a strong avoidance to rough play; in girls (assigned sex), a strong rejection of toys, games and activities which are typically feminine.
7. A strong discontent with the individual's own sexual anatomy.
8. A strong desire to have the primary and secondary sexual characteristics corresponding to the sex the individual feels.



Symptoms and causes of gender dysphoria might cause adolescents and adults to experience a marked difference between inner gender identity and assigned gender that lasts for at least six months. The difference is shown by at least two of the following:

1. A difference between gender identity and genitals or secondary sex characteristics, such as breast size, voice and facial hair. In young adolescents, a difference between gender identity and anticipated secondary sex characteristics.
2. A strong desire to be rid of these genitals or secondary sex characteristics, or a desire to prevent the development of secondary sex characteristics. A strong desire to have the genitals and secondary sex characteristics of another gender.
3. A strong desire to be or to be treated as another gender.
4. A strong belief of having the typical feelings and reactions of another gender.
5. Gender dysphoria may also cause significant distress that affects how you function in social situations, at work or school, and in other areas of life.
6. Gender dysphoria might start in childhood and continue into adolescence and adulthood. Or may have periods in which you no longer experience.
7. Medical treatment of gender dysphoria might include:
8. Hormone therapy, such as feminising or masculinizing hormone therapy.
9. Surgery to alter the chest, external genitalia, internal genitalia, facial features, and body contours, such as feminising or masculinising surgery.

The World Professional Association for Transgender Health provides the following criteria for hormonal and surgical treatment of gender dysphoria:



1. Persistent, well-documented gender dysphoria.
2. Capacity to make a fully informed decision and consent to treatment.
3. Legal age in a person's country or, if younger, following the standard of care for children and adolescents.
4. If significant medical or mental concerns are present, they must be reasonably well controlled.
5. Additional criteria apply to some surgical procedures.
6. A pre-treatment medical evaluation is done by a doctor with experience and expertise in transgender care before hormonal and surgical treatment of gender dysphoria. This can help rule out or address medical conditions that might affect these treatments. This evaluation may include personal and family medical history, physical exam, lab test, assessment of the need for age and sex-appropriate screenings, identification and management of tobacco use and drug and alcohol misuse, testing for HIV and other sexually transmitted infections, along with treatment, assessment of desire for fertility preservation and referral as needed for sperm, egg, embryo or ovarian tissue cryopreservation, documentation of history of potentially harmful treatment approaches, such as unprescribed hormone use, industrial-strength silicone injections or self-surgeries.

These recommendations offer a foundation for a range of gender-affirming therapies meant to harmonise a person's physical appearance with their gender identification. Even though treatment plans are getting more customised to fit each patient's particular needs, they nevertheless frequently combine a number of common interventions. In order to help with the process of gender affirmation, these may include hormone therapy, speech therapy, hair removal, surgery, puberty blockers, and other tools.

Gender Dysphoria: A Clarification from Islamic Epistemology

Gender Dysphoria in Islamic Scholarly Discourse

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 in this field and they also include *khunsa* as part of gender dysphoria issues. Zainuddin & Mahdi (2016) implicitly exhibit that in Islam, the person with somatic sex ambiguity due to a disorder of sex development (DSD), such as 46, XX congenital adrenal hyperplasia or 46, XY androgen insensitivity, is recognized as *khunsa*.

Khunsa (Hermaphrodite) and its Types

It is an organism having both male and female reproductive systems according to Rafiq (2022). Put another way, we may argue that a baby has both male and female traits at birth because he has testicles, pennies, and ovaries all at the same time. 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 a single khunsa.
4. **Complex problems or Sexual Development Servers (Unspecified Sexual problems Development):** Based on sexual conditions that are not yet characterised or on variants of the aforementioned disorders.

According to Rafiq (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 the 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, genotype alters 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 terms of Islamic jurisprudence, the *khunsa* group is divided into two, namely *khunsa musykil* which is doubtful and *khunsa ghair musykil* or *khunsa* which is not in doubt. Khunsa *musykil* is a *khunsa* whose gender cannot be directly determined because they are born without any genitalia and only have a device to urinate. *Khunsa ghair musykil* on the other hand, it can be ascertained that their skills are either geared towards women or men through physical signs or confirmed gender clinically.

Khunsa musykil 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 this case, one has to wait and observe for changes in puberty to ascertain the true gender of the *khunsa musykil*. One of the possible changes which will indicate the person's true sex is that the person will urinate exclusively from one of the two genitalia, or most of the urine comes out from one genital as compared to the other, or the urine stream ends from one genital rather than the other.

Other changes may be that the person attains menarche develops breasts or develops a sexual attraction to men or gets pregnant, in which case she is certainly female; or the person develops a deep voice or grows facial hair or develops a sexual attraction to women, in which case he should be designated a male. Other characteristics that may determine gender, but about which Muslim scholars have conflicting opinions include the location or anatomy of the orifice from which a person ejaculates and the number of ribs that he or she has.

Mukhannath

Another terminology of gender dysphoria written in Islamic scholarly works is *mukhannath*. Che Omar et al. (2020) 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 behaviour, conversation, dress, including sexual activity.

Scholars define *mukhannath* as falling into one of two categories. A *mukhannath*, or first kind, has physical characteristics similar to those of a woman. For this type, as the character is considered genuine, scholars opted that there is no harm for these people if they have certain features similitude to women since they are born with these features. In the meantime, the latter is a *mukhannath*, having the same features and look as a male, but he altered them because of his propensity for women. In this scenario, Muslim scholars include them as those who are cursed by the Prophet Muhammad PBUH as narrated in an authentic hadith narrated by al-Bukhari in hadith no. 5885.

لَعَنَ رَسُولُ اللَّهِ صلى الله عليه وسلم الْمُتَشَبِّهِينَ مِنَ الرِّجَالِ بِالنِّسَاءِ، وَالْمُتَشَبِّهَاتِ مِنَ النِّسَاءِ بِالرِّجَالِ.

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.

Methods of Assigning Intersex Identity in Islam

The office of the Mufti of the Federal Territory, states that there are a few other factors that are used to assign the gender of an intersex individual other than the physical appearance and genitalia, such as the chromosomes and gonads (testes and ovary).

Other than genitalia and physical appearance, the fuqaha lists further criteria for classifying intersex. Among these include the development of body hair, facial hair, beards, deep voice, and similar characteristics, which the fuqaha classify as masculine. If the situation is the opposite, the person is categorised as female.

Determining the person's sentiments of attraction is another method of assigning the identification for intersex. When an intersex person feels drawn to a man, that person is a female; conversely, when that person feels drawn to a female, that person is a male.

To summarize the criteria, Muslim scholars have set several ways to clarify the intersex's identification as it can be perceived as follows:

Urination

If the individual urinates only through the penis, then he is a male. Meanwhile, if the individual urinates only through the vagina, then she is a female. However, if the individual urinates through both, then the consideration falls through which genitalia the first time the individual urinates with.

Ejaculation and menstruation

If the individual ejaculates at a certain time, and the semen is ejaculated through the penis, then he is a male. If the semen flows through the vagina or she experienced menstruation, then she is a female. This is, however, on the condition that it happens repeatedly to support the first assumption.

Childbirth

Wiladah or the process of childbirth is concrete evidence that the individual is a female. Furthermore, it precedes other contradicting assumptions. The absence of menstruation when the individual has reached the age of puberty. This is an indication that the individual is a male. This is a similar method when determining from which genitalia the individual urinates. Thus, menstruation when the individual has reached the age of puberty is a determining factor as to the individual's gender.

Feelings of attraction

If an intersex individual is attracted towards a male, then she is a female. Consequently, if the individual is attracted to a female, then he is a male. However, this is only considered if there are no other signs that can be used to assign the individual's identity.

The emergence of certain characteristics

This includes bravery patience in fighting enemies, and strength. Thus, this shows the male characteristics of the intersex individual. In addition to this, the person also has the following criteria such as facial hair growth such as a moustache and beard, or the development of breasts and breast milk.

As for the second type of intersex (does not have a penis or vagina), then there are no signs to determine the individual's identity except with the feelings of attraction.

The Position of *Khunsa* in Certain Islamic Practices

The Prayer of Khunsa

According to Tak (1998; cited from Zainuddin & Mahdy, 2017), the *khunsa*'s obligations in regard to the daily prayer are the same as those of the adult female, i.e., it is highly recommended that the khunsa pray at home. The *khunsa*'s position in the prayer congregation is right in the middle, behind the adult males and the male children and in front of the female children and adult women. With regard to the compulsory *Jumaat* prayer, it is not obligatory for the *khunsa* to perform this prayer together with Muslim men in the mosques, unless the *khunsa*'s gender has been determined to be male.

Concerning the *khunsa*'s *'awrah* during prayer, if it is still uncertain to which gender the *khunsa* belongs, the *khunsa* should wear female attire i.e: be fully covered except for the face and hands. However, if the gender has been determined, the *khunsa* should follow that gender's attire accordingly.

In terms of being an imam, if the *khunsa* is still undecided on the gender to which he or she is assigned, then the *khunsa* cannot be an *imam* for other men (i.e., cannot lead the prayers), but the *khunsa* can be an imam for other khunsa and for women. However, a *khunsa* may not be able to be an *imam* for other *khunsa* as well as he or she may be a woman according to the scholars (Office of Mufti of Federal Territory).

The ʻAwrah of Khunsa

The ʻ*awrah* of *khunsa* is comparable to that of women, according to the *Hanafi* and *Shafiʻi* scholars. In other words, the *khunsa* are not allowed to reveal any portion of their body other than their face and palm. Furthermore, they indicate that a *khunsa* who is taking a bath should not reveal any areas of their body to the public. The reason for this is that when they interact with both men and women, their gender is still unclear.

The Inheritance of Khunsa

In cases where the sex and gender remain undetermined, the various schools of Islamic jurisprudence as well as the various Islamic scholars differ in their opinions about the portion of inheritance that a *khunsa musykil* is entitled to. The opinions of the *Maliki* and *Hanbali* schools as well as the scholars Abu Yusuf, Muhammad, Ibn Abbas, al-Sya'bi, Ibn Abi Laila, and al-Thauri are that the *khunsa musykil* is entitled to half of a man's share and half of a woman's share because the actual gender is uncertain (Al-Bakri, 2011). Abu Hanifah, however, has stated that the *khunsa* should receive the lowest and smallest portion of the inheritance (Al-Bakri, 2011).

According to the *Shafi'i* school, as the *khunsa musykil* is prohibited from marriage and does not bear children, such a *khunsa* does not have the status of father, mother, spouse, or grandparent when it comes to inheritance, but may have the status of child, sibling, and sibling of the parent of the deceased (Al-Khimet al., 2009). Once the *khunsa* has had children, then the sex has been determined. If the *khunsa* has impregnated a woman, then he is male. If the *khunsa* has become pregnant, then she is female.

The Bathing Rituals for the Deceased

The various Islamic schools of jurisprudence differ in their opinions about the obligation to perform the bathing rituals, about how to bathe the deceased *khunsa*, and about who should perform the bathing rituals for the *khunsa*. One opinion states that it is not obligatory to perform the bathing rituals for the *khunsa* at all; another is that it is obligatory to do so and that this responsibility falls upon the Muslim men and women in that area as well as upon the relatives of the *khunsa*. These opinions apply to the *khunsa musykil*. According to the school of *Maliki*, the *khunsa* should be bathed properly according to the rituals, and the cleaning of the body of the deceased should not be limited to *tayammum*, if there is the capacity and facilities to do so.

Khunsa's family members are supposed to execute *tayammum*, according to Hanafi scholars, rather than Muslim men or women. Should a *khunsa musykil* pass away without any immediate family, the body may be bathed by either gender as long as the *khunsa* is still a kid, according to the Shafi'i school. On the other hand, tayammum should be carried out if the khunsa who passed away was an adult; nevertheless, there are differing views over whether the body can be covered with cloth during the bathing procedures.

The Marriage of Khunsa

Scholars of the Hanafi school hold that a *khunsa* who feels drawn to marriage can wed a man or a woman. According to the *shari'ah*, a *khunsa's* father is allowed to wed his children as long as the *khunsa* harbours affection for the spouse they wed. Subscribing the same opinion, *Hanabilah* scholars hold that to clarify his eligibility to marry, it depends on *khunsa*'s acknowledgement by stating their gender identification. In the meanwhile, because of the uncertainty, a *khunsa* cannot marry or be married to his father, according to *Maliki* schools. Ibn al-Mundhir's records do not clearly indicate *Shafi'i's* position on this matter.

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07

ISSUE OF GENDER DYSPHORIA (GD): CRITICAL APPRAISAL FROM THE LENS OF INTEREST *(MASLAHAH)* IN ISLAM

Khairul Fahmi Jamaludin & Nor Athiah Mohd Noor

AbdulHamid AbuSulayman Kulliyyah of Islamic Revealed Knowledge and Human Sciences & Kulliyyah of Education, IIUM

ABSTRACT

This study aims to examine the issue of gender dysphoria and its position through the lens of interest (*Maslahah*) in Islam. The study adopts library research that explores diverse categories of gender dysphoria together with its factors and impacts. The study reveals various factors and negative impacts resulting from this condition. Based on the analysis, by applying the concept of interest (*Maslahah*), it proves that Islam doesn't perceive gender dysphoria as an interest that needs to be recognized. This is due to its questionable factors and negative impacts on various aspects of human life that are proven to be harmful not only for short-term purposes but also for long-term purposes, for that matter. It is hoped that this paper will give a better understanding of the issue and will benefit society by providing the answer sought by many, especially the Muslim community, who are curious about the position of gender dysphoria in Islam.

Introduction

Malaysia is a country in Southeast Asia and is known for its multiracial and multicultural society. Despite having citizens coming from different races, religions, and backgrounds, Malaysia is considered a Muslim country that practises and follows religious duty devoutly. This is evident in the Islamic values that have been entrenched in the administration of the Malaysian government as well as in the daily lives of its citizens as a society.

Having said that, in recent years, there have been numerous influences rooted in post-modern ideology coming from Western society that disturbed the "peace" in Malaysia, and one of them is gender dysphoria. Gender dysphoria has become a very sensitive and complex issue in Malaysia due to its controversial idea that the gender of a person should not be determined by their physical attributes but rather by their personal choice and inclination. They also argue that society should recognise their interests and treat them equally without any discrimination and bias. The above claim is clearly against the principle of Islam, which does not only assign gender based on physical stature but only recognises two types of gender, which are male and female. This is based on Quran 49:13:

"...O mankind, indeed we have created you from male and female and made you people and tribes that you may get to know one another..."

From the above verse, it can be understood that, apart from recognising only two types of genders, Islam impliedly prohibits any man or woman who wishes to identify him/herself with another gender than the one they were born with. Furthermore, this clash is not only based on religious principles but also on the customs of Malaysian society, which happens to be quite conservative in nature and only accepts male and female gender. The seriousness of this issue can be seen in the response of Malaysian society that worries about their children might get influenced by this condition. Furthermore, the action of several religious authorities, such as the *fatwa* institutions, that issued *fatwa* prohibiting Muslims from getting involved with the gender dysphoria-related movements also shows how serious this issue is (Noor, 2015).

Therefore, this article will explore the issue of gender dysphoria, its categories, together with its factors and impacts on society in three parts. In the first part, the article will discuss, inter alia, the concept, definition, factors, and impacts of gender dysphoria. Next, in the second part, the article will address the concept of interest (*Maslahah)* and its categories. Finally, in the last part, the article will analyse gender dysphoria within the concept and categories of interest (*Maslahah*) in order to determine its status in Islam.

Definition and Concept of Gender Dysphoria

According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2000), Gender Dysphoria (GD) is defined as a condition wherein an individual experiences noticeable incongruity between the gender they express or identify with and the biological sex they were assigned at birth. This incongruence leads to significant distress or impairment in various aspects of their lives, such as social interactions, work, or other important domains. It may encompass feelings of anxiety and distress related to various aspects of gender. Individuals experiencing this condition often exhibit a sense of gender nonconformity, which manifests through behaviors and appearances that deviate from societal norms associated with their assigned gender. Moreover, gender variance represents a key component of gender dysphoria, reflecting a broad spectrum of gender identities and experiences that challenge the traditional binary understanding of gender (Kaltiala-Heino et al., 2018). Those who are affected by GD often exhibit a strong desire to be recognized as a gender different from their assigned one, to alter their physical sex characteristics, or to strongly identify with the thoughts and behaviors typically associated with another gender.

Based on this understanding, physical attributes do not determine gender identity, but psychosocial factors contribute significantly to this matter. Their gender identities are based on their perception of themselves as well as their innate sentiments and instincts. From the gender identity that exists in each individual, gender expression will be manifested. For example, how a person expresses himself in terms of dressing, appearance, conversation, behavior, etc. Therefore, gender identity, instinct, and gender expression are not biological in nature but are formed by the environment, culture, or socialization process (Justice for Sisters, 2015). This is in line with the influence of post-modernist ideology in Western philosophy, which to a large extent emphasizes that all realities are social constructs. This principle leads to the understanding that we are all shaped by society to be male or female—not biology, but social constructs of our gender. It rejects the elements of grand narratives in morality, history, religion, and tradition.

Thus, when a person feels distress due to their gender not aligning with their desires and emotions, it is known as gender dysphoria which is considered as a construct that has been shaped by psychosocial factors. As an illustration, consider a person who identifies as a girl as they get older and was born a guy. This is common among all those who are referred to as queer people. This phenomenon has three internal causes: (1) gender nonconformity; (2) chronic distress; and (3) incongruence between bodily ownership and gender perception. People who suffer from gender dysphoria in society typically engage in a number of behaviors stemming from those three internal causes, including: (1) crossdressing from their birth gender; (2) selecting activities from the opposite gender; and (3) rejecting everything associated with their birth gender.

Following the above definitions, gender dysphoria can be conceptualised into two distinct categories: (a) body dysphoria and (b) social dysphoria (Davidson, 2016). Body dysphoria pertains to the distress or unease stemming from sex characteristics or physical attributes like genitals, breasts, or body hair (Davidson, 2016). The individual's experience of body dysphoria is often perceived as completely internalised or isolated. It refers to varying levels of aversion or avoidance towards the physical traits associated with the assigned gender at birth. In cases of severe body dysphoria, individuals may seek gender-affirming medical interventions to align their physical characteristics more closely with their gender identity. According to Pulice-Farrow et al. (2020), a thematic analysis of one open-ended prompt revealed that there are three main themes conceptualizing participants' thoughts and distress surrounding body dysphoria, namely; disconnection from the body, manifestations of distress, and changes in dysphoria.

The initial theme articulated by participants pertained to the sense of disconnection experienced by their bodies. This theme manifested in three principal dimensions: an overarching disconnection from the body; a disconnection contingent upon specific locations within the body; and a disconnection from culturally constructed masculine and feminine ideals. The phenomenon of disconnection from the body was observed with the greatest frequency within this dataset, with 69.8% of their participants reporting such experiences. The first principle is a general disconnect from the body, as described by the participants as a general disconnect from their own bodies. Participants described this theme of detachment using terms like "jarring," "inappropriate," "anomalous," or "disconcerting." The individuals described how their experiences with body dysphoria led them to believe that something essentially incorrect about their physical shapes existed.

Moreover, other participants expressed a sense of disassociation from their physical appearance: "I feel a deep sense of unease in my chest when I see people who represent the aesthetic I want to have—a sense that some physical characteristics are out of place, as well as a disconnection between my voice and my body." The second principle is location-specific disconnect from the body. A few individuals connected their feelings of detachment to a particular bodily part or region. Within this subtheme, the participants talked about feeling disconnected from these body parts, as if they belonged to someone else, or that it was strange or incorrect to touch or observe them. One person expressed the feeling that "what I see doesn't match what's in my head." Some individuals identified overtly gendered places or situations—like bathrooms or locker rooms—as where this disconnect frequently occurs. Lastly, they have a disconnection from masculine or feminine ideals. Several participants reported that gender dysphoria showed up in body regions that other people would normally interpret as male or feminine. The traditional ideas of masculinity and femininity were contrasted with these physical components. Certain participants expressed their feelings of never being able to achieve a stereotypically masculine or feminine ideal for their physique. According to one of the participants, "I get discouraged when I don't have the energy or time to put into looking feminine and beautiful."

Based The next theme is the manifestation of distress. The secondary theme articulated by the participants to elucidate their experiences of body dysphoria was through explicit depictions of distress. In conveying these depictions, participants underscored the multifaceted impact of body dysphoria on their physical, emotional, and psychological well-being. First, participants expressed their pain stemming from their body dysphoria through physical symptoms such as hurting, panic attacks, or stomach aches. "Skin hurt[ing]," "sore stomach," or "genitalia and breasts feel hot" could have indicated the presence of this. According to one participant, these bodily symptoms "appear deep in thought but also scared simultaneously—heightened sensory sensitivity as well as stress sensitivity"—and occur simultaneously with panic attacks. Second, they faced self-harm while managing distress. Participants also mentioned self-harm as a technique to express their anguish related to their body dysphoria. Although some of these responses may not have explicitly mentioned non-suicidal self-harm, our participants frequently expressed a desire to forcibly remove bodily parts or engage in extreme diets. "Silent scream, tearing myself up on the inside, using my nails to claw at the parts of my body that just don't fit," was how one participant put their desire to self-harm.

The last theme of how participants conceptualised body dysphoria was changed in dysphoria. The theme represents how the participants used changes throughout time as a means of describing their distress. A few people talked about how their body dysphoria evolved, varied, or took on different forms throughout time. Thirteen percent of our participants acknowledged this subject, which consisted of three subthemes: changes related to developmental milestones, changes related to transition milestones, and overall fluctuations in dysphoria.

On the other hand, social dysphoria involves discomfort arising from social interactions, particularly being perceived as the incorrect gender (Davidson, 2016). Social dysphoria, revolves around interactions with others, focusing mainly on immediate social interactions rather than broader societal or systemic influences, which are not currently encompassed in the existing definitions of the concept. In the same study by Pulice-Farrow (2020), a thematic analysis of one open-ended prompt revealed that there are three main themes conceptualizing participants' thoughts and distress surrounding social dysphoria, namely, external triggers and internal processing.

The first theme to emerge in relation to the social context of gender dysphoria was external triggers, which were primarily obtained from social interactions. When participants described specific dysphoric episodes, they frequently described a particular behavior or reaction from others that set off the dysphoric episode. This frequently took the form of misgendering. Misgendering is "like a gut punch, a visceral feeling of alienation and being misunderstood," according to one participant. Participants frequently talked about how being called by an incorrect name or pronoun could cause them to experience misgendering. "He, him, sir. Son. Deadname... those are all knives, and because I'm not passing, they are available for use by anybody. It is important to remember that gender dysphoria brought on by social encounters does not always result in in-person misery. It can also be caused by online encounters, as this quote illustrates. "I detest it the most when people address me online by my birth name. Why would you use my birth name when I am continuously telling you to use my preferred name? It makes me angry and want to strike them. The use of gendered language outside of names and pronouns was another way that misgendering was shown.

For instance, the participants experienced gender dysphoria when others employed gender-specific terminology in reference to them. “My parents or other individuals refer to me as dude, bro, son, brother, guy, etc. This evokes a sensation akin to nails on a chalkboard.” In addition to linguistic stimuli, participants articulated that the gendered assumptions held by others concerning their expected demeanor and interpersonal interactions provoked feelings of gender dysphoria.

The second theme is internal processing, in which gender dysphoria was expressed as concerning social interactions, particularly those that were expected. The symptoms of gender dysphoria include persistent thoughts, intrusive thoughts, and obsession with what other people are reading or thinking about their gender. As an illustration, one participant said, "My anxiety increases when I have intrusive thoughts about how other people perceive my gender." A significant number of individuals expressed that their internal processes involved a preoccupation with the opinions of others regarding their gender. One participant expressed, for instance, that she is "uncomfortable that other people are perceiving parts of my body that I'm uncomfortable with, as I don't want other people to be aware of those parts of my body." Participants defined gender dysphoria as internal processing (e.g., rumination on one's gender identity, concern, or obsession) focused on how one's gender was viewed by others. This processing was centered on interpreting previous social interactions as well as projecting future encounters.

Contributing Factors to Gender Dysphoria

There are several contributing factors that have been identified to have caused gender dysphoria based on previous studies. However, for the purpose of this article, the authors are going to focus on these four (4) factors, which are as follows:

a) Genetic Factors

Twin studies examining various gender dysphoria diagnosis revealed that 39.1% of monozygotic twins of the same or opposite sex exhibited concordance with gender dysphoria (GD), while all dizygotic twins displayed discordance (Heylens et al., 2012). This implies a significant role for genetic factors in the etiology of gender incongruence/dysphoria. Efforts to identify a potential candidate gene associated with gender dysphoria have focused on investigating polymorphisms in genes responsible for the synthesis or functions of sex steroids. Nonetheless, findings regarding correlations with the androgen receptor, the two estrogen receptors, and cytochrome p450 17A, which is crucial for steroid production, have been inconclusive (Bentz et al., 2008; Fernandez et al., 2014a, 2014b; Fernandez et al., 2015; Hare et al., 2009; Henningsson et al., 2005; Ujike et al., 2009).

b) Psychosocial Factors

Various psychosocial theories have been proposed to elucidate the etiology of gender dysphoria. According to the psychoanalytic viewpoint, Person and Ovesey (1974a,b) conceptualized gender identity conflicts as a mechanism to cope with separation anxiety, early identity development, and internal struggles. Consequently, psychoanalytic interventions should be tailored toward addressing denial (Person & L. Ovesey, 1974a,b). Socarides (1970) interpreted gender dysphoria as a protective response to homosexuality.

It was often thought that abnormal gender development resulted from different family dynamics or structures. For example, the socialization process that takes place in the family unit, such as the presence of many sisters, forms a feminine environment. This environment indirectly stimulates the emergence of inherent femininity within individuals experiencing psychological disturbances (Mansor & Abdullah, 2022). The environment in which children are nurtured (Mustafa al-Khin & Mustafa al-Bugha, 2011) exerts a considerable impact on their behavioral development in adulthood.

Other than that, strong closeness to the mother or missing motherhood in assigned females. Gender incongruence and gender dysphoria have been linked to a child's gender identity development being hampered by an absent father or strong parental wishes for a kid of a particular sex (Green, 1974; Levine & Lothstein, 1981; Meyer, 1982; Stoller, 1974). When these theories were investigated, no conclusive evidence was discovered (Cohen-Kettenis & Gooren, 2010; Zucker & Bradley, 1995). According to research by Marantz and Coates (1991) and Rekers, Mead, Rosen, and Brigham (1983), mothers of children with gender dysphoria were more likely to have depression and meet the criteria for borderline personality disorder. That being said, selection bias and the fact that these parents are more likely to seek assistance could potentially account for this outcome (Cohen-Kettenis & Gooren, 1999). Parental psychopathology was not found to be enhanced by Wallien et al. (2007) (Wallien, van Goozen, & Cohen-Kettenis, 2007). There has also been discussion of various recalling parental parenting approaches. When compared to non-transgender people, transgender guys have recalled that both of their parents were emotionally rejecting and that their mothers were more controlling and overprotective. According to transgender women, their mother was uninvolved and their father was more critical and domineering (Cohen-Kettenis & Gooren, 1999; Parker & Barr, 1982; Simon, Zsolt, Fogd, & Czobor, 2011). However, it is still up for debate whether this is a cause-or-effect phenomenon (Simon et al., 2011).

Besides that, subsequent theories have proposed that gender incongruence/dysphoria is caused by a combination of specific child and parental factors during critical early periods of the child's life. These factors include anxiety in the child, feminine appearance in boys, or more masculine appearance in girls, plus parental factors like not setting boundaries, fear of male aggression in mothers, or psychopathology in parents (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Marantz & Coates, 1991; Zucker & Bradley, 1995). But Wallien and colleagues (2007, 2008) were unable to corroborate increased anxiety in the child or increased psychopathology in the parents (Wallien et al., 2007; Wallien, 2008).

While some authors (Devor, 1994; Zucker & Kuksis, 1990) contend that childhood abuse experiences may play a role in the etiology of gender dysphoria, others (Andersen & Blosnich, 2013; Corliss, Cochran, & Mays, 2002; Simon et al., 2011) contend that sexual minorities are disproportionately vulnerable to abuse.

Additionally, peer pressure and contemporary media culture together constitute significant and crucial external factors of GD (Mansor & Abdullah, 2022). The influence of contemporary media culture, including internet engagement, is heavily affected by Western cultural paradigms that provide abundant opportunities for interpersonal interaction. Peer influence also plays a crucial role; associations with a diverse group of individuals can lead to a heightened likelihood of involvement in similar activities, with some individuals imparting life lessons regarding homosexual identities (Khir & Raksan, 2018).

c) Spiritual Factors

The inability to learn about Islam and the lack of a firm grasp on it in daily life are two things that may contribute to this uncertainty (Mansor & Abdullah, 2022). At home, parents are crucial to their children's education. In addition to teaching their children, parents have a duty to provide a pleasant environment and help them choose between right and wrong in Islam. Teens may experience this kind of disorientation due to a variety of circumstances, including friends, the environment, and unrestrained negative socialisation. In addition, they have an inferior attitude toward themselves and are readily swayed by celebrities, both domestically and abroad. They may also be badly impacted by the way society perceives them, which causes them to interpret everything unfavorably.

d) Instinctive Factor

Furthermore, this delirium is also driven by internal forces or self-instincts. The inclination to prefer the same sex, the impact of the past, and having an understanding or an open mind towards topics related to gender dysphoria are among various components of internal influence that have been confirmed by other investigations. According to studies by Ramli (1991) and Amran & Suriati (2013), homosexuals' instinct dictates that they should only be around other homosexuals; even then, they behave based on lust, which is motivated by the id (the principle of pleasure) rather than the super-ego (the moral principles that are prioritized). This symptom is also influenced by prior events, some of which include childhood sexual abuse, including being fondled, falling out of love, and being let down by the other sex (Mahmood, 2011).

Impact of Gender Dysphoria

After discussing the contributing factors, the authors are going to examine gender dysphoria's effects. Based on earlier research, a number of consequences of gender dysphoria have been identified. However, the writer will only concentrate on these two (2) effects for the purposes of this article, which are as follows:

a) Social Impact

Due to their gender experiences being at odds with societal norms, people with gender dysphoria face some degree of discrimination. Some people who find it difficult to accept criticism from others may have gone through a lot of traumas in their lives, which has caused them to conceal their thoughts about their gender identity to the point that they would even rather move to a new location and conceal their past after having sex reassignment surgery.

b) Psychological Impact

Compared to national averages, the transgender adult patients in one study (Zaliznyak et al., 2021) had higher rates of suicidality, anxiety, and depression. These results support a number of research studies that indicate transgender people are more likely than the general population to experience mental health issues. Discrimination and rejection from families and communities are common causes of poor mental health.

The severity of dysphoric symptoms can vary. While some people are able to cope with their discomfort, others lose their ability to function until the illness is treated. Severe anxiety, depression, and other psychological illnesses are common in people with GID. People who have GID may try to harm themselves or their genitalia.

After understanding the definition of gender dysphoria, its categories, as well as its factors and impacts on society, it's about time to move on to the second part of the article, which will focus on the concept of interest (*maslahah*) in Islam. This discussion will take place in the next sub-topic.

Definition and concept of Interest (*Maslahah*) in Islam

In Arabic, the word interest can be translated into *maslahah*, which literally means goodness or interest. This meaning comes from the word *aslaha (*اصلح*)* which can be understood as to do something that is good and beneficial. Another important meaning of the word *maslahah* is an act that is performed for the interest of the public. However, it is a figurative (*majazi*) meaning for the word *maslahah* (Hassan, 1971).

From a technical point of view, the word interest (*maslahah*) has been given several meanings by Muslim scholars. According to al-Ghazali (1993), interest (*maslahah*) includes anything that secures a benefit or rejects harm while simultaneously being in line with the Maqasid *shari'ah*. These objectives aim at protecting the five fundamental values, which include the protection of religion, life, intellect, lineage, and property. Anything that protects these five fundamental values is considered an interest (*maslahah*), while anything that can destroy them is considered a mafsadah. This definition, however, departs from its literal meaning.

Secondly, interest (*maslahah*) according to Abdissalam (2004), is related to goodness and can be divided into two parts. The first part is interest (*maslahah*) that is real and tangible in nature, such as the happiness from having tasty food and drinks. The second part is interest (*maslahah*) which is considered figurative in nature, such as happiness from making profit from business and agriculture. This second meaning is closer to its literal meaning.

Interest (*maslahah*) has several categories that must be further examined in order to have a clear understanding of this concept. These categories will be explained after this.

Categories of Interest (*Maslahah*) in Islam

Under the concept of interest (*maslahah*), it can be further classified into three (3) categories of interest (*maslahah*) which are Accredited interest, Discredited interest and Unrestricted interest that need to be explored one by one after this:

a) Accredited Interest (*Maslahah Mu'tabarah*):

It is a type of interest (*maslahah*) in which the Qur'an or sunnah has expressly mentioned and enacted a law for its realisation. The validity of this type of interest (*maslahah*) is decisive, which means it cannot be rejected and must be upheld at all costs. Muslim scholars have unanimously agreed that promotion and protection of this interest (*maslahah*) is a must, as it constitutes proper ground for legislation (Kamali, 2013).

For example, in order to protect the intellect of its followers, Islam has made the consumption of liquor prohibited. Anyone who fails to observe this prohibition will be punished with 80 lashes. The fact that consumption of liquor has become so rampant and has been consumed by a lot of people doesn't make it permissible for Muslims. This is because the prohibition of liquor is against the concept of interest (*maslahah*) that has been mentioned in the Qur'an and Sunnah (Kamali, 2013). Another example is that, in order to protect the dignity of its followers, Islam has made it illegal for Muslims to commit adultery. Anyone who fails to follow this prohibition will be punished with 100 lashes for unmarried persons and stone to death for married persons. The fact that adultery has become so common and has been committed by many people doesn't make it permissible for Muslims.

b) Discredited Interest (*Maslahah Mulghah*):

It is a type of interest (*maslahah*) in which the Qur'an and Sunnah have nullified it either clearly or by indication that could be found in *shari'ah*. Muslim scholars have unanimously agreed that no judicial ruling can be made based on this type of interest (*maslahah*). Hence, any ruling that is made based on this interest (*maslahah*) is invalid or discredited. In other words, any practice of the people that fall under this category is null and void (Kamali, 2013).

For example, the practice of usury that takes place in most banking institutions today doesn’t make usury permissible to Muslims, as the practice of usury is a clear violation of Allah’s prohibition. Anyone who is involved in practice will be sinful, and if he doesn’t repent before Allah, he will be punished in the hereafter (Hasan, 1971). Another example is the attempt to give equal shares to both son and daughter in inheritance based on the assumption that it would protect the public interest. This attempt does seem like a good and fair thing to do considering the changes in the world today. However, since there is a very clear verse in the Qur’an that assigns double portions to the son and only one portion to the daughter, this interest is clearly nullified and discredited.

c) Unrestricted Interest (*Maslahah Mursalah*):

It is a type of interest (*maslahah*) in which there is no explicit text from the Qur'an or Sunnah that either validates or invalidates it. Muslim scholars are not unanimous in accepting or rejecting this interest (*maslahah*) due to the absence of any supporting authorities from the Qur'an or sunnah (Kamali, 2013). However, since this type of interest (*maslahah*) is in line with the objective of *shari’ah* by securing the benefit and rejecting the harm, it has been used frequently by Muslim scholars in the past and present to enact various legal rulings in Islam.

For instance, the ruling enacted using this type of interest (*maslahah*) in the past is the codification of the Qur'an that has been performed by the companions based on the suggestion of Umar RA to Abu Bakr RA after the demise of Prophet Muhammad PBUH. Another example of a ruling enacted using this type of interest (*maslahah*) in the present is enacting various hukm or rules of law that have benefited so many people and protected them from harm such as traffic regulation, family regulation and so on. However, before this type of interest (*maslahah*) can become a valid one, there are several requirements that need to be fulfilled which are as follow:

i- The *maslahah* must be genuine (*haqiqiyyah*) and not just mere suspicion (*wahmiyyah*) that is not a suitable basis for enacting regulation.

ii- The *maslahah* must be general (*kulliyyah*) and not specific (*juz’iyyah*) in which it must secure benefit or reject harm to the people as a whole and not to a particular person or group of persons.

iii- The *maslahah* must be in line with *shari’ah* principles and not vice versa.

If the interest (*maslahah*) fulfills all the above requirements, only then it can be said that it is a valid interest (*maslahah*) that is suitable to be the basis for enacting hukm or regulation. If the interest (*maslahah*) couldn’t fulfil even one requirement, then it is not a valid interest (*maslahah*).

Analysis and Discussion

After going through a lengthy discussion where in the first part, the article has discussed gender dysphoria, its categories together with its factors and impacts to society. Next, in the second part, the article focused on the concept of interest (*maslahah*) in Islam together with its three (3) categories. And finally, after having full comprehension of the concept of gender dysphoria and the concept of interest (*maslahah*) in Islam, now moving on to the last part where the writer will examine gender dysphoria via the lens of interest (*maslahah*) in order to determine its position in Islam, as to whether it is permissible and is recognised in Islam or not.

Firstly, let’s look at the first category of interest (*maslahah*) i.e. Accredited Interest (*Maslahah Mu’tabarah*). Basically, it is the interest that has been recognised in Islam and has been mentioned either in Qur’an or Sunnah of the Prophet PBUH, in which its validity is definitive and must be upheld in whatever situation. If the issue of gender dysphoria were to be analysed from this category, it seems rather unsuitable due the fact that this issue of gender dysphoria has never been mentioned in either Qur’an or *Sunnah*. And this brings us to the next point, where in this first category of interest (*maslahah*), it's either securing benefit or repelling harm, which gender dysphoria is clearly not one of them. Furthermore, the issue of gender dysphoria is clearly against Islamic principle, where not only it doesn't secure benefit or reject harm, but it actually invites evil and promotes harm. In Islam, only two genders are recognised, i.e. male and female, and Islam strictly prohibits any attempt to identify with another gender which happens to be the essence of gender dysphoria. Besides, in Islam there is no room for consideration of a wish or desire of a person to identify or to become the opposite gender. This gender dysphoria condition clearly shows feelings of ungratefulness and dissatisfaction at what God has given him/her, which tantamount to changing the creation of God.

Secondly, the second category of interest (*maslahah*) i.e. Discredited Interest (*Maslahah Mulghah*), basically refers to the interest that has been nullified or invalidated either clearly or by way of indication in the Qur'an or Sunnah. No *hukm* or ruling can be made based on this category of interest (*maslahah*). If the issue of gender dysphoria were to be examined from this category, it is quite befitting due to the fact that it is a condition that goes against the clear principle enunciated in the Qur'an and Sunnah. As has been mentioned in the previous discussion, Islam only acknowledges two types of gender which are male and female, and to acknowledge another gender is a clear violation of this principle. The fact that so many people today are involved with gender dysphoria conditions doesn't make it permissible for the Muslim to do the same.

Furthermore, this gender dysphoria is not in line with the objective of *shari'ah* of preservation of life and lineage. By becoming a person with gender dysphoria, not only does this person want to change the creation of God, but these changes will lead to various harmful effects that could affect his/her health by taking all kinds of medicine and hormones in order to become the opposite gender, and this clearly violates the objective of preservation of life. For the preservation of lineage, gender dysphoria will definitely cause confusion with regard to the lineage of a person later on. This is because gender dysphoria usually leads to transgender problems, and these people have a very bad record when it comes to having a proper family and procreating children. Based on the above discussion, it is clear now why the issue of gender dysphoria falls under this category of interest (*maslahah*) and why it shouldn't be allowed and entertained in Islam.

Moreover, there have been many attempts from these movements that demand recognition and rights from the government of Malaysia. This recognition and right will, if allowed, open a very huge opportunity for them not only to promote their agenda but also to influence other people to express their "latent" feelings or desires that have been suppressed all this time. This is a very dangerous and risky thing to do because once the door is open, it can never be closed, and it will lead to many regretful consequences later on.

Lastly, moving on to the third category of interest (*maslahah*) i.e. Unrestricted Interest (*Maslahah Mursalah*). It basically refers to the interest that has not been regulated by the Legislator and there is no textual authority can be found on its validity or otherwise. However, due to the fact that it is in line with the objective of *shari'ah*, it has been used frequently by Muslim scholars in order to enact various *hukm* or regulations that have proven to benefit society. If gender dysphoria were to be analysed from this category, it seems inappropriate because *maslahah* under this category must be in line with the objective of *shari'ah*. Gender dysphoria is clearly in violation of two fundamental values under the objective of *shari'ah* which are preservation of life and lineage. Furthermore, as the word interest (*maslahah*) suggests, it should either preserve benefit or repel evil, which gender dysphoria is clearly not.

Next, in order to become a valid interest, there are several requirements that need to be fulfilled. Let's analyse this requirement one by one. Firstly, interest (*maslahah*) must be genuine and not mere suspicion, otherwise, it wouldn't be suitable ground for enacting hukm or the rule of law. Whereas, gender dysphoria is not a genuine interest, rather it is a suspicion of the person who refuses to come to terms with his/her original gender and wants to identify with the opposite gender. Instead of looking for proper counselling and treatment, these people are busy demanding their interest to be recognised by the government. This is considered as clear proof that the interest pursued by those with gender dysphoria is not genuine, rather it is a suspicion that is fueled by unchecked desire and lust. Secondly, interest (*maslahah*) must be general and not specific in which it must preserve benefit or reject harm to the people at large and not to a particular group of persons. Gender dysphoria on the other hand is only meant for specific to a group of people only and not to everyone. This means, they only pursue interests for their benefit as a group of persons rather than interests that could benefit people as a whole. So, it is clear that the second requirement to be a valid interest (*maslahah*) is not fulfilled. Now, let's move to the last requirement which is the *maslahah* must be in line with *shari'ah* principle and not vice versa. As has been discussed earlier, gender dysphoria's essence is to identify him/herself with the opposite gender which resulted from their unchecked desire. This is a clear infringement of the above objective of *shari'ah*, hence it fails to fulfil the third requirement.

Since gender dysphoria cannot fulfil the above three (3) requirements to be a valid interest (*maslahah*), it cannot be a suitable basis for enacting *hukm* or ruling, then, it should stay under the category of discredited interest. This is the reason why the interest that is being pursued by people with gender dysphoria is not recognised in Islam and their interest shouldn't be given any room for consideration at all.

Conclusion

After discussing all three (3) parts, we are going to summarize all of them before concluding this topic.

In the first part, the discussion is focused on the concept of gender dysphoria, categories together with its factors and impacts. From this part, it is clear that gender dysphoria is a condition when a person experiences an obvious difference between the biological sex they were assigned at birth and the gender they express or identify with. This difference causes them great grief or impairment in a number of areas of their lives, including relationships with others, their jobs, and other crucial areas. There are several factors that contribute to gender dysphoria such as genetic, psychosocial, spiritual and instinctive. These elements will impact an individual's life in a variety of ways, including social and psychological.

In the second part, the discussion is focused on the concept of interest (*maslahah*) in Islam and its categories. From the discussion, it is clear that in Islam, interest could be understood as an act that is performed for the public interest. This interest includes anything that protects the benefit or rejects the harm while simultaneously in line with the objective of *shari'ah*. Interest can be divided into three (3) categories which are accredited, discredited and unrestricted interest. In short, accredited interest (*maslaha mu'tabarah*) is an interest that is recognised in Islam and can be found either in the Qur'an or Sunnah. Discredited interest (*maslahah mulghah*) is an interest that is not recognised in Islam which is in contradiction with the *shari'ah* principle as well as the objective of *shari'ah*. Last but not least, unrestricted interest (*maslahah mursalah*) is interest that has no explicit text from the Qur'an and Sunnah that either validates or invalidates it. However, since this interest is in line with the objective of *shari'ah*, it has been used frequently by scholars to enact various hukm or legal rulings in the past and present.

In the last part, the discussion is focussed on analysing gender dysphoria from three (3) categories of interest (*maslahah*). From the analysis of three categories of interest, it can be said that gender dysphoria does not fall under the first category because it is not mentioned in either the Qur'an or Sunnah and it is something that goes against the principles of Islam. Gender dysphoria also does not fall under the third category because its essence is in clear infringement of the *shari'ah* principle, and it does not fulfil the requirement to be a valid interest (*maslahah*). Gender dysphoria is only suitable to be classified under the second category because it is something that does not secure benefit or reject harm, and at the same time, gender dysphoria wants to promote its essence i.e. to identify him/herself with the opposite gender which goes against the principle of Islam that only recognise two type of gender which is male and female.

Based on the above statements, it is clear now that gender dysphoria has no place in Islam due to its contradiction with Islamic principles as well as the harm it causes to various aspects of human life in both short and long terms. It must be noted that Islam is a religion of compassion and mercy to all mankind. All of the commandments and prohibitions that Islam has set are for the benefit of human beings in this world and in the hereafter. Islam doesn't discriminate against anyone no matter what their conditions are, however, Islam puts some boundaries in human life, so that the objective of *shari'ah* is fulfilled, and humans will enjoy their benefits to the fullest. As for the people with gender dysphoria, even though Islam does not recognise their interests and rights, doesn't mean Islam will not treat them as a human being. In Islam, the duty to help these people first and foremost will fall on the state which will give assistance through religious authorities. At the same time, all members of society from the experts, the parents and relevant parties should play their roles in preventing and treating these people. Those who have gender dysphoria should be given proper treatment so that they can live harmoniously in society according to the rules and regulations that have been prescribed by the government and religion without having to face any difficulties and problems.

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08

FRAMING AND/OR DEFRAMING THE SOCIOCULTURAL NARRATIVES OF GENDER DYSPHORIA WITH ISLAMIC REFERENCES

Rohaiza Rokis
AbdulHamid AbuSulayman Kulliyyah of Islamic Revealed Knowledge and Human Sciences, IIUM

ABSTRACT

This chapter explores the differential terms and concepts of gender dysphoria from an Islamic perspective. A particular concentrated discussion argues that gender dysphoric individuals are different from the LGBTQ+ communities. They are inherently pathological and require clinical interventions. On the contrary, the LGBTQ+ communities are depicted as having a diverse spectrum with varying sexual orientations and gender identities based on self-proclamation. Though both groups may identify gender differences and claim to start as early as their assigned sex at birth experience, the former group are clinically diagnosed, while the latter is just making claims about "who I am, how I feel". Making claims is easy but useless without specific directives evident for all to understand. Culture, upbringing, and personal identity may not necessarily align with clinical and pathological treatments. While gender dysphoric individuals suffer a diagnosed sociopsychological condition that gives them discomfort or distress regarding their gender identity, LGBTQ+ individuals primarily perceive their gender identity as deeply ingrained in their understanding of their inner sense of gender, which is not considered pathological. Thus, gender dysphoria is not universal, and not everyone experiences it. It is a diagnosed illness that causes anxiety and depression, which need clinical treatments. Based on framing and/or deframing the sociocultural narratives, this chapter attempts to make an awareness of gender dysphoria. It asserts that religion, social and environmental support, understanding, and affirmation of one's gender illness play crucial roles in managing gender dysphoria.

Introduction

"Framing" and "deframing" are terms used in social sciences, communication and media studies to describe how issues are presented, interpreted, and contextualised. This chapter puts an effort to "frame" the issues and "deframe" the context of gender dysphoria based on the shaping of how people perceive it.

The root of this chapter depends on the medical and clinical contexts of gender dysphoria. Gender dysphoria is a clinical diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). It is a sociopsychological term used to describe the distress or discomfort of an individual's gender identity. Individuals experiencing gender dysphoria may feel significant emotional and psychological distress due to the incongruence between their gender identity and experience with their assigned sex. This distress can manifest in various ways, including anxiety, depression, or a strong desire to be treated or recognised as a gender different from the one assigned at birth. However, it is not universal, and most significantly, gender dysphoria does not occur to anybody. In contrast, the gender identity that transgender individuals mainly experience is deeply held about their understanding of their inner sense of gender (Crocq, 2021), which is not pathological.

“Framing” the understanding of gender dysphoria as a sociopsychological is significant due to its apparent need for pathological treatment. Whilst “deframing” the inherent perception related to the sexual orientation of a person's enduring physical, romantic, and emotional attraction to others is significantly applicable, too, due to being unethical by some societal standards. In this liberalised postmodern era, especially within the Malaysian context, there has been a shift in the understanding and treatment of gender dysphoria. Treatment guidelines for gender dysphoria have been accepted, allowing for individualised and multidisciplinary approaches, including psychotherapy, social gender transition, and cross-sex hormone therapy (Hadj-Moussa et al., 2018). The evolving understandings of gender dysphoria reflect the changing societal attitudes and the recognition of alternatives for individuals experiencing gender dysphoria. Dysphoric individuals explicitly live through distress arising from disconnecting between assigned sex and experienced gender, which may be different from Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ+) individuals. Thus, not all transgender or gender-diverse people experience gender dysphoria (Blanchard et al., 1987; Elaut, 2022).

Gender dysphoric individuals are more complex than LGBTQ+ communities. Gender dysphoria and LGBTQ+ communities are not mutually exclusive or directly comparable concepts because the former refers to the distress or discomfort that may arise from the incongruence between a person's gender identity and the sex they were assigned at birth, yet the latter may not be. Gender dysphoria is a profoundly personal experience that varies from person to person. It involves complex feelings about one's gender identity, body, and social role. While some transgender individuals may experience gender dysphoria, others may not.

Many gender dysphoric individuals find support and belonging within the LGBTQ+ community, as it provides a space where they can connect with others who share similar experiences and identities. However, not all gender dysphoric individuals may identify with the LGBTQ+ label or community, as gender identity is separate from sexual orientation. It is recognised as a medical diagnosis in the DSM-5 and may require medical interventions, such as hormone therapy or gender-affirming surgery, for some individuals to alleviate distress. However, social support, acceptance, and inclusion are also crucial for the well-being of gender dysphoric individuals, highlighting the importance of societal attitudes and policies in creating affirming environments.

Gender dysphoria is a legitimate disorder discussed by medical doctors, fuqaha', socio-culturalists, psychotherapists, and other disciplines. The relationship between Islam and aspects of non-normal sexualities has been a complex and sensitive issue, often influenced by cultural, social, and historical factors (Tehmina, 2022; Zainuddin & Mahdy, 2016). Gender dysphoria is not a social media trend or a choice or even based on a preferred individualised lifestyle because it is neither sexual orientation nor sexual identity. It has been historically and scientifically backed as a valid disorder. As of 2018, 0.005% of assigned male at birth (AMAB) adults and 0.003% of assigned female at birth (AFAB) were diagnosed with gender dysphoria (Blanchard et al., 1987; Crocq, 2021; Elaut, 2022). Thus, not all transgender individuals experience gender dysphoria. Many LGBTQ+ are comfortable with their gender identity and do not experience significant distress related to the incongruence between their gender identity and assigned sex.

Understanding Gender Dysphoria through Sociological Theories

Gender dysphoria and transgender are related concepts, but they are not the same. Gender dysphoria is a psychological term that refers to the distress a person experiences due to a mismatch between their gender identity and the sex assigned at birth. On the other hand, being transgender refers to a person whose gender identity does not align with the sex they were assigned at birth. Not all transgender individuals experience gender dysphoria, and not all people with gender dysphoria identify as transgender. Gender dysphoria can lead to severe emotional and psychological distress if left untreated. It can be relieved by expressing one's gender in a way that aligns with their gender identity.

From a sociocultural perspective, individuals who experience gender dysphoria feel distressed due to the difficulties encountered by social disapproval of one's culture. It is a complex phenomenon wherein individuals experience discomfort or distress due to a misalignment between their assigned gender at birth and their gender identity. This condition can lead to various challenges, including cultural stigmatisation, relationship difficulties, mental health issues, and an increased risk of self-harm and suicidality. Societal understanding of gender dysphoria has evolved, with a shift towards recognising gender as a spectrum rather than a binary concept, aiming to reduce stigma and promote timely support and education. Contextually, gender dysphoria cannot be solely understood through individual experiences but must be analysed within the broader context of societal norms, cultural expectations, and power dynamics. The management of gender dysphoria within the sociocultural context may involve a combination of medical, psychological and cultural considerations, in which approaches differ based on individual interpretations and beliefs.

Sociological perspectives include symbolic interactionism, social constructionism, and feminist theory, providing an understanding of how societal factors influence the experiences of individuals with gender dysphoria. The history of gender dysphoria in sociology reflects a significant evolution in the understanding and treatment. The social constructionist model of gender, sex, and sexuality emerged in the 1970s as a byproduct of feminist and sociological theories, contributing to a more nuanced understanding of gender identity.

Symbolic Interactionism

Symbolic interactionism emphasises the role of symbols, meanings, and social interactions in shaping individual identity and behaviour. Within this framework, gender dysphoria can be understood as a result of the discrepancies between the meanings attached to biological sex and gender identity within a given society. Individuals with gender dysphoria may experience conflicts between the gender roles and expectations imposed upon them by society and their internal sense of gender identity.

The interactions between individuals and society, such as socialisation processes, stigmatisation, and discrimination, play a crucial role in shaping the experiences of individuals with gender dysphoria. When symbolic interactionism is applied to the understanding of gender dysphoria, it explores how the meanings attached to gender influence the experiences of individuals with gender dysphoria and how social interactions shape their identity formation. It provides insights into how individuals make sense of their gender identity within societal norms, expectations, and interactions. In such a case, gender is viewed as a socially constructed concept imbued with symbolic meanings learned and negotiated through interactions. From an early age, individuals are socialised into gender roles and norms that dictate how they should behave, dress, and express themselves based on their assigned sex at birth. These gender expectations are reinforced through various social institutions, such as family, education, media, and religion. For individuals with gender dysphoria, the conflict between their internal sense of gender identity and external societal expectations can lead to feelings of confusion, alienation, and discomfort.

The context of symbolic interactionism suggests that identity is not fixed but emerges through ongoing interactions with others and the interpretation of symbols and meanings attached to oneself. Individuals with gender dysphoria engage in the process of identity negotiation and management as they pass through the complexities of their gender identity within social contexts. This process involves experimenting with different gender presentations, seeking validation and acceptance from others, and forming connections with supportive communities. Social interactions, such as coming out to friends and family, seeking medical transition options, or advocating for gender-affirming policies, play a crucial role in shaping the identity development of individuals with gender dysphoria.

Symbolic interactionists shed light on the stigma and labelling processes experienced by individuals with gender dysphoria. Society often attaches negative stereotypes and judgments to non-conforming gender identities, labelling them as deviant or abnormal. This stigma can lead to social ostracism, discrimination, and internalised shame among individuals with gender dysphoria. Moreover, the medicalisation of gender dysphoria, as defined in diagnostic manuals such as the DSM-5, can further reinforce the pathologisation of transgender identities and perpetuate stigma (American Psychiatric Association, 2013). Symbolic interactionism calls attention to the power dynamics inherent in labelling processes and the need for destigmatisation and acceptance of diverse gender identities.

By understanding gender dysphoria within the context of societal norms and interactions, society can work towards creating more inclusive and supportive environments that affirm the diverse gender identities and expressions of all individuals.

Social Constructionism

Social constructionism suggests that reality is socially constructed through shared meanings, language, and cultural practices. Gender dysphoria is viewed as a socially constructed phenomenon influenced by cultural norms, historical contexts, and institutional practices. Within this framework, gender is not a fixed or inherent characteristic but a fluid and contingent identity shaped by social processes. The categorisation of individuals into binary gender roles, male or female, is a social construct that may not accurately reflect the diverse range of gender identities and expressions.

The theory suggests that gender dysphoria challenges traditional notions of gender by highlighting the existence of non-binary and transgender identities that transcend conventional categories. Social constructionism, an essential perspective in sociology, posits that reality is shaped by social processes, language, and cultural meanings rather than being inherent or objective. When applied to the understanding of gender dysphoria, social constructionism provides a framework for analysing how societal norms, institutions, and power dynamics construct and enforce binary gender categories, influencing the experiences of individuals whose gender identity does not conform to these norms. The intersection of social constructionism and gender dysphoria examines how the construction of gender norms contributes to the stigmatisation, marginalisation, and medicalisation of transgender and non-binary identities.

Social constructionists challenge the notion of gender as a fixed and natural binary category, highlighting instead the fluid and contingent nature of gender identities. In many societies, gender is constructed along a binary framework, with rigid expectations regarding behaviour, appearance, and roles based on assigned sex at birth. These gender norms are perpetuated and reinforced through social institutions such as family, education, religion, media, and law, shaping individual identities and interactions. Individuals with gender dysphoria often experience distress and discomfort due to the mismatch between their internal sense of gender identity and the external societal expectations imposed upon them. The construction of binary gender norms leads to the marginalisation and stigmatisation of transgender and non-binary individuals. Those who do not conform to traditional gender roles may face discrimination, violence, and social ostracism as their identities challenge the existing power structures and norms. The labelling of gender dysphoria as a mental disorder in diagnostic manuals such as the DSM-5 (American Psychiatric Association, 2013) reinforces the pathologisation of transgender identities, contributing to the stigmatisation and medicalisation of gender non-conformity. In such a case, the role of language, discourse, and social institutions in shaping perceptions of gender dysphoria and perpetuating stigma.

Despite the challenges posed by societal norms and stigma, social constructionism also highlights the agency of individuals and communities in resisting and subverting dominant gender narratives. Through acts of self-expression, activism, and community building, transgender and non-binary individuals challenge binary conceptions of gender and advocate for gender diversity and inclusion. Social media platforms, grassroots movements, and advocacy organisations provide spaces for individuals with gender dysphoria to connect, share experiences, and mobilise for social change. By challenging the construction of gender norms and promoting alternative narratives, these efforts contribute to the destigmatisation and empowerment of transgender and non-binary communities.

Social constructionism offers valuable insights into the construction, enforcement, and resistance of gender norms about gender dysphoria. By deconstructing binary categories and examining the social processes that shape gender identity, we can better understand the experiences of individuals with gender dysphoria and work towards creating more inclusive and affirming environments. Embracing diversity, challenging stigma, and advocating for social change are essential to fostering acceptance and equality for all gender identities.

A sociolinguistic reference indicates the usage of the “gender dysphoria” term to be replaced with the diagnosis of “gender identity disorder”, which signifies a shift towards a less stigmatising approach to diverse gender identities.

Feminist Theory

The feminist theory examines gender dysphoria within the broader context of patriarchal structures, power relations, and systems of oppression. Gender dysphoria can be understood as a manifestation of the restrictive gender norms imposed by patriarchal societies, which dictate how individuals should behave, express themselves, and conform to traditional gender roles, which would lead to gender binaries and perpetuate inequality. Moreover, transgender individuals, particularly transgender women of colour, are disproportionately affected by violence, discrimination, and social marginalisation, highlighting the intersectionality of gender dysphoria with other forms of oppression, such as racism, sexism, and classism.

Feminist theory provides a critical lens through which to examine gender dysphoria, offering insights into how societal power structures, patriarchal norms, and systems of oppression intersect with experiences of gender identity. By highlighting the interconnectedness of gender, sexuality, race, class, and other axes of identity, feminist theory sheds light on the complex dynamics underlying gender dysphoria. It offers pathways towards empowerment and social change. It critiques traditional gender norms and binaries, which contribute to the marginalisation and pathologisation of transgender and non-binary identities. Patriarchal societies uphold rigid expectations regarding masculinity and femininity, perpetuating inequalities and limiting individual agency. Individuals with gender dysphoria often experience distress and discrimination as they navigate societal expectations that do not align with their gender identity. Feminist theorists advocate for the deconstruction of gender norms and the recognition of diverse gender identities and expressions beyond the binary framework.

A central concept in feminist theory emphasises the interconnectedness of various forms of oppression, such as racism, sexism, classism, ableism, and transphobia. Transgender and non-binary individuals, particularly those from marginalised communities, experience intersecting forms of discrimination and violence. Feminist analysis acknowledges the unique challenges faced by transgender women of colour, disabled individuals, and other marginalised groups within transgender communities. By centring intersectionality, feminist theory highlights the importance of addressing multiple axes of oppression in efforts to support individuals with gender dysphoria and promote social justice.

Feminist theorists critique the medicalisation and pathologisation of gender dysphoria, which reinforces binary notions of gender and reinforces power differentials between medical professionals and transgender individuals. The classification of gender dysphoria as a mental disorder in diagnostic manuals such as the DSM-5 perpetuates stigma and discrimination, framing transgender identities as inherently pathological (American Psychiatric Association, 2013). Feminist scholars advocate for alternative models of care that prioritise informed consent, autonomy, and affirmation of gender diversity. By challenging the medicalisation of gender dysphoria, feminist theory supports the empowerment and self-determination of transgender and non-binary individuals.

Feminist theorists inspire activism and advocacy within transgender and non-binary communities, fostering solidarity, visibility, and social change. Transgender and non-binary individuals, along with allies, organise grassroots movements, protests, and policy initiatives to challenge discrimination, promote legal recognition, and advance transgender rights. Feminist principles of empowerment, intersectionality, and social justice guide these efforts, amplifying the voices of marginalised individuals and centring their experiences in advocacy work. By mobilising collective action and challenging oppressive structures, feminist theory contributes to the empowerment and liberation of transgender and non-binary communities.

Feminist theory offers valuable insights into the complexities of gender dysphoria, highlighting the intersections of gender, power, and oppression. By critiquing traditional gender norms, centring intersectionality, challenging medicalisation, and fostering empowerment and activism, feminist perspectives contribute to a more inclusive and equitable understanding of gender diversity. By centring the voices and experiences of transgender and non-binary individuals, feminist theory inspires transformative change towards a society that affirms and celebrates all gender identities.

"Framing a New, Deframing the Old" Gender Dysphoria from Sociocultural Lens

Framing is a way of presenting information that influences the interpretation and understanding of information. "Framing" can influence opinions, attitudes, and decision-making to generate support or enthusiasm, evoke specific feelings or reactions and emphasise urgency and the need for immediate action. On the other hand, "deframing" means challenging or altering the existing frames through which information is presented. In the Malaysian context, the established narratives of gender dysphoria may not be well understood. Thus, this discussion offers alternative viewpoints, questioning assumptions, or challenges dominant narratives about gender dysphoria.

To frame gender dysphoria's narrative means to refer to how individuals, communities, media, and societies present and discuss it. The framing of the narrative involves shaping perceptions, attitudes, and understanding of individuals who suffer from gender dysphoria and their experiences. The choice of words and terminology used to address issues in gender dysphoria can significantly impact how the narrative is perceived. Framing the narrative within the human rights and equality context emphasises the fundamental principles of justice, fairness, and dignity for all individuals, regardless of their sexual orientation or gender identity.

Sharing the personal stories and experiences of individuals who suffer from gender dysphoria helps humanise the narrative. This approach can foster empathy, understanding, and connection, breaking down stereotypes and misconceptions. Acknowledging and incorporating the intersectionality of identities is crucial. People can belong to multiple marginalised groups, and recognising these intersections helps create a more comprehensive and inclusive narrative. Framing discussions around health, mental health, and well-being contribute to a more holistic understanding of the challenges faced by the community. This can include addressing issues such as discrimination, stigma, and access to healthcare.

Moreover, society must represent issues of gender dysphoria in a positive light in media, literature, and other forms of cultural expression. Positive representation helps challenge stereotypes and fosters a more inclusive and affirming environment. Discussing challenges such as discrimination, bullying, and disparities in healthcare can raise awareness and inspire advocacy efforts. Framing these challenges within a context of resilience and strength can empower the community. One must acknowledge that there is diversity of thought within religious and cultural communities regarding gender dysphoria issues, which helps foster a more nuanced and respectful discussion. Highlighting inclusive perspectives within various faith traditions contributes to a broader understanding.

Moreover, framing the gender dysphoria narrative as an opportunity for education and awareness encourages open dialogue and dispels myths and misconceptions about it. Providing accurate information helps build a foundation for understanding and acceptance. Overall, framing the gender dysphoria narrative involves intentional and thoughtful communication to shape a narrative that is inclusive, respectful, and aligned with equality and human rights principles. It aims to contribute to a more accepting and supportive society for individuals who suffer from gender dysphoria.

At the same time, it is essential for society to deframe transgender lifestyles from gender dysphoria. Deframing narratives of transgenderism from gender dysphoria will dismantle the stigma labelled by society because gender dysphoric individuals are categorised as medically challenged groups of people and do not have the same experiences as transgender individuals. The stigmatising framework reinforces negative stereotypes about gender dysphoria and contributes to their marginalisation within the same category of transgender and non-binary individuals. In short, deframing gender dysphoria from LGBTQ+ individuals challenges these stigmatising narratives and promotes more affirming and inclusive perspectives that recognise the medical aspect of human variation in their creation.

Furthermore, deframing the narrative of transgenderism from gender dysphoria is significantly relevant because transgender individuals are comfortable with their gender identity, and they do not experience distress related to it. They can usually define and articulate their gender identities on their terms without being constrained by external norms or expectations. In contrast, medically diagnosed gender dysphoric individuals are not able to manage their emotions and thus easily have nervous breakdowns, emotional distress, anxiety, depression, and discomfort with their bodies or social roles. Respect for individuals' autonomy and self-identification is crucial for affirming their sense of self and facilitating their well-being.

When society is taught to deframe gender dysphoria as a mental health issue, it can contribute to the pathologisation and medicalisation of transgender identities, potentially leading to uplifting stigma, discrimination, and barriers to accessing appropriate care. Deframing involves recognising gender dysphoria as a valid aspect of human experience that may require support and affirmation that inherently indicate mental illness or dysfunction. It can also help remove barriers to accessing gender-affirming healthcare, including hormone therapy, surgery, and mental health support.

By destigmatising transgender and non-binary identities and promoting evidence-based, patient-centred care, deframing supports the well-being and dignity of individuals seeking gender-affirming interventions.

Gender Dysphoria and its Discussions from Islamic Perspectives

The Islamic view on gender identity disorder is complex and varies depending on the interpretation of Islamic teachings and cultural norms. Some Islamic scholars and medical professionals have discussed the issue from the perspective of Islamic jurisprudence and bioethics. Sheikh Rashid al-Olaimi of Kuwait has stated that provoking persons with gender dysphoria is a grave sin. The National Shari'ah Council of Malaysia advised a patient with gender dysphoria to pray as a man and have regular sessions with a psychiatrist. The Assembly of Muslim Jurists of America has stated that using hormones for medical treatment is permissible. Still, it is forbidden if it is for changing nature by making a man who is utterly male into a female. The Islamic Republic of Iran has allowed sex reassignment surgery for individuals with gender dysphoria, but only after a thorough psychological evaluation and approval from a religious authority. However, some Islamic scholars argue that sex reassignment surgery is changing the creation of Allah and is an expression of discontent with what Allah has chosen for the individual.

Specifically, from the context of gender dysphoria, Islam also regards it as a complex and debated subject. Islamic perspectives on gender-related issues, including gender dysphoria, are influenced by cultural, religious, and ethical values. According to Islamic jurisprudence, individuals with gender dysphoria are encouraged to seek holistic care, taking into consideration religious and cultural factors. The issue of gender dysphoria is not solely attributed to nature or nurture in Islamic law, and individuals are encouraged to conform to their biological sex. The medical and ethical debate on gender dysphoria is of particular interest to the Muslim community, and there are differing opinions on the permissibility of sex reassignment surgery within Islamic teachings. While there are ongoing discussions and debates, it is essential to approach the topic with sensitivity and understanding of the religious and cultural factors involved. There are differing opinions on these matters.

The Islamic Fiqh Council of the Muslim World League, dated the 20th of August 2007, Decision no.5, Session 11, further elaborated the fatwa ruling on the prohibition of sex reassignment surgery. It was a deliberate answer to a question posted by Dr Hatem al-Haj, a Muslim physician, who sought the Council to re-study this issue carefully and re-issue a ruling on this case since many Muslims are affected by this condition. On LGBTQ+ matters, the Council has a transparent verdict, as quoted:

It is not permissible for either a man whose male organs are fully formed or a woman whose female organs are fully formed to change into the other gender. The attempt to do so is a crime, the perpetrator of which deserves to be punished for changing the creation of Allah. He has forbidden this changing, in His Saying (may He be exalted), when He informs us of what Satan said (in meaning) {…and indeed I will order them to change the nature created by Allah…}[Al-Nisa' 4:119]

Furthermore, the Council also derives from the Sahih Muslim, on the authority of Ibn Mas`oud, who said: "Should I not curse those whom Allah's Messenger cursed, when it is in the Book of Allah". He then referred to Al-Hashr, 59:7, which states: "Whatsoever the Messenger Muhammad SAW gives you, take it, and whatsoever he forbids you, abstain (from it)".

The unavoidable truth is that the wisdom of prohibiting these operations is clear to rational members of various religions and societies due to the danger these types of behaviours present to the social and moral fabric. The Council further argues that even if some people believe there to be some benefit from this sex reassignment surgery, the result is negative, and their evil is far greater than their good. Furthermore, reassignment does not end these people's suffering. Moreover, transition does not make a man a woman in the true sense because he can get pregnant, give birth and breastfeed. As for the female-to-male transsexual, she cannot be entirely male because she is permanently infertile.

People are tested by Allah differently. For some, they were tried with a sexual desire greater than others. Others are tested of intense greed, but that does not make stealing permissible for them. Accordingly, Allah does not account for His humans, just merely having a thought and obsessions as long as these do not drive them to any prohibited action or speech. Imam Ibn ul-Qayyim has said something invaluable in this regard. His stated:

Keep ill thoughts at bay, for if you do not, they will become ideas. Then, keep bad ideas at bay, for if you do not, they will become desires. Fight them; they will become determined and resolved if you do not. Then, if you do not keep them at bay, they will become actions, and if you do not fight this with its opposite, it will become a habit, and it will be difficult for you to get away from it.

Whoever keeps these thoughts away and bears patiently, Allah will reward this trial. Patience is a virtue known to every Muslim. The Council believes that humans are advised to be treated medically – if recommended by a trustworthy doctor – by taking hormones which would establish their "actual" gender.

Whoever keeps these thoughts away and bears patiently, Allah will reward this trial. Patience is a virtue known to every Muslim. The Council believes that humans are advised to be treated medically – if recommended by a trustworthy doctor – by taking hormones which would establish their "actual" gender.

Overall, the issue of how Islam treats gender dysphoric individuals is complex and subject to diverse interpretations within the Islamic community, and the views are evolving. There is no clear consensus on how Islam treats gender dysphoric individuals. Islamic scholars and medical professionals have discussed the issue from the perspective of Islamic jurisprudence and bioethics. In the meantime, societies must deframe their general narratives of gender dysphoric individuals as differing from LGBTQ+ communities. The framing of gender dysphoric individuals is within medical and pathological perspectives.

The treatment of individuals with gender dysphoria within Islam can vary depending on cultural, theological, and individual factors. It is essential to approach this topic with sensitivity, empathy, and a recognition of the diversity of perspectives within Muslim communities. Be aware that attitudes and opinions may evolve. Open and respectful dialogue is crucial for fostering understanding and promoting inclusivity.

Conclusion

Gender dysphoric individuals and LGBTQ+ communities are both complex entities shaped by diverse experiences and intersections. Framing involves presenting information that influences how it is perceived. In contrast, deframing involves challenging or altering existing frames to encourage a more critical and open-minded approach. Both processes are integral to communication and discourse, shaping how individuals interpret and make sense of the world around them.

In this case, gender dysphoria is a multifaceted phenomenon that requires an understanding from various sociological perspectives. Symbolic interactionism emphasises the role of social interactions and meanings in shaping individual experiences of gender dysphoria. Social constructionism highlights the fluidity and contingency of gender identities, challenging binary conceptions of gender. Feminist theory contextualises gender dysphoria within broader systems of power, oppression, and inequality, advocating for social change and inclusivity. By examining gender dysphoria through sociological lenses, we can better understand the complex interplay between individuals, society, and gender identity and work towards creating a more inclusive and equitable world for all individuals, regardless of their gender identity or expression.

In summary, deframing the understanding of gender dysphoria is crucial for challenging stigma, respecting autonomy, promoting social inclusion, supporting mental health, and facilitating access to gender-affirming care. Framing gender dysphoric individuals from an Islamic standpoint emphasises distinctions between gender dysphoric individuals and the LGBTQ+ community. They are inherently pathological and necessitate clinical intervention, contrasting it with the LGBTQ+ community, which encompasses a broad spectrum of sexual orientations and gender identities based on self-identification. While both groups may recognise differences in gender from early stages, gender dysphoric individuals receive clinical diagnoses, whereas LGBTQ+ individuals primarily assert their gender identities based on personal understanding and feeling.

The chapter stresses that gender dysphoria is not universal and requires clinical intervention due to its impact on mental health while advocating for religious, social, and environmental support as crucial elements in managing the condition.

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NOTES ON CONTRIBUTORS

Abdul Hadi Said is an assistant professor in the Department of Family Medicine in the Kulliyyah of Medicine, International Islamic University Malaysia (IIUM). He earned his Medical Doctor (MD) degree from USM in 2008. He furthered his studies by pursuing a Master in Medicine (Family Medicine) at the same university. He has been actively involved in the field of family medicine as an academician/researcher, focusing on non-communicable disease such as bronchial asthma. He has been involve as one of the team members of the IIUM's Gender Dysphoria Flagship Project since 2019.

Nurulhasanah Mustapar is an academic and medical professional with a background as practitioner in the field. She earned her Medical Doctor (MD) from Universiti Putra Malaysia in 2006 and further specialized in Anatomic Pathology by obtaining her Master of Pathology (MPATH) from Universiti Sains Malaysia in 2020. Dr. Nurulhasanah began her professional career as a Medical Officer at the Ministry of Health, Malaysia, where she served from 2006 until 2013. She then transitioned to academia, joining the International Islamic University Malaysia as a lecturer at Department of Basic Medical Sciences, Kulliyyah of Medicine since 25 October 2013. Her areas of expertise and interests include anatomy, histology, general pathology, forensic medicine and cancer biology. Currently she actively involves with the Gender Dysphoria Flagship Project and continues to contribute to both the academic and medical communities.

Maizura Mohd Zainudin is a medical professional and academician with a passion for advancing medical education and research. An alumna of the International Islamic University Malaysia (IIUM), she earned her Bachelor of Medicine and Bachelor of Surgery (MBBS) degree there before pursuing her PhD in Medical Health Sciences, specializing in physiology, at University Kebangsaan Malaysia. Currently, she serves as a lecturer at IIUM. Her research primarily focuses on cardiovascular health, with a particular emphasis on hypertension and endothelial dysfunction, where she has made notable advancements. Her works has been recognized with prestigious honors, including the Young Scientist Travel Award at the Federation of the Asian and Oceanian Physiological Society Congress (FAOPS) in 2019.

Mohd Zhafri Mohd Razib is an assistant professor in the Department of Family Medicine at the Kulliyyah of Medicine, International Islamic University Malaysia (IIUM). He earned his Bachelor of Medicine and Bachelor of Surgery (MBBS) degree from IIUM in 2012. He furthered his studies by pursuing a Master in Medicine (Family Medicine) at the same university. He has been actively involved in teaching and contributing to the field of family medicine, focusing on promoting healthy lifestyles and preventing sexually transmitted infections (STIs) among key populations. He is committed to enhancing the health and well-being of the community, with a particular emphasis on preventive care and education.

Ramli Musa is a professor in the Department of Psychiatry, Kulliyyah of Medicine, International Islamic University Malaysia. Presently he is also the head of the department. He is also active in charity and NGO works. He is the chairman of Pahang Mental Health Association (PAMHEC) and Advisor for Persatuan Ibu bapa Anak-anak Istimewa Pahang (PIANiS) - an NGO for parents support group.

Ahmad Akram Mahmad Robbi is an assistant professor in the Department of Fundamental and Interdisciplinary Studies, AbdulHamid AbuSulayman Kulliyyah of Islamic Revealed Knowledge and Human Sciences, International Islamic University Malaysia. He received his PhD in *Fiqh and Usul al-Fiqh* from the same university. He conducts research in Islamic jurisprudence including in family issues, Islamic banking and finance, and Islamic economy.

Khairul Fahmi Jamaludin is an assistant professor at Kuliyyah of AbdulHamid AbuSulayman Kulliyyah of Islamic Revealed Knowledge and Human Sciences, International Islamic University Malaysia (IIUM). He researches in areas of *Usul al-Fiqh*, *Fiqh* and *Fatwa*, and contemporary issues related to Islamic law. Before joining IIUM, he was a Shariah executive manager at Agrobank. His latest research project is "*Analisa Keperluan Penubuhan Badan Profesional Pengajian Islam di Malaysia*" under the grant of the Ministry of Higher Education, Malaysia. Among his latest publications are: "Proposal on the Guideline to Manage Orphan's Property" and "*Pengamalan dan Penerimaan Hadith Daif dalam Islam*," and "*Piawaian Ahl al-Hadith vs Piawaian Ahl al- Usul.*"

Nor Athiah bt Mohd Noor is a PhD candidate at the Kulliyah of Education, International Islamic University Malaysia (IIUM). She specialises in social foundation of education. She has a bachelor's degree in Psychology and a Master's degree in Education from the university. She has presented papers in several conferences including local and international conferences. In 2023, she was awarded two awards for best paper and and best presenter in the 3rd International Conference on Contemporary Muslim world (ICCMWII). Her latest publication is entitled "Exploring the Perception of IIUM Students Towards the Concept of Social Solidarity in Multicultural Muslim Students: A Phenomenological Study" (International Journal of Modern Education).

Rohaiza Rokis is an associate professor in the Department of Sociology and Anthropology, AbdulHamid AbuSulayman Kulliyyah of Islamic Revealed Knowledge and Human Sciences, International Islamic University Malaysia (IIUM). She graduated with a bachelor's degree in Sociology and Anthropology from the university, then earned M.Sc in Applied Social Research from the University of Stirling and PhD in Sociology from the University of Bristol. She specialises in sociology of work and research methodologies. Her research interests also include women, work and employment, and gender studies. Her works have been published in Asian Journal of Women Studies and Asian Social Science.

Aida Farihah Amir Haszuwanni is a researcher at the Kulliyyah of Medicine, International Islamic University Malaysia (IIUM). Her research covers the field of gender studies, etiology, epidemiology and genetics.

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"AND OF ALL THINGS WE CREATED TWO MATES
(MALE AND FEMALE) PERHAPS YOU WILL REMEMBER"

(ADH DHARIYAT :49)

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