CASE REPORT

Managing Gender Dysphoria Within Religious Boundaries: A Case Report on a Muslim with a Religious Education Background

Nur 'Athira Faisal Sabri[1], Tengku Mohd Saifuddin Tengku Kamarulbahri[2], Hijaz Ridzwan[1]

[1] Department of Psychiatry, Kulliyyah of Medicine International Islamic University Malaysia, Bandar Indera Mahkota, 25200 Kuantan, Pahang Darul Makmur, Malaysia.
[2] Department of Psychiatry, Faculty of Medicine, Universiti Sultan Zainal Abidin, 20400, Kuala Terengganu, Terengganu, Malaysia.

ABSTRACT

Gender dysphoria, characterised by a significant incongruence between one's assigned biological sex and experienced gender, presents unique challenges in Muslim societies. Religious teachings emphasising adherence to the natural order and societal norms often exacerbate the psychological struggles faced by individuals with this condition. This case report highlights the experience of a 25-year-old Muslim with a religious education background navigating gender dysphoria. The patient presented with major depressive symptoms, including low mood and anhedonia. He also experienced distress due to the conflict between his gender identity and religious teachings. He was treated with sertraline and supportive psychotherapy, leading to gradual symptom improvement. The report also emphasises the need for culturally sensitive and multidisciplinary approaches to depressive disorder in individuals with gender dysphoria in Muslim societies. These approaches should address the psychological impact while respecting religious beliefs, ensuring comprehensive and compassionate care.
Malaysian Journal of Medicine and Health Sciences (2026) 22(SUPP4):164-167.doi:10.47836/mjmhs.22.s4.24

Keywords: Depressive Disorder, Gender Dysphoria, Islam, Muslim, Religion

Corresponding Author:
Hijaz Ridzwan, MMed (Psychiatry)
Email: hijazridzwan@iium.edu.my
Tel : (+603) 6421 6421

INTRODUCTION

Gender dysphoria, defined as the incongruence between one's biological sex and gender identity, poses unique challenges in Muslim societies where cultural and religious norms strongly influence identity and behaviour (1, 2). Within Islamic contexts, it is often seen as a deviation from 'fitrah' (natural order), creating profound conflicts for individuals, particularly those immersed in Islamic studies (3). In Islamic theology, 'fitrah' refers to the innate nature or original disposition of human beings, which includes alignment between biological sex and gender identity. We present a case of gender dysphoria of a Muslim client with underlying depressive disorder. This case highlights the unique dilemmas faced by individuals with gender dysphoria in Muslim society, particularly with the background of religious education. Unlike other cases, this patient's distress was intensified by his background in Islamic theology, where teachings on gender roles directly conflicted with his identity, leading to deep internalised guilt. It highlights the urgent need for culturally sensitive approaches that integrate psychological support with an understanding of religious and societal norms.

CASE REPORT

A 25-year-old male presented with depressive symptoms that persisted for two months and worsened over the last two weeks. His condition culminated in repeated self-harm episodes via impulsive medication ingestion and superficial wrist cutting. He was referred to psychiatric services after his first self-harm episode. He reported low mood, anhedonia, reduced energy, poor concentration, impaired sleep, and significant weight loss (10% over two months). These symptoms were accompanied by frequent feelings of guilt over his sexual orientation and gender identity, which conflicted with his religious beliefs and fear of disappointing his family. He also experienced recurrent panic attacks, characterised by

palpitations, shortness of breath, tremor, and nausea, which occurred almost daily prior to initiating treatment.

The most recent stressor involved an unrequited romantic attraction to a male coworker. After being rejected and blocked by the coworker, he impulsively ingested medication on multiple occasions over two weeks. Although there was no suicidal intent, these actions were driven by emotional distress and a desire to alleviate internal pain. Notably, he began to improve after two weeks of treatment with sertraline, reporting reduced depressive symptoms and cessation of self-harm.

He had a significant past major depressive episode six years ago during his second semester pursuing a degree in Islamic studies. At that time, he experienced similar symptoms of persistent low mood, poor sleep, reduced appetite, and passive death wishes. This episode was triggered by interpersonal conflicts involving a romantic relationship with a male roommate, which ended after three months. He engaged in self-harm during this period by cutting his wrist, primarily to gain attention from his partner. The depression lasted for six months and eventually improved with emotional support from a friend and a change in academic environment, leading him to pursue a diploma in medical and health sciences, which he completed with distinction.

His family history revealed significant dysfunction, including his parents' divorce due to his father's infidelity. Mr. X has a close relationship with his mother, who provided emotional support and guidance, but he described his father as uninvolved and estranged since the divorce. Despite the challenges, Mr. X has shown resilience, excelling academically and professionally as a medical assistant.

Mr. X's struggles with his sexual orientation and gender identity have been a recurring source of distress. He acknowledged having romantic feelings for males since childhood and has experienced gender dysphoria, including a desire for female physical characteristics. He reported occasionally wearing female clothing and admiring feminine figures, such as Barbie, whom he viewed as ideal representations of beauty. These feelings have caused significant internal conflict, exacerbated by his religious upbringing and societal expectations. Although gender identity conflict was present since childhood, depressive symptoms emerged during adolescence, especially in response to relationship stressors and religious conflict.

On mental state examination, Mr. X appeared thin, with good hygiene, but demonstrated poor eye contact and a low mood. His speech was slow and low in tone, and his affect was congruent and appropriate. There was no evidence of formal thought disorder or suicidal ideation, and he demonstrated good insight into his condition.

Mr. X was diagnosed with major depressive disorder of moderate severity, gender dysphoria, and panic attacks. His treatment included sertraline, which led to symptom improvement, and supportive psychotherapy to address his internalised guilt and develop healthier coping mechanisms. A safety plan was implemented to reduce the risk of future self-harm, and his family was involved in providing emotional support. Particular attention was given to integrate the patient's religious beliefs and cultural context into the therapeutic process. While standard pharmacological treatment with sertraline addressed the biological aspects of his depressive symptoms, the psychological intervention was deliberately adapted to reflect culturally sensitive principles. The therapeutic approach focused on resolving the patient's internal conflict between his gender identity and his religious upbringing (particularly the feelings of guilt, shame, and spiritual inadequacy). Therapy was carefully structured to avoid reinforcing feelings of sinfulness. Sessions focused on reducing guilt, promoting self-compassion, and validating the patient's struggles within his religious framework. Elements of guilt processing and spiritual reconciliation were central to the supportive therapy. Discussions during sessions were carefully framed within the patient's belief system, acknowledging his struggle with 'fitrah' and the fear of violating religious norms. Therapeutic conversations encouraged self-compassion, allowed space for moral reflection, and validated his lived experience without forcing identity-related decisions. The emphasis was not on changing his identity but on helping him manage psychological distress while remaining grounded in his religious values.

DISCUSSION

Gender dysphoria is a complex condition that has been the subject of extensive debate and scrutiny across disciplines. It refers to the significant incongruence between an individual's assigned biological sex and their identified gender (1). This condition has been an enigma and a contentious issue among experts from various disciplines for a long time (2). Despite its growing recognition globally, research on gender dysphoria remains minimal in most Muslim-majority countries, highlighting the need for context-specific investigations (4). There is a paucity of published cases from Southeast Asia exploring gender dysphoria within the framework of Islamic religious education, making this report a rare contribution from the region. Addressing this gap is critical to advancing understanding and support for individuals with gender dysphoria in these regions.

Explanations for gender dysphoria vary significantly, reflecting the complexity of its origins and manifestations. While gender identity is not solely shaped by social environments, certain biological factors also contribute to its development (5). Despite extensive research, no

single genetic or biological factor has been definitively linked to gender dysphoria. Instead, scholars suggest that dysphoric behaviour arises from a complex interplay of psychological and biological factors (1). Understanding these diverse perspectives is essential to developing comprehensive and inclusive approaches to managing gender dysphoria.

Islamic perspectives on gender dysphoria emphasise its contradiction to the natural order ('fitrah') and advocate for interventions to restore the individual's innate disposition. From this standpoint, the condition is regarded as a social problem that contravenes Islamic norms and faces opposition from governments and religious authorities who consider emulating the opposite gender unlawful (3). Additionally, gender dysphoria is perceived as detrimental to essential aspects of Muslim life, including worship ("ibadah") and transactions ("muamalat") (3). People with gender dysphoria face difficulties in fulfilling their roles and responsibilities due to discomfort with traditional gender expectations and societal discrimination. Islam emphasises that husbands remain responsible for providing for their families, which further complicates these obligations (5). A nuanced understanding of these religious perspectives is vital for addressing the needs and challenges faced by individuals with gender dysphoria within Islamic contexts.

The social and psychological impacts of gender dysphoria are profound, particularly in developing and Muslim-majority nations. Cultural and religious constraints exacerbate the challenges faced by individuals with gender dysphoria (2). Moreover, the socio-economic conditions of the transgender community are generally deplorable in many Muslim countries (4). Globally, gender dysphoric individuals have faced a long history of social discrimination, marginalisation, abuse, and neglect (2). Furthermore, individuals with gender dysphoria often experience negative mental health outcomes, including body image concerns, anxiety, and other comorbidities (1). Addressing these widespread social and psychological challenges are important in managing people with gender dysphoria with mental health issues.

The management of gender dysphoria involves navigating complex clinical, ethical, and cultural dimensions. Evidence-based guidelines for managing gender dysphoria have been established and generally involve a combination of hormonal treatments and psychological support (1, 2). However, these interventions present ethical and medical challenges, particularly within the context of Muslim healthcare systems (2). In this case, clinical management combined pharmacological and psychotherapeutic strategies, with particular attention to the patient's cultural and religious context. Sertraline effectively reduced depressive and anxiety symptoms, while supportive psychotherapy was tailored to address internalised guilt related to his gender identity and religious beliefs. The therapeutic work centred on emotional reconciliation and spiritual self-compassion, without pressuring identity change. Sessions were framed within the patient's belief system, acknowledging his struggle with fitrah and the fear of religious transgression. This culturally sensitive approach allowed for psychological healing while respecting the patient's faith and values. This case also illustrates the need for multidisciplinary interventions that are sensitive to both psychological and religious dimensions, particularly in settings where identity conflict is intensified by doctrinal teachings.

CONCLUSION

Gender dysphoria presents unique challenges in Muslim society due to cultural and religious beliefs. Individuals, particularly those in religious settings, face profound dilemmas reconciling personal identity with faith, often leading to mental health struggles. The limited research and stigma surrounding gender dysphoria in these contexts illustrates the need for culturally sensitive, evidence-based approaches. By integrating scientific understanding with religious and societal considerations, inclusive strategies can be developed to support affected individuals while respecting cultural values and promoting their well-being. Although Islamic perspectives describe gender dysphoria as contradictory to 'fitrah', the therapeutic process avoided reinforcing these views in a punitive manner. Instead, therapy emphasised the patient's relationship with God as merciful and forgiving, framing discussions around compassion and hope. This allowed the patient to reduce guilt and depressive symptoms rather than exacerbating them. Future research should focus on developing culturally adapted psychotherapeutic frameworks for managing gender dysphoria in Muslim populations and evaluating their outcomes. Greater attention is also needed on collaborative care models that involve religious leaders and mental health professionals to ensure holistic support.

ACKNOWLEDGEMENT

The authors sincerely thank the Dean of the Faculty of Medicine, Universiti Sultan Zainal Abidin (UniSZA), for supporting the publication of this manuscript. Verbal informed consent for publication was obtained from the patient. All identifying details have been anonymised in accordance with ethical publication standards. This case report has not been previously published.

REFERENCE

1. Damri R, Wida AQP, El Fuadhilah HA, Uyun Q. An Overview of Gender Dysphoria: Factors, Effects, Treatments, and Islamic Perspective. Asian Journal of Islamic Psychology. 2024;1(2):16-32.

doi: 10.23917/ajip.v1i2.5706
2. Taslim N, D Canales A, Alshehab MT. Gender dysphoria: a medical and ethical perplexity as distinct from reality and the rational approach for muslim young people. Psychiatria Danubina. 2021;33(broj 4):475-84. doi: 10.24869/psyd.2021.475
3. Zainol NZN, Johar SS, Rosman AS, Khan A, Mahmud M. Third Gender from Islamic Law and its Impacts towards Muslim Culture in Malaysia. NeuroQuantology. 2022;20(1):189. doi: 10.14704/nq.2022.20.1.NQ22073
4. Taslim N, Ahmad S, Rehman SU, Alghamdi AT, Alkatheri HAH, Iqbal A, et al. A literature analysis of scientific research on gender incongruence in Muslim nations. Journal of Public Health Research. 2022;11(4):22799036221124054. doi: 10.1177/22799036221124054
5. Budiya B, Smeer ZB, Sumbulah U. Gender Dysphoria in the Context of Compulsory Livelihood in Islam: Building Bridges Between Tradition and Social Change. Dialogia. 2024;22(1):69-85.