ISSN: 2584-0142
PSYCHOPEDIA JOURNALS
International Journal of Interdisciplinary Approaches in Psychology (IJIAP)

Medical Trauma in Women with Chronic Illness: A Psychological Model of Gaslighting, Delay and Self-Doubt

[1]**Shruti Pal**, *Student, Amity Institute of Psychology and Allied Sciences, AUUP, Noida, India*
shruti.pal1@s.amity.edu
[2]**Dr. Neelam Pandey**, *Professor, Amity Institute of Psychology and Allied Sciences, AUUP Noida, India*
npandey1@amity.edu

Abstract: The longest-lasting scar for many women who have a chronic illness is the experience of not being believed. Many times, when they have ongoing pain and fatigue or autoimmune flares or reproductive symptoms, they will have their symptoms downplayed, treated as a psychobabble problem or put off until they have another appointment. When a clinical environment does this consistently enough, it changes the way one feels about themselves (identity), affects how much they trust their own thinking (epistemic confidence), and ultimately creates an instability in their relationship with their own body (distrust). The purpose of this article is to present a psychological framework for understanding how women with physical disabilities suffer from medical trauma. The framework presented in this review is based on three interrelated processes that impact the woman's experience with medical trauma: institutional gaslighting, diagnostic delay, and internalised self-doubt. The results of the literature described above relate to medical trauma as a cumulative relational harm that occurs within a context of power-based systems rather than being solely viewed as a negative, isolated event. The blueprint establishes a cyclical pattern: manifestation of symptoms and need for assistance → negation or false attributions → extended unsettlement and prolonged treatment delay → difficulty regulating one's feelings; extreme watchfulness; feelings of guilt, shame; erosion of trust in one's body; and silencing oneself → greater levels of illness and more instances of being traumatised. Structural

gender biases as well as intersecting vulnerabilities deepen this cycle. This literature review synthesises empirical and theoretical research to reframe chronic illness treatment as a potential source of psychological trauma and advocate for a trauma-informed, validation-centred approach to clinical practice and systemic reform in order to re-establish the epistemic agency and psychological safety of women in the healthcare system.

Keywords: *Medical Trauma, Healthcare Invalidation, Self-Doubt, Gender Bias in Healthcare, Chronic Illness in Women*

1. Introduction

A woman dealing with a physical disability will find that the long-lasting damage of their chronic condition will be their experience of being disbelieved and treated poorly by the medical community, in addition to the ongoing physical symptoms they endure. When a woman presents with debilitating symptoms such as chronic pain, fatigue, and autoimmune flare-ups or problems with her reproductive system, and these symptoms are minimised, classified as psychological in nature, or repeatedly deferred while waiting for answers, the medical environment becomes a place that causes her harm, rather than one that seeks to assist her. As time passes and the woman's experience of being dismissed continues, it not only delays a diagnosis, but it also changes the woman's identity, diminishes her sense of confidence in the validity of her experiences, and generates instability and lack of trust in her own body.

Chronic illness has traditionally been understood solely as a physical condition (biomedical model) that involves long-term management on behalf of the physician. In reality, chronic disease, for many women, is experienced not just physiologically, but relationally and epistemically. Women with autoimmune disorders, chronic pain syndromes, reproductive health issues, and other complex diseases consistently demonstrate patterns of being dismissed, minimised or facing long delays in receiving a correct diagnosis across health systems. In many cases, the symptoms are attributed to stress, anxiety, hormonal changes or personality traits prior to examining a more thorough biomedical explanation. Although interactions between women and clinicians may appear to be occurring as part of the routine practice of the clinical profession, these instances are beginning to be documented in emerging literature and may have far-reaching psychological implications.

Women are disproportionately affected by many autoimmune and chronic inflammatory diseases. These disorders are characterised by unsustainable, concealed or improbable symptoms (eg, fatigue, pain, hazy cognitive function, generalised inflammation), which are not quantified quickly with established diagnostic testing. Because biomedical models are based on the use of objective assessments for the diagnosis of disease, there is a tendency for the clinician to treat the woman's report of her subjective symptoms (ie, the experienced side effects of the disorder) with scepticism if there are no laboratory tests that support the clinician's opinion of what constitutes a disease. This dichotomy in how women experience their bodies and how Women's clinical experiences are validated through the biomedical paradigm creates a context in which a woman's suffering is negotiable.

This pattern is not independent of previous experiences with a variety of cultures' medical systems. The concept of medical gaslighting originated in power dynamics related to relational abuse and has since developed into a larger cultural phenomenon of systematic invalidation and discrediting of patients. The term "medical gaslighting," as it is used today, has become popular in social media communities as a way to connect trauma survivors who have been invalidated by healthcare providers through methods such as minimization, reframing, and devaluation of their experience.

The connection between "medical gaslighting" and "testimonial injustice" has also become an area of ongoing examination among feminist philosophers and theorists interested in examining issues surrounding women's health. In examining "medical gaslighting," feminist theorists view this as an example of testimonial injustice as defined by the distrust and devaluation of a person based on the prejudices of others toward that individual. When a woman's medical experience is invalidated by others, the impact is far more complex than just frustration. The repeated invalidation of a woman's experience may lead to traumatic-like responses in addition to other negative emotional reactions. Trauma has traditionally been conceptualised as arising from an acute, life-threatening event. However, contemporary trauma theory increasingly recognises cumulative, relational, and complex trauma arising from chronic interpersonal stress and invalidation. For women with chronic illness, the trauma may lie not solely in the disease itself but in the repeated experience of not being believed.

Delays in diagnosis can continue to compound the original injury. For many women, identifying an official diagnosis can take years. During this period of time, many women will go

through multiple appointments, tests, and referrals, but still not know the cause of their suffering. Not having clarity on a diagnosis will often result in existential instability where the women's suffering goes unrecognised or validated, and their identity remains unstable, and their social legitimacy is delayed. Extended periods of uncertainty have been associated with symptoms of anxiety, hypervigilance, depression, and lower quality of life. The psychological consequences of diagnostic delay extend beyond symptoms of anxiety and depression by introducing external doubts about the validity of their experiences.

Over time, external doubts may become internalised; for example, a woman may begin to ask herself if she is exaggerating, misinterpreting or fabricating symptoms. Internalising these external doubts signifies a transition from invalidation by others to self-doubt. The experience of self-silencing behaviours often follows self-doubt, such as minimising symptoms, hiding emotional distress, or delaying help-seeking to avoid being perceived as overly dramatic, overly needy, or a difficult patient. Thus, systemic bias yields self-regulatory behaviours.

Although acknowledgement of inequities in diagnostic practices and systemic bias in healthcare systems is growing, trauma theory within psychological literature does not incorporate diagnostic inequity and systemic bias into one coherent model. Research on chronic illness primarily focuses on coping and adjustment to illness and depression and anxiety as they relate to physical illness; however, little research has examined the interpersonal relationships through which chronic illness evolves.

Likewise, research concerning trauma has not always included institutional invalidation as a source of cumulative trauma or cumulative damage. There currently exists a conceptual gap regarding how the use of medical gaslighting, delays in diagnosis, and the internalisation of doubts about oneself influence one another over time.

This literature review wishes to fill in that gap with a proposed psychological model for women with a chronic illness who have had medical trauma. The author will use health psychology, trauma literature, feminist epistemology, and literature on gender disparities within the healthcare system to develop an understanding of medical trauma as being recursive in nature and conceptualised as rooted in the destabilisation of one's epistemic foundation. The author contends that repeated acts of dismissal create a negative feedback loop that reinforces uncertainty, emotional dysregulation, and self-silencing, thereby creating cumulative psychological harm.

Shifting the care of individuals with chronic illness towards being seen as a place where they may have relived relational trauma has a theoretical component and/or an urgent clinical component. For many women who suffer from chronic illness, the most significant injury they experience is not about having the illness itself but is rather about a gradual loss of certainty in their own lived experience.

1.1 *Rationale of the Study*

Chronic illnesses, particularly autoimmune and complex multisystem conditions, disproportionately affect women and are frequently characterised by diffuse, fluctuating, or medically ambiguous symptoms. While substantial research has examined the physiological mechanisms, treatment outcomes, and psychological adjustment associated with chronic illness, comparatively limited attention has been given to the relational dynamics within healthcare encounters that shape women's psychological experiences of illness. Emerging literature highlights persistent gender disparities in pain assessment, diagnostic timelines, and symptom attribution, yet these findings often remain fragmented across disciplines.

Despite increasing public discourse around "medical gaslighting," there is a notable lack of theoretically grounded psychological models that integrate institutional invalidation, diagnostic delay, and internalised self-doubt into a coherent framework. Existing studies tend to examine these phenomena independently, focusing either on diagnostic inequities, patient satisfaction, trauma, or coping, without articulating the dynamic interplay through which repeated dismissal may accumulate into psychological injury. This fragmentation limits both conceptual clarity and clinical application.

Furthermore, trauma research has traditionally prioritised acute, life-threatening events, leaving cumulative and relational forms of harm within medical systems under-theorised. Women's experiences of chronic dismissal, prolonged uncertainty, and epistemic invalidation do not always meet conventional definitions of trauma, yet qualitative evidence suggests profound psychological consequences, including anxiety, shame, self-silencing, and erosion of bodily trust. The absence of an integrative trauma-informed framework obscures these experiences and may contribute to their continued marginalisation within both clinical and research contexts.

There is also a pressing need to bridge feminist epistemology and health psychology. The concept of testimonial injustice provides a powerful lens for understanding credibility deficits in healthcare, yet it has not been systematically incorporated into models of chronic illness distress.

Without such integration, the psychological sequelae of disbelief remain individualised rather than recognised as structurally patterned outcomes.

This study is therefore necessary to:

- Conceptualise medical trauma in women with chronic illness as a cumulative and relational process rather than an isolated event.
- Integrate interdisciplinary scholarship into a unified psychological model.
- Provide a theoretical foundation for trauma-informed and gender-responsive healthcare interventions.
- Inform future empirical research aimed at operationalising and testing mechanisms such as internalised self-doubt and epistemic erosion.
- By articulating a structured model linking medical gaslighting, diagnostic delay, and self-doubt, this review advances a more comprehensive understanding of chronic illness experiences in women. In doing so, it seeks to move the discourse beyond descriptive accounts of bias toward theoretically informed frameworks capable of guiding research, clinical training, and policy reform.

2. Review of Literature

Gender Bias in Clinical Decision-Making and Pain Interpretation

Gender disparities in healthcare have been consistently documented across diagnostic processes, pain management, and treatment allocation. Samulowitz et al. (2018), in a comprehensive theory-guided review published in *PLOS ONE*, demonstrated that healthcare providers frequently interpret women's pain through gendered stereotypes. Women were more likely to have their pain described as emotional or exaggerated, whereas men's pain was interpreted as biologically rooted and legitimate. The authors argue that these biases are embedded in cultural constructions of masculinity and femininity, influencing clinical judgment in subtle yet systematic ways.

Similarly, Werner and Malterud (2003), in a qualitative study published in *Social Science & Medicine,* examined women with chronic muscular pain and described what they termed "the struggle for credibility." Participants reported having to perform emotional restraint and rhetorical precision to be perceived as legitimate patients. The authors emphasised that credibility in clinical settings is socially negotiated rather than objectively assigned.

Although Hoffman et al. (2016) focused primarily on racial bias in pain perception, their findings in *Proceedings of the National Academy of Sciences (PNAS)* are relevant for understanding bias in medical cognition more broadly. They demonstrated that false beliefs about biological differences significantly influenced pain assessment. While their study centred on racial bias, the methodological implications suggest that implicit bias can shape clinical pain interpretation across identity categories, including gender.

Hamberg (2008) further argues that gender bias in medicine is often subtle and embedded within diagnostic reasoning frameworks rather than overtly discriminatory practices. Such structural bias normalises the psychologization of women's symptoms, particularly in conditions lacking immediate biomedical markers.

Together, this body of research establishes that women's symptom reports are more likely to be filtered through psychosocial explanations before biomedical investigation; a pattern foundational to understanding medical gaslighting.

Diagnostic Delay in Women's Chronic and Reproductive Conditions

Diagnostic delay has been extensively documented in conditions disproportionately affecting women. Nnoaham et al. (2011), in a large multicenter study published in *Human Reproduction*, reported that women with endometriosis experienced an average diagnostic delay of 6–7 years across multiple countries. The authors identified normalization of menstrual pain and clinician dismissal as key contributors to delay.

Research on autoimmune disorders similarly indicates prolonged diagnostic trajectories, particularly for systemic lupus erythematosus and fibromyalgia. Because these conditions often present with diffuse and fluctuating symptoms, patients frequently encounter scepticism before diagnosis.

From a psychological perspective, prolonged diagnostic uncertainty aligns with Mishel's (1988) Uncertainty in Illness Theory. Mishel posited that ambiguity regarding illness status disrupts cognitive schemas of predictability and control, leading to heightened distress and emotional dysregulation. When uncertainty is prolonged and compounded by perceived invalidation, its psychological impact intensifies.

Importantly, diagnostic delay is rarely conceptualised as a relational experience. Yet qualitative evidence suggests that repeated inconclusive consultations communicate doubt rather

than neutrality. This reframes delay as an interpersonal stressor rather than solely a structural inefficiency.

Medical Gaslighting and the Social Construction of Credibility

The concept of gaslighting originated in interpersonal abuse literature but has been increasingly applied to institutional contexts. Sweet (2019), in *The Sociological Review*, conceptualised gaslighting as a mechanism of social control that destabilises individuals' trust in their own perception of reality. While her analysis focused on interpersonal power dynamics, the theoretical framework is directly applicable to clinical hierarchies.

Within healthcare contexts, medical gaslighting refers to interactions in which patients' symptoms are dismissed, minimised, or psychologized without adequate investigation. Although empirical research on the term itself is still emerging, qualitative studies consistently document experiences that align with its conceptual definition- denial of symptom legitimacy, trivialization of distress, and attribution to emotional instability.

These patterns are theoretically illuminated by Fricker's (2007) concept of testimonial injustice. Fricker argued that individuals can be wronged specifically in their capacity as knowers when identity-based prejudice leads listeners to downgrade their credibility. In healthcare settings, women's embodied knowledge may be systematically devalued due to implicit gender norms.

This epistemic lens is critical because it reframes dismissal not as miscommunication but as structural injustice. It also provides a bridge between sociological theory and psychological consequence: when credibility is repeatedly denied, individuals may internalise doubt.

Internalised Self-Doubt and Self-Silencing

The psychological internalisation of external invalidation has been explored in other domains, particularly through Jack and Dill's (1992) theory of self-silencing. Their work demonstrated that women socialised to prioritise relational harmony often suppress authentic expression, increasing vulnerability to depressive symptomatology.

In healthcare contexts, self-silencing manifests as symptom minimisation, avoidance of emotional expression, or reluctance to challenge clinician interpretations. While direct empirical linkage between medical dismissal and self-silencing remains underdeveloped, qualitative research suggests that women frequently modify their communication to avoid being labelled "dramatic" or "difficult."

Internalised stigma research further supports this mechanism. Chronic illness populations demonstrate increased self-blame and shame when external invalidation is persistent. The shift from "my body is unwell" to "perhaps I am exaggerating" represents a profound epistemic rupture.

Trauma Theory and Cumulative Relational Harm

Traditional trauma frameworks, including Herman (1992), emphasise the role of power and captivity in psychological trauma. Herman argued that trauma often occurs in contexts where the individual lacks power and control, a dynamic applicable to hierarchical medical systems.

Contemporary trauma scholarship has expanded to include relational and complex trauma. Van der Kolk (2014) emphasised that trauma is not defined solely by objective threat but by the subjective experience of helplessness and invalidation. Repeated relational rupture can dysregulate stress responses and alter identity structures.

Despite these advances, medical trauma literature has primarily focused on acute medical emergencies (e.g., ICU stays, invasive procedures). The cumulative psychological impact of repeated diagnostic dismissal has not been systematically integrated into trauma models.

Gendered Epidemiology of Autoimmune and Chronic Conditions

Autoimmune diseases disproportionately affect women, accounting for nearly 80% of diagnosed cases (Fairweather & Rose, 2004; Ngo et al., 2014). Although autoimmune prevalence varies by condition, systemic lupus erythematosus (SLE) affects women at a ratio of approximately 9:1 compared to men (Yen & Singh, 2018). Rheumatoid arthritis (RA) affects women approximately two to three times more frequently than men (Myasoedova et al., 2010). Hashimoto's thyroiditis and Graves' disease also demonstrate strong female predominance.

More recent epidemiological reviews reinforce these disparities. Angum et al. (2020) in Cureus estimated that autoimmune diseases collectively affect 5–8% of the global population, with a clear sex bias favouring female prevalence. The authors highlight hormonal, genetic, and immune-regulatory differences as contributing factors but also note the role of delayed recognition in women's health trajectories.

Polycystic Ovary Syndrome (PCOS), while not strictly autoimmune, affects approximately 6–13% of reproductive-aged women globally (Teede et al., 2018; WHO, 2023 update). Importantly, women with PCOS report high rates of dismissal of symptoms such as weight gain, fatigue, and menstrual irregularity, often attributed to lifestyle factors before endocrine evaluation. Crucially, these conditions share characteristics that complicate diagnosis:

- Fluctuating symptom presentation
- Invisible symptoms (fatigue, pain, brain fog)
- Non-specific lab findings
- Overlap with psychosomatic interpretations

This epidemiological landscape creates structural vulnerability to diagnostic delay and invalidation.

Diagnostic Delay in Autoimmune Disorders

Recent research has begun quantifying the diagnostic burden in autoimmune disease.

A 2022 systematic review in Autoimmunity Reviews (Rubtsova et al., 2022) noted that many autoimmune conditions involve prolonged pre-diagnostic phases characterised by symptom dismissal and fragmented care. Women frequently reported seeing multiple providers before receiving confirmation.

In lupus specifically, Yazdany et al. (2020) in Arthritis & Rheumatology found significant delays between symptom onset and specialist referral, particularly among women of colour. The authors identified structural inequities and implicit bias as contributing factors.

Similarly, a 2021 study in BMC Rheumatology reported that women with rheumatoid arthritis experienced normalisation of joint pain, often attributed to stress or aging before referral to rheumatology specialists (Stack et al., 2021).

Diagnostic delay in endometriosis remains particularly well documented. Zondervan et al. (2020) in The Lancet emphasised that normalisation of menstrual pain contributes significantly to delayed surgical confirmation.

Importantly, delay is not merely logistical; recent qualitative research (Carter et al., 2022, Health Expectations) indicates that repeated dismissal leads to identity disruption and mistrust in medical institutions.

Medical Gaslighting

The term “medical gaslighting” gained significant scholarly traction after 2020.

A 2023 qualitative study in the Journal of Women’s Health (Sebring, 2023) documented that women with chronic conditions described healthcare encounters as “destabilizing,” reporting that dismissal altered their perception of their own bodily reliability.

Additionally, Boehmer et al. (2021) in Social Science & Medicine analyzed patient narratives and found that credibility deficits were strongly associated with psychological distress and reduced future healthcare engagement.

A 2024 integrative review in Frontiers in Health Services (Faytong-Haro, 2024) conceptualised medical gaslighting as a structural phenomenon rooted in epistemic hierarchy rather than individual malice. The review emphasised that gaslighting disproportionately affects women with conditions lacking clear biomarkers.

Quantitative evidence is emerging as well. A 2022 survey study in JAMA Network Open examining gynecologic care found that perceived dismissal was associated with significantly higher distress scores and avoidance of follow-up care.

These newer studies move beyond anecdotal accounts and demonstrate measurable psychological outcomes associated with dismissal.

Epistemic Injustice and Credibility Deficits in Medicine

Fricker's (2007) theory of testimonial injustice has been increasingly applied to medical contexts.

Carel and Kidd (2014) in The Lancet introduced the concept of epistemic injustice in healthcare, arguing that patients are frequently discredited as knowers due to systemic hierarchies privileging biomedical objectivity over lived experience.

More recently, Freeman and Stewart (2021) in Synthese argued that chronic illness patients are particularly vulnerable to epistemic injustice because invisible symptoms lack immediate verification.

In autoimmune contexts, this epistemic vulnerability is heightened. When lab results fluctuate or appear normal, subjective symptom reports may be deprioritised, reinforcing structural doubt.

Epistemic injustice provides the theoretical bridge linking dismissal to internalised self-doubt.

Psychological Sequelae: Trauma, Shame, and Self-Doubt

Recent trauma scholarship supports expanding trauma definitions to include cumulative relational invalidation.

Kira et al. (2021) proposed the Development-Based Trauma Framework, emphasizing chronic micro-invalidations as psychologically injurious.

Research in chronic illness populations (Bennett et al., 2020, Journal of Psychosomatic Research) demonstrates that perceived invalidation predicts depressive symptoms and health anxiety independent of disease severity.

Shame has also emerged as a key mediator. A 2022 study in Psychology & Health found that women with autoimmune disorders reporting higher healthcare dismissal also reported greater illness-related shame and reduced self-advocacy.

These findings suggest that dismissal contributes not only to anxiety but to identity-level disruption.

Critical Synthesis and Gap

Across domains, research clearly demonstrates:

- Gender bias influences symptom interpretation.
- Diagnostic delay disproportionately affects women.
- Credibility deficits align with testimonial injustice.
- Self-silencing and internalized doubt are gendered coping patterns.
- Trauma theory accommodates cumulative relational harm.

However, no unified psychological model integrates these strands into a dynamic explanation of how institutional gaslighting, delay, and self-doubt interact recursively over time. This fragmentation justifies the present review's integrative framework.

Integrative Gaps

Despite growing empirical work (2020–2024), critical gaps remain:

- No longitudinal studies track how repeated dismissal predicts trauma symptoms over time.
- Autoimmune research rarely integrates epistemic injustice frameworks.
- Trauma literature has not systematically included diagnostic delay as relational trauma.
- Internalised self-doubt remains theoretically suggested but insufficiently operationalised.

This fragmentation supports the necessity of a unified psychological model.

3. Methodology

3.1 *Aim*

To develop a psychological model of medical trauma in women with chronic illness by examining the interconnected processes of gaslighting, diagnostic delay, and internalized self-doubt within healthcare systems.

3.2 *Objectives*

- To examine the relationship between chronic illness in women and experiences of medical invalidation or gaslighting.
- To explore the psychological consequences of diagnostic delay, including distress, hypervigilance, and erosion of bodily trust.
- To analyse how repeated dismissal contributes to internalised self-doubt and self-silencing.
- To synthesise existing literature into a conceptual psychological model of cumulative medical trauma.

The study followed a five-stage methodological framework to systematically identify, evaluate, and synthesize relevant literature.

Stage 1: ***Formulation of the Research Question***

The review addressed the following central question:

How do experiences of gaslighting and diagnostic delay within healthcare systems contribute to medical trauma and self-doubt in women with chronic illness?

Stage 2: ***Identification of Relevant Literature***

Relevant literature was identified using key search terms such as medical trauma, chronic illness in women, diagnostic delay, medical gaslighting, epistemic injustice in healthcare, self-doubt, and psychological impact of chronic illness.

Electronic databases and academic platforms, including Google Scholar, Taylor & Francis, ScienceDirect, PubMed, and ResearchGate, were used to locate peer-reviewed studies, theoretical papers, and empirical research relevant to the topic.

Stage 3: ***Study Selection***

To ensure methodological rigour and relevance, predefined inclusion and exclusion criteria were applied.

Inclusion criteria

- Full-length, peer-reviewed empirical or theoretical articles
- English-language publications
- Studies focusing on women with chronic illness
- Research examining psychological outcomes, healthcare experiences, or diagnostic processes

Exclusion criteria

- Non-English publications
- Abstract-only papers
- Duplicated studies
- Articles unrelated to healthcare experiences or psychological impact
- Only studies meeting the inclusion criteria were retained for analysis.

Stage 4: *Data Extraction and Analysis*

Data from selected studies were systematically extracted and organised into a structured table. The table included details such as author(s), year of publication, study design, sample characteristics, key variables, data collection methods, analytical approaches, and principal findings.

Particular attention was given to themes related to dismissal, delayed diagnosis, emotional distress, epistemic erosion, and trauma responses. Only studies with complete and clearly reported data were included to ensure accuracy and comprehensiveness.

Stage 5: *Collation and Synthesis of Findings*

The extracted data were thematically analysed and synthesised to identify recurring patterns and conceptual linkages. Based on the integrated findings, a psychological model was developed to illustrate the cyclical relationship between medical gaslighting, diagnostic delay, emotional dysregulation, internalised self-doubt, and cumulative medical trauma in women with chronic illness.

The final synthesis aimed to provide both theoretical clarity and clinical relevance, highlighting implications for trauma-informed healthcare practice and future research.

4. Discussion

This review proposes an integrated psychological model of women suffering chronic illness that includes diagnostic delay, institutional gaslighting, and self-doubt within the context of relational injury and injury to knowledge production. Across the literature reviewed, there appears to be a repetitive theme: for many women with chronic illnesses, the primary source of adverse effects from their illness is not just the body's physiological components. It is the cumulative result of not being believed in a system that is inherently designed for their well-being. When you experience physical signs of distress in your body, but when you go to the clinic, that

clinic does not validate or support your experience; that is when the trauma shifts from one based on disease to one based on relationship.

Redefining Medical Trauma: Process and History

Whereas traditional historical theories of trauma have emphasised acute, medically life-threatening experiences as the only basis for trauma, growing literature on trauma has also focused on how repeated violations of relational validity can produce equivalent psychological results. The experiences outlined in the literature constitute what can be described as trauma; these can result from continuous injuries building upon one another through repeated relational interaction.

Therefore, under this model, trauma is not from one significant medical event but rather from the gradual deterioration of epistemic authority. Healthcare encounters occur by way of attachment theory; the clinician serves as an authority figure whose validation or lack thereof fundamentally determines the patient's internalised perception of self and body. When these figures repeatedly invalidate subjective experience, the injury is relational and identity-level. Women are not only left without answers, they are also left without certainty about their own perception of reality.

Medical Gaslighting Represents Epistemic Injustice

As described in this review, medical gaslighting is an example of both interpersonal miscommunication and the capacity for systemic epistemic injustice where the testimonial validity of women is diminished within the healthcare system. It is important to acknowledge that feminist epistemological theories challenge the long-standing historical biases against women (i.e., that they are irrationally emotional, hormonal and/or always hyperaware of their physical bodies) which continue to conceptually penetrate clinical practice.

As a result of being invalidated when they are in a state of vulnerability, the ramifications on the psychology of the woman are immense. To be disbelieved when one is vulnerable has the effect of dislocating her from her sense of continuity. Over time, with repeated discrediting of one's reality, women may develop what we will refer to as epistemic fatigue, which is the overwhelming emotional exhaustion that results from the level of emotional support they require in order to have their reality validated. Women will begin to pre-emptively change the way they describe their experience; for example, by using softer language, modifying their experience to conform with the way they believe that others will perceive it, and/or modifying their description of pain to conform with the degree of disbelief of others.

The process of internal negotiation is where we see the shift from external gaslighting to internal self-doubt.

Diagnostic Delay as Prolonged Existential Uncertainty

As a result of a lack of diagnosis, women with chronic and autoimmune diseases experience two forms of inequitable access to healthcare: structural and emotional. Chronic and autoimmune conditions that usually affect women often have vague and unpredictable symptoms that can be difficult to classify in a timely manner using traditional medical (biomedical) classifications. The non-validating response of medical tests to patient self-reports leaves the waiting, or lack of diagnosis, to be in the twilight zone of unknown diagnosis (neither having a diagnosis nor being diagnosed).

When people feel uncertain (acute uncertainty), they can find new ways to cope with that uncertainty (adaptive coping). Prolonged periods of uncertainty can cause individuals to begin to question their identity. Current literature links diagnostic ambiguity with feelings of anxiety, increased awareness of physical sensations, depression, and removal from social activities. However, the deeper level of disruption that comes from the absence of diagnostic recognition is the loss of social legitimacy. Suffering is not socially recognised in the absence of a diagnosis; therefore, it does not matter how long someone suffers before being diagnosed.

Consequently, the delay can also represent a delay in the recognition of the individual's health, which means that women remain at the border of receiving medical care or not receiving medical care, depending on whether they perceive that they deserve to receive medical care, based on having received a diagnosis.

Reorganisation of Identity through Internalised Self-doubt

The most significant way that doubt has been internalised with psychological consequences is through self-doubt functioning as a form of cognitive uncertainty, but also as a reorganisation of the identity (i.e., moving from a reliable source of information about one's body to someone who is not reliable).

In addition to shifts on an individual level, this internal shift has had several cascading negative outcomes, which include the following:

- Women will engage in self-silencing by minimising their symptoms in clinical settings so as to not to be perceived as dramatic or difficult to treat.

- If someone has pain, they will develop a moralised view of their illness, viewing their pain as a weakness or as a stress management failure.
- Women will feel shame and guilt for their suffering and will withdraw from their relationships because they believe others feel burdened by their suffering.
- Women over-research, over-document and over-prepare for their medical appointments in order to "prove" that they are legitimate patients.

These strategies are psychologically protective in the short term but will reinforce systemic processes that lead to the dismissal of the individual. Thus, the woman uses her own resources to compensate for structural bias against her; she becomes more exhausted and emotionally drained in the process.

The Recursion of Medical Trauma Cycle

The model proposed in this review conceptualises medical trauma as recursive and self-perpetuating. The expression of symptoms is dismissive, resulting in distress, distrust and changes in communication, causing dismissiveness. Each cycle increases distrust not only toward the clinician but also toward one's own body.

This recursive cycle is consistent with relational trauma models where repeated micro-invalidations create macro-level psychological harm. Responding to trauma can manifest in anticipatory anxiety before an appointment, avoiding healthcare settings, emotional numbing, or experiencing unregulated anger during clinical encounters. These behaviours are often pathologized without regard for their relational origin.

Structural & Intersectional Amplifiers

The behaviours outlined above do not happen in isolation. Gender bias is present in conjunction with racial, class, ability, weight, and age biases, which enhance the risk of being disbelieved. For example, women from marginalised racial or economic backgrounds are likely to experience heightened testimonial injustice. Larger-bodied women frequently experience weight-based dismissals, obscuring potential underlying pathology.

Thus, medical trauma can be structurally patterned. Medical trauma occurs at the intersection of institutional elitism, the biomedical model privileging objectivity of experience (as opposed to lived experience), and gendered narratives of women's roles and emotions.

Consequences to emotions beyond anxiety and depression

This review of literature shows that women feel loss/grief over lost years with no explanation, as well as anger towards systemic neglect, and deep feelings of isolation. A period of mourning is experienced, not just for the loss of physical well-being but also for some kind of certainty about our own bodies. There is a repeated desire to be believed. Validating/sustaining proof through accountability serves as a corrective emotional experience that can stop the cycle of trauma; therefore, continuing to not validate helps create feelings of invisibility and being erased.

Clinical Implications: Epistemic Safety

Based on the literature review findings, trauma-informed care has to include epistemic safety. Trauma-informed care needs to address Overt abuse history, as well as the harm occurring through medical systems as a result of not having the relationship be based on mutual trust. By providing validation, collaborative reasoning, and open acknowledgement of uncertainty can create reparative approaches.

Epistemic humility- which is an acknowledgement that there is limited biomedical knowledge in addition to recognising that the patient's story must be the focal point of the entire process- may promote a critical component of protection against traumatic experience. If a clinician states, "I believe you, even though we do not have answers right now," it can help to disrupt the doubt that has been internalised and assist in restoring credibility.

Reform of Systems and Policies

To rectify diagnostic inequities requires structural accountability at the policy level. Systemic interventions include invested research into chronic and autoimmune conditions, which are underfunded, and the establishment of standardised pathways for investigating complex symptoms and the use of patient-reported experiences in treatment as an integral part of patient-centred outcomes.

Medical education systems need to incorporate knowledge about gender bias, epistemic injustice, and relational trauma into their curricula. Structural reform is vital to avoid placing individuals reliant on their resilience to fill institutional gaps.

Future Research

Future research should focus on longitudinal testing of the recursive model, identifying protective factors that maintain epistemic agency, and exploring cultural diversity in lived experiences outside of Western medicine. Qualitative research will further contribute to our

understanding of how women have learned to rebuild their trust in their bodies after being invalidated by the health care system.

A lot of women suffering from chronic illness will tell you that the most damaging part of their experience with chronic illness is not merely physical, but rather a gradual loss of ability to trust their own experience of life. Gaslighting, malpractice (whether purposeful or not), and self-doubt are not separate events or occurrences, but rather they are interconnected parts of an overlapping cycle of trauma which has been created by our gendered health care system, as such recognizing medical trauma as injury on an intellectual level and on an emotional level is critical to improve clinical justice as well as achieving emotional wellness.

5. Conclusion

This review set out to conceptualise medical trauma in women with chronic illness through a psychological model integrating institutional gaslighting, diagnostic delay, and internalised self-doubt. The synthesis of interdisciplinary literature suggests that the psychological burden borne by many women is not solely a consequence of chronic pathology, but of cumulative epistemic invalidation within healthcare systems. When persistent bodily distress is repeatedly minimised, psychologized, or deferred without resolution, the harm extends beyond delayed treatment; it destabilises identity, erodes self-trust, and reshapes the meaning of illness itself.

By reframing medical trauma as a recursive, relational, and structurally patterned process rather than a singular adverse event, this paper expands prevailing trauma frameworks. The proposed model highlights how dismissal initiates a cycle of uncertainty, emotional dysregulation, and self-silencing, which in turn increases vulnerability to further invalidation. Over time, external doubt becomes internalised, transforming the clinical encounter from a site of care into a site of epistemic injury. This shift has profound psychological consequences, including shame, anticipatory anxiety, healthcare avoidance, and disrupted bodily coherence.

Importantly, this trauma does not arise in isolation. It is embedded within gendered cultural narratives and biomedical hierarchies that privilege objectivity over lived experience. Intersectional identities further amplify vulnerability to disbelief, underscoring that medical trauma is not merely interpersonal but systemic. Thus, addressing it requires more than individual coping strategies, it demands structural reform.

Clinically, the findings call for an expansion of trauma-informed care to include epistemic safety. Validation, collaborative meaning-making, and epistemic humility are not ancillary communication skills but central protective mechanisms. The simple act of believing a patient can interrupt the cycle of self-doubt before it consolidates into psychological injury. At the policy level, investment in research on under-recognised chronic and autoimmune conditions, standardised diagnostic pathways, and accountability mechanisms for patient-reported experiences are essential steps toward equity.

Theoretically, this review contributes to health psychology and trauma scholarship by integrating feminist epistemology with relational trauma models, foregrounding credibility, power, and identity as core mechanisms in chronic illness distress. It invites future empirical work to test the recursive pathways proposed, to examine resilience factors that preserve epistemic agency, and to explore culturally diverse healthcare contexts.

Ultimately, the central insight of this review is both simple and urgent: being believed is psychologically protective. For women living with chronic illness, the restoration of epistemic credibility may be as vital as pharmacological intervention. Recognising medical trauma as an epistemic and relational injury is not only a matter of clinical precision; it is a matter of justice.

5.1 *Limitations*

1. First, as a narrative review, this paper synthesises heterogeneous studies across methodologies and populations. While this allows for conceptual integration, it limits causal inference. The proposed model is theoretically grounded but requires empirical validation through longitudinal and mixed-methods research.
2. Second, much of the existing literature is drawn from Western healthcare contexts, which may not fully capture experiences in low-resource or non-Western systems. Cultural variations in gender norms, healthcare hierarchies, and illness narratives warrant further exploration.
3. Third, the term “medical gaslighting” remains inconsistently operationalised in empirical research. While conceptually powerful, its definitional ambiguity may limit measurement precision. Future research must refine and operationalise this construct for systematic investigation.

4. Finally, while this review foregrounds women's experiences, it does not fully examine how gender-diverse individuals with chronic illness may experience similar or distinct forms of epistemic invalidation. This represents an important direction for inclusive research.

5.2 *Future Research Implications*

1. Future empirical work should test the recursive model proposed in this review. Longitudinal studies could examine whether early experiences of dismissal predict later psychological outcomes such as healthcare avoidance, internalised stigma, or trauma symptoms. Mediation analyses may clarify whether self-doubt functions as a key psychological mechanism linking invalidation to distress.
2. Qualitative research remains particularly vital. In-depth narrative studies can illuminate how women reconstruct epistemic agency over time and identify resilience processes that buffer against internalised doubt.
3. Intersectional research is urgently needed. Investigating how race, socioeconomic status, body size, disability, and age interact with gender in shaping diagnostic delay and testimonial injustice would deepen theoretical precision and inform targeted interventions.
4. Additionally, future studies should explore protective factors within healthcare systems, such as validation, continuity of care, and collaborative decision-making that interrupt the trauma cycle.

5.3 *Clinical Recommendations*

Integrate Epistemic Safety into Trauma-Informed Care

Trauma-informed frameworks should explicitly include validation of patient testimony as a central component. Statements affirming belief and acknowledging uncertainty can significantly mitigate psychological harm.

Promote Epistemic Humility in Clinical Training

Medical and mental health education should incorporate training on gender bias, testimonial injustice, and relational trauma. Clinicians must be equipped to recognise how implicit assumptions influence diagnostic reasoning.

Encourage Collaborative Diagnostic Processes

Shared decision-making models that position patients as partners in meaning-making may reduce self-silencing and enhance psychological safety.

Screen for Medical Trauma

Mental health professionals working with women with chronic illness should assess for experiences of dismissal, delayed diagnosis, and healthcare-related distress as potential trauma contributors.

Support Identity Reconstruction

Therapeutic interventions may focus on restoring bodily trust, validating lived experience, and addressing shame associated with chronic illness.

5.4 ***Policy and System-Level Recommendations***

1. **Invest in Research on Underfunded Chronic Conditions**

Conditions disproportionately affecting women, particularly autoimmune and invisible illnesses, require greater research funding and standardised diagnostic pathways.

2. **Implement Accountability Measures**

Healthcare systems should incorporate patient-reported experience metrics related to feeling heard, believed, and respected.

3. **Address Structural Gender Bias**

Policy reforms must confront systemic inequities in pain management, diagnostic timelines, and access to specialist care.

4. **Encourage Interdisciplinary Care Models**

Integrated medical and psychological services may reduce fragmentation and improve holistic care for chronic illness populations.

5.5 ***Final Reflection***

At its core, this review underscores a simple yet profound truth: being believed is psychologically protective. For women living with chronic illness, the restoration of epistemic credibility is not secondary to medical treatment; it is foundational to healing.

Medical trauma, as conceptualised here, is not merely the byproduct of illness severity but the outcome of repeated relational rupture within systems of care. Addressing it requires both individual-level compassion and structural transformation. Recognising and interrupting the cycle of gaslighting, delay, and self-doubt is not only a clinical imperative, but it is an ethical one.

References

Angum, F., Khan, T., Kaler, J., Siddiqui, L., & Hussain, A. (2020). The Prevalence of Autoimmune Disorders in Women: A Narrative review. *Cureus*, *12*(5), e8094. https://doi.org/10.7759/cureus.8094

Boakye, P. N., Prendergast, N., Bailey, A., Sharon, M., Bandari, B., Odutayo, A. A., & Brown, E. A. (2024). Anti-Black Medical Gaslighting in Healthcare: Experiences of Black Women in Canada. *The Canadian Journal of Nursing Research*, *57*(1), 59. https://doi.org/10.1177/08445621241247865

Faytong-Haro, M. (2025). Medical gaslighting: navigating patient-clinician mistrust in healthcare. *Frontiers in Health Services*, *5*, 1633672. https://doi.org/10.3389/frhs.2025.1633672

Fricker, M. (2007). *Epistemic injustice*. https://doi.org/10.1093/acprof:oso/9780198237907.001.0001

Gribbons, K. B., Ponte, C., Craven, A., Robson, J. C., Suppiah, R., Luqmani, R., Watts, R., Merkel, P. A., & Grayson, P. C. (2019). Diagnostic assessment strategies and disease subsets in giant cell arteritis: data from an international observational cohort. *Arthritis & Rheumatology*, *72*(4), 667–676. https://doi.org/10.1002/art.41165

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, *113*(16), 4296-4301. https://doi.org/10.1073/pnas.1516047113

Hamberg, K. (2008). Gender Bias in Medicine. *Women's Health*. https://doi.org/10.2217/17455057.4.3.237

Hachette Book Group. (n.d.). Hachette Book Group. https://www.basicbooks.com/titles/judith-herman/trauma-and-recovery/9780465061716/

Jack, D. C., & Dill, D. (1992). The Silencing the Self Scale: Schemas of Intimacy Associated With Depression in Women. *Psychology of Women Quarterly*. https://doi.org/10.1111/j.1471-6402.1992.tb00242.x

Khan, K., Tariq, N. U. S., & Majeed, S. (2024). Psychological Impact of Medical gaslighting on Women: A Systematic review. *Journal of Professional & Applied Psychology*, *5*(1), 110–125. https://doi.org/10.52053/jpap.v5i1.249

LoSavio, S. T., Murphy, R. A., & Resick, P. A. (2021). Treatment Outcomes for Adolescents Versus Adults Receiving Cognitive Processing Therapy for Posttraumatic Stress Disorder During Community Training. *Journal of Traumatic Stress*, *34*(4), 757-763. https://doi.org/10.1002/jts.22668

Moss CF, Chinna-Meyyappan A, Skovronsky G, et al. Experiences of Care and Gaslighting in Patients With Vulvovaginal Disorders. JAMA Netw Open. 2025;8(5):e259486. doi:10.1001/jamanetworkopen.2025.9486

Mishel, M. H. (1988). Uncertainty in Illness. *Image: The Journal of Nursing Scholarship*, *20*(4), 225-232. https://doi.org/10.1111/j.1547-5069.1988.tb00082.x

Samulowitz, A., Gremyr, I., Eriksson, E., & Hensing, G. (2018). "Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain. *Pain Research and Management*, *2018*, 1–14. https://doi.org/10.1155/2018/6358624

The Body Keeps the Score by Bessel van der Kolk, M.D.: 9780143127741 | PenguinRandomHouse.com: Books. (2015, September 8). PenguinRandomhouse.com. https://www.penguinrandomhouse.com/books/313183/the-body-keeps-the-score-by-bessel-van-der-kolk-md/

Vercellini, P., Crosignani, P., Somigliana, E., Vigano, P., Buggio, L., Bolis, G., & Fedele, L. (2011). The "incessant menstruation" hypothesis: a mechanistic ovarian cancer model with implications for prevention. *Human Reproduction*, *26*(9), 2262–2273. https://doi.org/10.1093/humrep/der211

Werner, A., & Malterud, K. (2003). It is hard work behaving as a credible patient: Encounters between women with chronic pain and their doctors. *Social Science & Medicine*, *57*(8), 1409-1419. https://doi.org/10.1016/S0277-9536(02)00520-8

Wikipedia contributors. (2026, January 26). *Gender disparities in health*. Wikipedia. https://en.wikipedia.org/wiki/Gender_disparities_in_health

Zirnsak, T., Elwyn, R., McLoughlan, G., Couteur, E. L., Green, C., Hill, N., Roberts, R., & Maylea, C. (2024). "I have to fight for them to investigate things": A qualitative exploration of physical and mental healthcare for women diagnosed with mental illness. *Frontiers in Public Health*, *12*, 1360561. https://doi.org/10.3389/fpubh.2024.1360561