

MEDICAL GASLIGHTING

NO ONE IN YOUR CORNER: MEDICAL GASLIGHTING, EPISTEMIC INJUSTICE,
AND THE ABSENCE OF PATIENT ADVOCACY

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ABSTRACT

This dissertation examines medical gaslighting, which is the invalidation, minimization, and psychologization of patients' health concerns by healthcare providers, with particular attention to its disproportionate impact on women. Drawing on a dual-methodological approach that combines theoretical scholarship with qualitative analysis of first-person memoirs, this study explores the ways that medical gaslighting both reflects and extends upon, as well as complicates, existing conceptualizations of gaslighting and the ways in which structural power imbalances within clinical settings can cause epistemic harm regardless of practitioner intent.

The theoretical basis draws on the works of key scholars such as Elizabeth Barnes, Kate Abramson, Andrew Spear, Miranda Fricker, and Rachel McKinnon, illuminating gaslighting as a phenomenon that operates interpersonally, epistemically, and structurally. This framework is situated in a historical analysis of patriarchal influences on medicine from the Hippocratic Corpus, to the persistence of hysteria and misogynistic clinical norms, to shed light on the gendered dynamics of contemporary medical practice.

Three memoirs are thematically analyzed: Sarah Ramey's *The Lady's Handbook for Her Mysterious Illness*, Lisa Lynch's *The C-Word* and Porochista Khakpour's *Sick*. Three interlinked findings are made: the systemic neglect of women's pain, the erasure of women's medical narratives through testimonial injustice and the internalization of gaslighting as self-blame and epistemic abuse. Together, these stories reveal medical gaslighting not as an individual aberration but as a structural pattern, sustained by institutionalized gender bias and the devaluation of women's bodily knowledge.

The conclusion of the dissertation is that meaningful reform of medical gaslighting requires understanding it as a systemic epistemic harm situated in the architecture of medical authority and gendered power. The conclusion calls for structural remedies, not just individual education, to combat medical gaslighting.

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Dedication

To my mother, Nada Abusbeih Aburmeileh, the woman I admire most.

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INTRODUCTION AND PROBLEM STATEMENT

The phenomenon called gaslighting evokes a sense of unease due to its unsavory connotation. Gaslighting, a form of manipulation that has reached its pinnacle in terms of complexity and resistance, originated from the play “Gas Light” authored by Patrick Hamilton. This theatrical work played a significant role in popularizing the term and subsequently its use in the realm of psychological manipulation. The play “Gas Light” portrays a married pair in which the husband manipulates the mental well-being, self-assurance, and perception of reality of his wife. The husband successfully employs a strategy of manipulation by gradually reducing the intensity of the gaslights in their home. When questioned about the alteration in the gaslights, he vehemently refutes any involvement in their manipulation. By shifting the power dynamics, the husband has acquired a heightened perception of trustworthiness and mental stability, resulting in his words assuming authoritative status. In virtue of his elevated position of authority within the relationship, he possesses the capability to confine his wife metaphorically, so creating a scenario in which her cognitive processes become detrimental. The individual who has experienced gaslighting is currently faced with a deficit in self-reliance, a distorted understanding of the world, and a diminished level of assurance, hence encountering difficulties in reestablishing their personal identity and asserting their own subjective reality.

To understand the complexity of the term medical gaslighting, it is essential to analyze its two component parts: the phenomenon of gaslighting and its manifestation in a medical environment. According to psychoanalyst Dr. Robin Stern, gaslighting refers to the deliberate manipulation of an individual’s perception of reality, leading them to doubt

their own sanity. Individuals who are subjected to gaslighting techniques are effectively coerced into doubting and rejecting their own cognitive processes, emotional experiences, and personal identity. Stern highlights the possibility that those engaging in gaslighting may lack self-awareness regarding their actions. This manipulative strategy can be employed either intentionally or inadvertently, although it is the victim who ultimately bears the negative consequences

The literature review first sets up the study's theoretical base. Fundamental psychological research on gaslighting, especially the contributions of Robin Stern, offers a framework for comprehending gaslighting as a mechanism that manipulates individuals into questioning their own perceptions and mental stability. This theoretical framework is subsequently applied to the medical field through investigations into medical authority, epistemic injustice, gender bias in healthcare, and power imbalances between patients and providers. Historical examinations of medicine, especially concerning women's health, elucidate the influence of institutional authority on the validation and dismissal of symptoms.

Secondly, this study includes qualitative analysis of first-person accounts, such as memoirs and podcast narratives written or told by women who talk about experiences that are similar to medical gaslighting. These narratives constitute primary data, elucidating the embodied, emotional, and relational repercussions of dismissal within clinical environments. Through careful reading and thematic analysis, we can find patterns that happen over and over again, such as denying symptoms, downplaying pain, making physical illness seem like a mental illness, and losing trust in oneself. People pay attention not only to what is said, but also to tone, self-doubt, apology, and narrative

structure, which often show how people have internalized the effects of being dismissed over and over.

Lastly, the study engages in critical reflection by comparing what it learns from the literature with what it learns from real-life stories. This comparative analysis assesses the alignment of first-person testimonies with established psychological definitions of gaslighting and identifies areas where they either expand or complicate these definitions. For instance, while conventional frameworks typically regard gaslighting as intentional manipulation, narrative evidence indicates that in medical contexts, dismissal may transpire both intentionally and unintentionally, yet still inflict comparable epistemic harm. This reflective aspect enables the study to examine whether current definitions adequately encompass the structural and institutional facets of medical gaslighting.

This methodological approach aims to reconcile theoretical scholarship with experiential narratives, thereby bridging the divide between academic discourse and lived experience. The combination of literature review and narrative analysis makes the case stronger that medical gaslighting is not just a one-time event or a story, but a pattern that is part of larger systems of medical authority and gendered power influences.

The dissertation centers on the following primary question:

How does medical gaslighting, as experienced and narrated by women in first-person accounts, reflect, expand, or complicate existing definitions of gaslighting, and how do structural power imbalances within clinical settings contribute to the epistemic harm of symptom dismissal regardless of health practitioners' intent?

Part A: What we already know about medical gaslighting

CHAPTER ONE

GASLIGHTING

To understand medical gaslighting, I examine five theoretical approaches that each illuminate different dimensions: Barnes on appropriate vs. inappropriate applications, Abramson on intentionality and moral harm, Spear on epistemic dimensions, Fricker on testimonial injustice and identity power, and McKinnon on well-intentioned gaslighting. Together, these frameworks reveal gaslighting as operating at multiple levels—interpersonal, epistemic, and structural.

Gaslighting is a complex phenomenon that has received significant attention from researchers. As the term gaslighting becomes more prevalent, there is an increasing focus on defining this phenomenon, identifying instances of gaslighting, and developing strategies to protect ourselves from becoming victims of gaslighting. This chapter will primarily examine the current body of literature encompassing gaslighting, specifically defining this phenomena and exploring its application within a medical environment. Over the past decade, there has been ongoing debate among scholars over the criteria for identifying cases of gaslighting and determining whether it is suitable to classify an episode as such. By incorporating the study of Willis Klein, Elizabeth Barnes, and Miranda Fricker, I aim to encompass a wide range of perspectives on the definitions and manifestations of gaslighting as a phenomenon, in addition to their specific studies on the subject. Additionally, I will incorporate the viewpoints of other researchers to thoroughly examine different perspectives on gaslighting.

In addition to discussing gaslighting, I will clarify the concepts of epistemology and epistemic injustice, which are employed by both Klein and Fricker to reinforce the phenomenon of gaslighting. Klein, who is currently pursuing a PhD in experimental psychology, specifically investigates the psychological impacts of gaslighting and strategies for recovering from epistemic abuse. Epistemology is the philosophical discipline concerned with the nature, origins, and limits of knowledge; it focuses on the cognitive connection between the mind and reality (Martinich & Stroll, 2023). In a recent joint presentation by Klein (2023) and Jennifer A Bartz, a psychology professor at McGill University, a comprehensive overview of the historical progression of gaslighting was provided. Their presentation titled, "A Historical Review of Gaslighting: Tracing Changing Conceptualizations Within Psychology and Psychiatry", laid out the evolution of the term and its emergence as a widely acknowledged psychological phenomenon (Klein & Bartz, 2023). As for Miranda Fricker's publication, "Epistemic Injustice: Power and the Ethics of Knowing," delves into the concept of epistemic injustice, which refers to a specific form of injustice related to knowledge. Epistemic injustice refers to the act of committing a wrongdoing against an individual based on their role as a knower (Fricker, 2007, p. 1). She states that her work specifically addresses two types of injustice: testimonial injustice and hermeneutical injustice (Fricker, 2007, p. 1). Below, I will explore these concepts in the context of gaslighting.

1. Projective Identification

Barnes (2023) emphasizes the unique aspects of gaslighting compared to other concepts, such as testimonial justice and standpoint epistemology, and that is because gaslighting originated as a concept in "popular discourse" before being incorporated into

academic philosophy by psychoanalysis. Through comparing both Barnes and Klein's historical overview of the phenomenon I learned that both agree that gaslighting is a term that gained popularity in the 1930s-1940s, and was initially introduced in fiction through Patrick Hamilton's screenplay (Klein & Bartz, 2023). I present a succinct historical timeline outlining the initial applications of the notion that subsequently influenced what is currently referred to as medical gaslighting. From 1969 to 1979, psychiatric case studies recorded occurrences of institutionalization based on deceptive premises, underscoring manipulation and reality distortion in clinical environments (Klein & Bartz, 2023). Although these instances were not expressly termed "medical gaslighting" in the modern context, they illustrate early trends of credibility distortion and misuse of authority. Subsequent to the deinstitutionalization period, spanning from 1981 to 1996, the word gaslighting emerged more prominently in psychodynamic research, where it was defined as a variant of projective identification (Klein & Bartz, 2023). This phase signifies the incremental theoretical evolution of the concept rather than the comprehensive framework of medical gaslighting as currently comprehended.

As mentioned, in 1946, Melanie Klein coined the term "projective identification." She discussed an internal psychological process in which aspects of the ego were incorporated into aspects of the object to protect and safeguard themselves. Subsequent to her proposal, Kleinians have further developed and incorporated her concept into their theoretical framework and approach (Waska, 1999, p. 225). Projective identification is a psychological defensive mechanism that is used as a kind of communication. In psychodynamic research, it has been seen as a technique to bring about psychological change with another person or oneself. This phenomenon was predominantly observed in

patients who sought to psychologically detach themselves from undesirable and alarming aspects of their own being (Waska, 1999, p. 226). The projective aspect arises when an individual unconsciously ascribes elements of their emotional state to another person, subsequently interacting with that person as though those projected emotions authentically belong to them, thus fostering a distorted perception of mutual understanding or psychological unity (Waska, 1999, p. 226). It is essential to recognize that projective identification lacks a broadly accepted interpretation of the concept among scholars. Certain researchers argue that it transcends a mere protection mechanism and encompasses intricate interpersonal dynamics. In psychodynamic research, projective identification is predominantly characterized as a defensive mechanism, and this description will be utilized throughout the discourse on gaslighting in this dissertation.

Over time, gaslighting gained attention as it was more discussed in memoirs and self-help books, such as Robin Stern's "The Gaslight Effect," which gained notice in 2008 (Klein & Bartz, 2023). This led to an increased awareness of gaslighting among the public. However, it was in 2014 when the concept truly flourished, as epistemologists began exploring the application of gaslighting to epistemic injustices (Klein & Bartz, 2023).

Elizabeth Barnes (2023), a philosophy professor specializing in metaphysics, political philosophy, feminist philosophy, and ethics, who ponders the crucial matter of when we are morally bound to place our trust in someone. Barnes provides a comprehensive analysis of the current understanding of gaslighting, including a brief overview of the initial definitions of medical gaslighting. For example, Barnes' research discusses the drawbacks of gaslighting in doctor-patient relationships. It explores

alternative approaches and highlights the challenges physicians face when it comes to trusting patients' narratives. She explores the concept of gaslighting and its connection to medical gaslighting, especially emphasizing the disputed illness commonly known as "chronic Lyme disease" as an example to support her argument. Chronic Lyme disease remains a medically contentious diagnosis. Numerous patients report enduring and incapacitating symptoms following treatment for Lyme disease; however, some physicians contest whether these symptoms indicate a continuing infection. This disparity results in a credibility dilemma, wherein patient accounts frequently contradict the predominant biological paradigms.

Barnes employs this argument to demonstrate the epistemic vulnerability of patients when their symptoms lack definitive biomarkers or do not conform to accepted diagnostic classifications. In such cases, clinicians may interpret chronic pain, exhaustion, or cognitive impairments as signs of worry or psychosomatic causes instead than symptoms of an underlying medical problem. Although such replies are not necessarily intended to do harm, they can still result in testimonial injustice. The patient's credibility is compromised not by irrationality or lying, but because his or her experience contradicts recognized medical principles.

Barnes employs chronic Lyme illness to illustrate how medical uncertainty can transition from acknowledging the confines of knowledge to insidiously transferring skepticism onto the patient. When the boundaries of medical knowledge are perceived as fixed, unexplained illnesses are regarded as personal misconceptions rather than deficiencies in comprehension. The structural qualities of medical authority transform ambiguity into rejection. Chronic Lyme functions in her analysis as both a disputed

diagnosis and a case study demonstrating how gaslighting may occur even within benevolent therapeutic practice, eroding patient self-trust and reinforcing power disparities.

I want to make it clear that my dissertation will not only address physicians or patients who have been subjected to gaslighting by physicians. Instead, this topic will be one of several perspectives that I will be examining within different frameworks. I will examine the difficulties associated with detecting cases of medical gaslighting, with a special emphasis on its intangible nature and the absence of concrete proof, which contributes to the complexity of diagnosing gaslighting. Prior to discussing the challenges associated with identifying it, I would like to utilize a distinctive approach emphasized by Barnes in her study. Her approach acknowledges the excessive utilization of gaslighting by individuals. By utilizing Barnes' study, I comprehensively address various aspects of gaslighting, including its appropriate and inappropriate applications. By doing so, I aim to reduce possible bias, since I acknowledge the possibility of gaslighting being excessively employed, so diluting its significance. In order to mitigate the devaluation of the concept of gaslighting, as highlighted by Barnes, it is advisable to establish clear parameters on the situations in which labeling a scenario as gaslighting is warranted.

1.1 Applications of Gaslighting

In her insightful analysis, Barnes delves into the intricate dynamics of personal testimony, belief, and knowledge, shedding light on the profound impact on both interpersonal connections and self-perception. Barnes emphasizes the importance of acknowledging and respecting others' perspectives, highlighting the potential negative

consequences of dismissing others' experiences. Barnes also highlights the significance of considering the collective impact of disregarding the testimonies of certain groups. It is interesting to consider the "theoretical framework" that underlies discussions about individuals' ability to assert control over their own voice and experiences, as it can sometimes be seen as a form of gaslighting.

Barnes acknowledges that the portrayal of gaslighting in the "Gaslight" play and film is an early example of this manipulative tactic, suggesting that it may have originated from this source. Barnes delves deeper into the subject, highlighting how gaslighting is:

generally taken to refer to instances in which another person (or persons, institutions, etc.) imposes their own interpretation or narrative onto an individual's experience. In doing this, they do not treat that individual as an authority about her own experience. Calling these aspects of the person's experience into question can then have a profound destabilizing effect on the person—it forces them to doubt whether their experiences are real, whether they can trust themselves, whether they have 'lost their mind', etc. And, in tandem, it gives someone else unwarranted authority over that person's interpretation of the world. (Barnes, 2023, p. 650).

Barnes distinguishes her research from other researchers, whom I will address subsequently, by adopting a unique method to define gaslighting. Rather than providing examples of patients suffering from gaslighting or discussing its relevance, she takes a contrary stance by asserting that gaslighting is excessively applied. Barnes delineates the

precise constraints within which gaslighting can be applied. I find Barnes' analysis of the excessive usage of gaslighting to be quite informative, as it offers further illustrations for identifying instances of gaslighting. While it is important to recognize when someone is making someone else doubt their own experiences, Barnes points out that focusing too much on specific rules for what counts as gaslighting might cause us to miss other genuine instances of it. It is more efficient to highlight the lack of credibility or presence of gaslighting rather than providing a detailed explanation and analysis of every individual occurrence. The circumstances and context surrounding each instance of gaslighting are important, but excessive specificity in determining the necessary elements for a scenario to be classified as gaslighting may inadvertently exclude other instances of gaslighting. While it is impractical to list every possible instance of gaslighting, it is more feasible to identify what situations and behaviors do not constitute gaslighting. This approach allows for a more efficient and effective means of explaining the concept of gaslighting, as explained by Barnes with great clarity,

Sometimes doubt is justified, and sometimes doubt, even if unwarranted, doesn't connect to larger forms of systemic harm. People can be wrong about their own experience, misinterpret their own experience, or misapply their own experience. And even in cases in which they aren't wrong, not all disagreement is gaslighting. Gaslighting arises when people are forced to doubt, in specific and destabilizing ways, things which they ought to have special first-person authority over. (Barnes, 2023, p. 650).

The crux of Barnes's statement is in her emphasis on the gaslighter's intentions when it comes to the impact of gaslighting rather than the victim's experience. She provides an instance where gaslighting is not suitable and discusses Klein's (et al., 2023) theory that gaslighting relies on the status of "close relationships" and how this grants the gaslighter the necessary "epistemic" advantage to engage in gaslighting. In other words,

gaslighting often happens in close relationships because the person doing it uses the trust and intimacy to make the other person doubt themselves.

Barnes describes a situation in which she and her husband are departing from their residence. He inquires whether she possesses her keys, and despite her affirmation, he persists in reiterating his query, placing emphasis on whether she truly possesses her keys. Within this particular scenario, Barnes would not classify this behavior as gaslighting. She asserts that her husband, having a deep understanding of her over a long period of time, is aware that she frequently thinks she has her keys when she actually does not. Consequently, he is considered the more reliable source of evidence, as described by Barnes. The repeated questioning, he engages in is not classified as gaslighting, given their mutual past experiences.

In her analysis, Barnes establishes the distinction between this and the film *Gaslight*, providing a concise summary of the latter wherein a woman is systematically induced to question her own senses by her spouse as a means of psychological manipulation. He intentionally reduces the brightness of the gas lamps, but when questioned, he denies having done so. Although she perceives the lamps as being dimmed, he insists that they are not and accuses her of having a false perception. Therefore, this particular case exemplifies the quintessential example of gaslighting. The woman's ability to rely on her senses is crucial. She can clearly observe that the lamps are lowered. Therefore, being informed that her perception is incorrect with the intentions for her to not trust her fundamental understanding of the world is the essence of gaslighting.

The notable aspect of Barnes' theoretical framework on gaslighting is its comprehensive inclusion of various existing frameworks on the subject. Barnes provides insight into Abramson (2014) research on the phenomenon of gaslighting, emphasizing that the act of gaslighting hinges on the deliberate intentions of the perpetrator. Here, we can define the perpetrator as the agent who intentionally undermines another person's sense of reality, judgment, and self-trust. The key emphasis here is on the deliberate intention behind their actions. The gaslighter actively works to make the victim doubt their perceptions, memories, and even their sanity. The victim, according to Abramson, is the individual whose capacity for independent judgment and deliberation is targeted and eroded by the perpetrator's manipulative behavior. The victim experiences a gradual judgment of their confidence in their own thoughts, feelings, and experiences, often leading to confusion, anxiety, and dependence on the perpetrator's version of reality. Gaslighting hinges on the perpetrator's conscious aim to distort the victim's reality for the purpose of gaining power and control. Without this deliberate intention to manipulate, the interaction would likely fall under a different category of communication breakdown or conflict. Thus, to qualify as gaslighting, the perpetrator must actively manipulate and pressure the victim into adopting the perpetrator's perspective. Spear (2019) agrees with Abramson's discourse on gaslighting, although contends that deliberate manipulation in isolation is inadequate, underscoring the importance of epistemic criteria. Spear outlines two essential criteria for gaslighting: firstly, the perpetrator deliberately manipulates the victim into doubting their own trustworthiness regarding specific aspects of their own experiences, and secondly, the perpetrator exploits the victim's feelings of uncertainty to make them rely on the perpetrator's judgment. The second criterion is the epistemological

criterion. In certain situations, the perpetrator manipulates the victim into surrendering their own perspective to the perpetrator's interpretation of the circumstance or context.

2. Intentional

Additionally, Abramson presents gaslighting through the historical lens of the play *Gaslight*. Abramson intends to convey how abhorrent it is for individuals or groups to engage in gaslighting as a mode of communication. Abramson characterizes the term "gaslighting" as "therapeutic" and "colloquial," which aligns with Barnes's notion that "gaslighting" originates from "popular discourse" and is accountable for identifying a distinguishable phenomenon in human interactions (Abramson, 2014, p. 2). Abramson emphasizes that she will only discuss specific facets of gaslighting interactions in her objective, focusing primarily on the psychology of gaslighters and their targets. First, Abramson alludes to the reason why her paper focuses on the experiences of women rather than males who have been gaslighted.

There's nothing necessarily sexist about gaslighting. As a matter of fact, however, gaslighting interactions are often sexist in various ways. To begin with (1) women are more frequently the targets of gaslighting than men, and (2) men more often engage in gaslighting. More importantly, gaslighting is frequently, though again, not necessarily, sexist in the following ways: (3) it frequently takes place in the context of, and in response to, a woman's protestation against sexist (or otherwise discriminatory) conduct; (4) some of the forms of emotional manipulation that are employed in gaslighting frequently rely on the target's internalization of sexist norms, (5) when gaslighting is successful when it actually undermines the target

in the ways it is designed to do it can reinforce the very sexist norms which the target was trying to resist and/or those on which the gaslighter relies in his/her manipulation of the target, and (6) sometimes it is some subset of those very sexist norms which the gaslighter seeks to preserve through his/her gaslighting conduct. Gaslighting can be sexist in all of these ways, or none of them. And it can be sexist in some, but not all of these ways. (Abramson, 2014, p. 3)

Abramson clarifies that gaslighting is not intrinsically sexist, having bias or animosity towards the victim's sex is not necessary to gaslight them. However, incidents relating to "sexism" are common in gaslighting. The focus is not so much on the requirements for gaslighting but rather on the prevalence of sexist undertones in incidents of gaslighting. Abramson further explains that she mentions sexism in part because of the "wrongs of gaslighting," which are frequently sexist; therefore, in order to discuss this phenomenon, sexism's active involvement must be acknowledged. In her work, Abramson presents eight distinct illustrative cases that serve to demonstrate the phenomenon of gaslighting, regardless of any sexism present in the examples. In conclusion, she asserts that an examination of the function of sexism in gaslighting will furnish instances where sexism can "frame" gaslighting, be utilized as "leverage," and be "reinforced" via sexism when gaslighting is effective, thereby concealing sexism (Abramson, 2014, p. 3).

Prior to delving into the illustrative cases, Abramson emphasizes Kant's moral theory, specifically the concept of autonomy. Kant's interpretation of autonomy was crucial in comprehending and rationalizing the power that moral obligations possess over us (Stanford Encyclopedia of Philosophy, 2022). Abramson acknowledges that further

analysis is required to comprehend the deficiencies inherent in the specific methods by which gaslighters manipulate their targets and the resources they employ to do so; Kantian theory merely provides a superficial comprehension.

In regard to the eight illustrative cases utilized by Abramson to aid in the concentration on gaslighting, I have selected three cases in consideration of the numerous theoretical frameworks that will be examined, one of which is Abramson's framework on gaslighting. I believe that the three illustrative cases are closely related to the central scenario that Abramson focuses on in her essay. Although not more significant than the other five cases Abramson presents, these cases are useful in demonstrating that gaslighting affects individuals indiscriminately.

Illustrative cases:

2. A junior academic woman is standing at the department's front desk. A senior male colleague passes by and slaps her on the butt. She reports the incident to another senior colleague. The second colleague responds, "Oh, he's just an old guy. Have some sympathy! It's not that big a deal." A third colleague responds, "Don't be so sensitive." (Abramson, 2014, p. 4)

5. A gay junior academic discovers a job candidate has publicly avowed anti-gay views. After discussions with her colleagues and Chair about her concerns, she asks to meet with the candidate on a campus visit. The Chair arranges the visit the one weekend he knows the junior academic will be away. In frustration, she posts copies of the university's non-discrimination statement on department bulletin boards before leaving. They disappear. She reposts them. The Chair appears at her office, torn statements in hand, and threatens her. Later she discovers that the Chair has signed a public petition asserting that it should not be regarded as a violation of disciplinary standards to fire academics for being gay. She expresses grave concerns to her colleagues about her job. They respond: "You're just acting out"; "don't be paranoid"; "that's crazy". (Abramson, 2014, p. 4)

6. A female graduate student deals with sexual harassment. Confronts her harasser. He responds by first denying any problem, then, "see, there wouldn't be this problem if there weren't any women in the department", and finally, "you're

just prude.” She talks to another student. The second graduate student retorts, “he was just joking.” (Abramson, 2014, p. 5)

The illustrative cases are not fabricated; according to Abramson, cases two and six are self-reported incidents in which victims of gaslighting provided the information; the fifth case is from the article “What is it like to be a woman in philosophy?”. The selection of these cases is significant due to the diversity of dismissals that are being levied against women under these conditions. The terminologies “too sensitive,” “paranoid,” “crazy,” and “prude,” along with the existentialist denial of “bad faith” (Abramson, 2014, p. 5), serve as the foundational elements of the conceptual structure that delineates gaslighting. By means of real-life anecdotes, Abramson visually depicts through real-life experiences women having their experiences with anything worth being upset over is being flatly denied. Two phrases that I find powerful in describing these actions that Abramson uses are when the voices surrounding the victim are trying to “radically minimize” and “reconceptualize” the victims experience so that the perpetrator doing this is not uncomfortable with what is happening (Abramson, 2014, p. 5). I find these phrases to be particularly evocative.

In an effort to provide greater clarity, Abramson provides a detailed account of her definition, highlighting the recurring theme in the illustrative cases: the victim's protests are met with increasingly negative judgmental tones such as “that's crazy,” “it's not a big deal,” and “you're overreacting.” To further compound the situation, should the victim manage to endure such treatment, their very survival will be pitted against them. Presently, women encounter weaponized survival remarks such as “Well, you survived, didn't you?” “It all worked out in the end,” and additionally “That was just a minor blip.” (Abramson, 2014, p. 6.) Subsequently, the victim has endured this distressing incident

without anyone ever recognizing their pain or acknowledging the atrocities they have witnessed. Rather than receiving praise for their courage to speak out and their resolve to persevere in doing so, they were met with remarks that implied they were overly sensitive and crazy, and that any "difficulty" they encountered could have been "all in themselves." This concludes Abramson's summary of the phenomenon known as gaslighting.

It is evident from Abramson's framework on gaslighting that the perpetrator intends to undermine the victim's credibility on the basis of their own experiences and perceptions in every instance of gaslighting she describes. In general, Abramson concurs that the purpose of the voices, referred to as the perpetrator, is to reconceptualize the victim's experiences, irrespective of whether they are connected to the aggressor. By entirely destabilizing and altering the victim's recollection of reality, gaslighting seeks to seize control of the conversation as the authoritative figure. In this regard, the theoretical framework on gaslighting proposed by Andrew Spear (2019) argues that Abramson's version is significant but lacks one factor. In Spear's essay "Epistemic Dimensions of Gaslighting: Peer-Disagreement, Self-Trust, and Epistemic Injustice" he declares Abramson's paper as the "most comprehensive analysis of gaslighting to date" as of the publication date of his essay (Spear, 2019, p. 68). In contrast to his prior acknowledgment, Spear suggests that Abramson's logic diminishes the significance of gaslighting by placing excessive emphasis on the gaslighter and the immorality of his deeds. According to Spear, this focused attention diminishes the significance of the gaslighters' legitimate use of epistemological strategies and their exploitation of the victim's substantial and fundamental epistemic relationship in order to devote less focus from the victim's perspective and reasoning process.

Spear stipulates that while recognizing the necessity of intention for gaslighting to occur, he contends that the practice also possesses fundamental epistemic dimensions. Spear presents a compelling argument by stating that upon adopting this framework, we recognize that the gaslighter may provide epistemological reasoning to their victims as a means of gaslighting, irrespective of whether or not these reasons have been constructed (Spear, 2019, p. 68). Spear further asserts that in order to establish their position in relation to the victim, each gaslighter must make at least this type of implicit epistemic claim, and this particular epistemic claim influences the victim's experience of the gaslighting. This interpretation of gaslighting is well-founded when Spear extends it to the victims' perspective, suggesting that their implicit self-trust regarding their perception of themselves as the nexus of "experience, thought, and judgment" will be called into question in addition to their "moral or psychological" convictions (Spear, 2019, p. 68–69).

Both Abramson and Spear center their discourse on the film *Pat and Mike* as its central subject. Abramson employs this film as an example to illustrate her conceptualization of gaslighting as the gaslighter's malicious intent. Spear deconstructs Abramson's illustration and reconstructs it according to his ideology, which posits that gaslighting encompasses not only the perpetrator's intentions but also the fundamental epistemic dimensions that extend from the gaslighter to victim relations. The film follows an accomplished golfer named Pat who is engaged to Collier. Collier would prefer that Pat gives up golfing and dedicates herself to him after their marriage. Pat's desire to continue pursuing full-time career ambitions rather than being limited to housework responsibilities irritates him, or as Abramson puts it, "threatens his personal sense of

manhood" (Abramson, 2014, p. 7). Pat manages to make it to the championship round despite Collier's persistent badgering; this is where the gaslighting becomes apparent, as he develops worries about her golfing ability and is administrative about communicating these worries to her. Collier arrives at the championship round with one last attempt to project his concerns onto her while displaying his signature concern expression. Upon looking up, Pat is met with one of Collier's numerous worried expressions. This is sufficient to shake Pat's confidence and cause her to miss her last and final easy shot (Abramson, 2014, p. 7).

Abramson offers this set of dialogues that is used as the main focal point in both her and Spear's essays.

Collier: How about looking on the bright side of this for instance? Take this—As long as your job's out of the way, move the date up, tie the old knot? I think you've done enough, worked long enough, don't you?

Pat (distressed): oh, too much (*looks down*)

Collier (interrupting Pat): After all, what you trying to prove, who you trying to lick?

Pat (determinedly, upset): Myself. (*pounds fist in air*)

Collier: Just the kid who'll do it (*Puts his leg up and looks at her dubiously and patronizingly*)

Pat: Collier, do you sort of, I don't think you mean to, but do you think of me as just the little woman?

Collier: That's right, and myself as a little man. (*Squeezes her shoulders like a small child*).

Pat (quite distressed): Right now, now I feel like a sort of flop that you're rescuing. I'm flummoxed, that's what I am. Maybe we ought to wait until I don't feel so carved up, so nobody.

Collier: Why don't you just let me take charge!

Pat (fatigued): I have to be in charge of myself.

Collier: Oh what's the good of that, I mean after all?

Pat: I have to have time to think it over.

Collier: Well, just make sure you don't think it under. It's a nice long ride, just take your time. (*Opens newspaper to end conversation*). (The screen-play for *Pat and Mike*, quoted in Abramson 2014, p. 7)

Abramson interprets this exchange as a clear example of gaslighting and recognizes that categorizing it as an instance of projective identification can be challenging (Abramson, 2014, p.7). It is important to remember that the term "projective identification" was used to describe the original investigation of gaslighting in psychodynamic research (Klein & Bartz, 2023). The initial scientific acknowledgment of gaslighting is subtly embedded within a situation that might be regarded as an unequivocal instance (Abramson, 2014, p. 7). One should contemplate the potential number of unobserved occurrences of gaslighting due to the difficulty in discerning the perpetrator's tendency to shift blame onto their victim. Abramson effectively illustrates the concept of gaslighting by shifting focus on Colliers' protective behavior, broadening the scope beyond the concept of "projective identification." Collier's apprehensions over Pat's aptitude for success as a golfer are perceived as a means to safeguard his own ambitions. Collier is exasperated by Pat's inclination for an alternative trajectory in life, a viewpoint that Collier vehemently opposes. Collier's behavior, characterized by openly attempting to "radically undermine" Pat and dismissively questioning the worth of Pat's decisions under the guise of love and trust, is perceived as gaslighting (Abramson, 2014, p. 7).

Spear agrees with Abramson regarding Collier's objective of persuading Pat to give up resisting his vision of their relationship and abandon her aspirations. Collier aims to accomplish this by undermining her competence in handling matters and subtly hinting at the potential loss of affection for Pat (Spear, 2019, p. 71). However, the key distinction between Spear's work and Abramson's lies in their divergent perspectives on gaslighting and their respective analyses of the mechanisms employed by gaslighters. Abramson

asserts that the gaslighter aims to influence their victim into relinquishing their autonomy in self-evaluation. However, she does not elaborate on how the gaslighter's relationship profoundly affects this ability. Spear argues that the gaslighter aims to erode the victim's self-assurance and weaken their objections in order to manipulate the victim into accepting the gaslighter's version of reality over their own. The gaslighter possesses epistemic authority, which provides the victim with primarily epistemic grounds to doubt their own perceptions and judgments.

Abramson discusses a relationship between the gaslighter and the victim but does not further explore the consequences that their relationship will have on the act of gaslighting. The theory proposed by Spear posits that the effectiveness and prevalence of gaslighting are contingent upon the relevance of relationships, which contradicts the framework proposed by Abramson. The empirical examples she provides illustrate that gaslighting can occur in any context, regardless of the pre-existing connection or lack of relationship between the victim and perpetrator. However, Spear argues that gaslighting is a two-fold phenomenon that depends on the victim having a relationship with the gaslighter. What interests me about Spear's observation is that Abramson's examples and explanations of gaslighting do allow for epistemic aspects. It is evident from the most discussed and featured example—that of an engaged and soon-to-be married victim and perpetrator—that both writers acknowledge the potential of the epistemic components to exacerbate the effects of gaslighting.

Even Spear acknowledges this, however, he argues that Abramson opposes interpreting gaslighting from an epistemic perspective.

On Abramson's view, gaslighting is only happening if the gaslighter attempts to motivate his victim to accept these attitudes toward herself and what he wants by means of manipulation. Yet, as already suggested, it seems clear that gaslighting at least *can* be about the epistemic status of the gaslighter and about giving the victim primarily epistemic reasons to distrust her own experience and judgment. (Spear, 2019, p. 75)

Having read Abramson's and Spears' essays, I believe their frameworks may restrict gaslighting to the scope of interpersonal interactions between the perpetrator and victim, which could undermine the overall goal of defining gaslighting. My aim is to define gaslighting and analyze the traits and characteristics associated with it, without confining it to certain conditions for its presence. Abramson and Spear provide accurate depictions of gaslighting but also limit its scope in two ways. First, the perpetrator must have the aim to manipulate and be aware that their acts cause harm. Secondly, as highlighted by Spear, the perpetrator must have a close relationship with the victim for gaslighting to occur, and the intensity of the gaslighting effects increases with the level of closeness between them. While I acknowledge the potential impact of a close relationship on a perpetrator's influence over their victim, I believe it is important to consider that individuals with no relation can also cause significant harm, possibly even more so.

3. Testimonial Injustice and Power Play

Testimonial injustice refers to the situation where bias leads a listener to assign a lower level of trustworthiness to a speaker's statements. On the other hand, hermeneutical injustice occurs earlier in the process, when a lack of shared interpretive resources puts someone at an unfair disadvantage in understanding and explaining their social experiences. An example that Fricker offers is of the first scenario (testimonial injustice) which could be the police exhibiting disbelief towards you only based on your race; an

instance of the second scenario (hermeneutical injustice) could be enduring sexual harassment in a society that still lacks a fundamental understanding of this issue (Fricker, 2007, p. 1). Fricker goes on to explain that testimonial injustice arises from bias in the distribution of credibility, while hermeneutical injustice stems from systemic bias in the allocation of communal hermeneutical resources.

In the initial chapter of her book, Fricker provides a definition of power and its various manifestations by employing a traffic analogy. She utilizes active and passive situations to illustrate the interdependence between active and passive types of power, and to demonstrate that social power is the ability we possess as social actors to shape the course of events in the social realm.

Consider, for example, the power that a traffic warden has over drivers, which consists in the fact that she can fine them for a parking offense. Sometimes this power operates actively, as it does when she actually imposes a fine. But it is crucial that it also operates passively, as it does whenever her ability to impose such a fine influences a person's parking behavior. (Fricker, 2007, p. 9).

Regarding the relationship between the two types of power, Fricker clarifies that the passive operation of power will decrease as the active operation decreases. In other words, "unless a certain number of parking fines are actively doled out, the power of traffic wardens passively to influence our parking behavior will also fade" (Fricker, 2007, p. 10). Furthermore, it is worth noting that Fricker acknowledges power as a distinct capacity that persists even when it is not being actively utilized. She emphasizes that

power exists even in periods of inaction. Fricker further illustrates her point by providing an additional portrayal of authority as a capability, using the example of a traffic warden.

Consider our traffic warden again. If a driver, in a crazy state of urban denial, pays no heed one afternoon to what traffic wardens can do, parking wantonly on red lines and double yellow lines entirely without constraint, then we have a situation in which the traffic warden's power is (pro tem) quite inoperative—it is idling. But it still exists. (Fricker, 2007, p. 10).

The example above depicts how power is a capacity on social agents such as people, groups, or institutions (Fricker, 2007, p. 10). According to Fricker, this is referred to as “dyadic” due to the relationship between one party using power and another party whose actions are duly influenced. Fricker's discussion of power as a capacity is relevant to my dissertation as it demonstrates the social influence that power has on both parties involved. This will aid in representing the experiences of gaslighters and victims when discussing the framework of gaslighting, gaslighting cases will highlight the parallels between the two parties involved and the roles they perform under the influence of power. Fricker examines the concept of "identity power" in the context of "imaginative social coordination" (Fricker, 2007, p. 14). Her definition of "identity power" is crucial for my paper, as it will form the foundation for discussing gender and the dynamic that exists between genders. Specifically, I will focus on societal perspectives of gender rather than individual gender identities.

3.1 Identity Power

Identity power refers to the influence exerted on our perception of the world as a collective society, determining societal norms about gender, sexual orientation, and age. Fricker defines identity power as "what it is or means to be a woman or a man, or what it is or means to be gay or straight, young, or old...like social power more generally, identity power can always be exercised actively and passively", it is the influence exerted in situations where power dynamics rely on commonly held social beliefs, such as gender norms and the definition of gender identity (Fricker, 2007, p. 14). I find this term crucial as it signifies an individual's manifestation of individuality, while simultaneously establishing constraints on a society on permissible actions, speech, and their intended significance. According to Fricker, determining whether an operation of identity power is active or passive depends on the imaginative social coordination of both parties, "must share in the relevant collective conceptions of what it is to be a man and what it is to be a woman, where such conceptions amount to stereotypes" (Fricker, 2007, p. 14). When we compare this notion to Fricker's previous example of a driver disregarding a traffic warden, rendering their authority ineffective, we can observe clear parallels that suggest a similar outcome can occur in an imaginative social coordinate aimed at establishing stereotypes.

With another example, more specific to identity power,

Consider a social order in which a rigid class system imposes an asymmetrical code of practical and discursive conduct on members of different classes, so that, for instance, once upon a time (not so long ago) an English 'gentleman' might have accused a 'member of the working classes' of 'impudence', or 'insolence', or 'cheek', if he spoke to him in a familiar a manner. In such a society the gentleman might exercise a plain material power over the man by, say, having

him sacked (maybe he was a tradesman from a company that needed the gentleman's patronage); but this might be backed up and imaginatively justified by the operation of identity power (the social conception of him as a gentleman and the other as a common tradesman is part of what explains his capacity to avenge the other's 'impudence'). The gentleman's identity carries with it a set of assumptions about how gentlemen are to be treated by different social types, and in virtue of these normative trappings the mere identity category 'gentleman' can reinforce the exercise of more material forms of social power. (Fricker, 2007, p. 15-16)

I appreciate this example since it provides an opportunity to draw parallels with gaslighting, a topic that I will get into and expand upon in this paper. It is crucial to have in mind the notion of identity power and how specific attributes that constitute an individual's identity might possess a social charge, such as the speaker's accent. In this case, I am employing Fricker's illustration of the speaker and hearer as victim (speaker) and gaslighter (hearer). The purpose of using this scenario and defining identity power is to demonstrate how prejudice can either enhance or diminish a speaker's credibility. Consequently, this can lead to the speaker's credibility falling below the threshold for belief, resulting in the hearer's prejudice causing them to overlook valuable information. In the case of gaslighting, it causes the hearer to disregard what the speaker is saying.

3.2 Philosophical Portrayal of Testimonial Injustice

Fricker's uses Harper Lee's novel "To Kill a Mockingbird" to illustrate a situation of testimonial injustice, specifically through the prosecution of the character Tom Robinson. Testimonial injustice is a flexible concept that varies depending on the situation it represents. In the case of Tom Robinson, testimonial injustice occurred due to his race. Similarly, in my dissertation on gaslighting, testimonial injustices can be observed based on a victim's gender and their perception of reality. This leads to both Tom Robinson's case and victims of gaslighting experiencing injustices that undermine

their credibility as speakers and their ability to assert their own voice on their experiences, thoughts, or beliefs.

The narrative centers around Tom Robinson, a young black man, who is unjustly charged and prosecuted for the crime of raping a white girl. The narrative is intentionally structured and crafted to ensure that the readers are fully aware of Tom Robinson's innocence. Despite his innocence, he endures numerous instances of testimonial injustices as a result of his race. It is readily apparent that regardless of Tom Robinson's responses to the prosecution, he will be regarded as untruthful due to the assumption that his act of running implies guilt. A notable instance of diminished epistemic trust is shown in the prosecutor's interrogation of Tom Robinson over his encounters with the white woman who had been raped.

'Why were you so anxious to do that woman's chores?'

Tom Robinson hesitated, searching for an answer. 'Looked like she didn't have nobody to help her, like I says-'

... Mr Gilmer smiled grimly at the jury. You're a mighty good fellow, it seems - did all this for not one penny?

'Yes suh. I felt right sorry for her, she seemed to try more'n the rest of 'em-'

'You felt sorry for *her*, you felt *sorry* for her? Mr Gilmer seemed ready to rise to the ceiling.

The witness realized his mistake and shifted uncomfortably in the chair. But the damage was done. Below us, nobody liked Tom Robinson's answer. Mr Gilmer paused a long time to let it sink in. (*To Kill a Mockingbird*, quoted in Fricker 2007, p. 24)

In this instance, Fricker explains that the all-white jury's already limited trust in Tom Robinson was completely diminished. This occurred because it was considered socially unacceptable for a black individual to express sympathy towards a white individual. Such sympathy was seen as implying a sense of superiority over the other race (Fricker, 2007, p. 24). If the jurors had concurred with Tom Robinson and comprehended

the significance of his empathy, it would imply that they had placed epistemic trust in him while harboring distrust towards the white girl. This scenario is deemed implausible for the same rationale that a traffic warden wields passive power over drivers. As previously stated, the traffic warden possesses passive power by imposing fines on drivers, thereby influencing them to park appropriately. Similarly, the jury acts as the imaginative social coordinate that assumes Tom Robinson's guilt based on his race and alleged lack of ability to hold sympathy for a race considered more valuable than his own. This notion has a detrimental impact on his identity power and Fricker underscores this by stating “They find him guilty. And it is important that we are to interpret the novel so that the jurors really do find him guilty. That is to say, they do not privately find him innocent yet cynically convict him anyway” (Fricker, 2007, p. 25)

In her work, Fricker has categorized Tom Robinson's case as a notable example of testimonial unfairness. The author classifies it into many types, such as prejudiced credibility deficit, incidental, systematic, identity prejudice, and identity-prejudicial credibility deficit (Fricker, 2007, p. 27-28). She argues that although the initial analysis may lead us to view this as a prejudicial credibility deficit, it actually goes further as a situation of incidental testimonial injustice. This is because the jury entered the court case with a strong and inflexible bias against black individuals, leading to Tom Robinson being given a significantly lower level of credibility due to prejudice. Regarding Tom Robinson's race, Fricker argues that we can interpret it as a manifestation of systematic testimonial injustices. This is significant because systematic prejudices are formed based on various aspects such as “social activity—economic, educational, professional, sexual, legal, political, religious” (Fricker, 2007, p. 27). Consequently, the term testimonial

injustices is not confined to a specific type of situation related to social activities or imaginative social coordination, as mentioned earlier. This phenomenon results in an identity-prejudicial credibility deficit, as the speaker experiences testimonial injustices and a loss of credibility due to prejudice from the listener (Fricker, 2007, p. 28). Conclusively, Fricker provides a valuable framework on gaslighting, while McKinnon's (2017) chapter "Allies Behaving Badly" may further the discussion.

4. Intentionality and Epistemicism

McKinnon (2017) argues that concentrating the focus on the perpetrator's intention is excessively restrictive when addressing cases of gaslighting. McKinnon argues that gaslighting can be perpetrated by someone with well-meaning and positive motives. Instead of perceiving the perpetrator as using their knowledge and connections to the victim, it is more accurate to say that the perpetrator is disregarding the victims' authority over their own experiences. McKinnon contends that the behavior described can be classified as gaslighting from an "epistemic" perspective. She suggests that the offenders, driven by their own biased assessment, persistently impose their unfounded interpretation. In her essay on gaslighting, she gives an example of the trans community receiving support that is from a more privileged community. McKinnon emphasizes that when she uses the term trans, she refers to a "generic 'trans' denotes maximal inclusivity, including trans masculine people, agender people, and so on. The primary focus of this chapter, though, is on trans women's experiences" (McKinnon, 2017, p. 173). McKinnon argues that allies, despite having good intentions, engage in gaslighting, which leads to a sort of epistemic injustice, namely testimonial injustice as described by Fricker.

McKinnon explains that an ally is someone who supports and advocates for individuals from marginalized groups, such as a cisgender person supporting a trans person, a white person supporting a person of color, or a man supporting a woman. (McKinnon, 2017, p. 168). This, in my opinion, is an important representation showing how testimonial injustice can be connected to gaslighting. It highlights that gaslighting is not necessarily sexist, as previously suggested by Abramson, but rather can be used in a discriminatory manner, as shown by Fricker and McKinnon. McKinnon's example incorporates the epistemic dimensions discussed by Spear. However, McKinnon's essay will distinguish itself by portraying the perpetrator as well-intentioned yet still engaging in gaslighting and undermining the victim's testimonial justice.

McKinnon gives an account of an office environment where she follows Victoria, a transgender woman who identifies with she/her/hers pronouns. One of her coworkers, James, starts telling a story about Victoria at a department holiday party. He then mispronouns her five times, referring to Victoria with he/him/his pronouns. Victoria is upset by this and reaches out to a friend for support, only to have the following exchange occur:

Susan: "I'm sure you just misheard him: you're on edge and expect to hear mispronouncing. I just don't believe that James would do that. He won a university diversity award for his supporting queer issues, after all. Besides, he's been a supporter of yours in the past too. He really is your ally."

Victoria: "Well, he's done it a bunch of times in the past few months. The last time was two weeks ago in his office."

Susan: "You say that he's done it before, and maybe he has, but I've never heard him do it before" (McKinnon, 2017, p. 168).

McKinnon states that Susan has dismissed Victoria's testimony and cast doubt on the accuracy of her experiences with James. Susan suggests that any mispronouncing by

James towards Victoria are insignificant because she has never witnessed it herself, implying she prioritizes her own understanding of James and Victoria over Victoria's testimony, despite Victoria being the one insulted and having the uncomfortable experience with James.

Victoria's descriptions of her interactions with James constitute what we call testimony, and Susan denies it by diminishing Victoria's trustworthiness, which Fricker describes as testimonial injustice. According to McKinnon, Susan engages in this behavior by questioning Victoria's ideas of reality and implying that Victoria is more emotional because she is transgender, most likely due to her use of estrogen-based hormone replacement therapy (McKinnon, 2017, p.169). McKinnon makes the following point: it is a common belief in patriarchal societies that emotionality is at odds with rationality, and women in particular are targets of this belief (regardless of whether they are cis or trans), with their testimonies being discounted as a result. In addition to the various frameworks covered on gaslighting in order to understand what the phenomenon is, I believe it is equally important to understand the root of the association between gaslighting and women being predominantly victims, how patriarchy ties in with testimonial injustice, and why it is primarily women who fall victim to these preconceived notions of doubts about their perceptual reliability.

The many frameworks presented by researchers illustrate the manifestations of gaslighting in diverse settings. McKinnon discusses the influence of patriarchy on gaslighting themes, whereas Fricker shows how discriminatory ideas can lead to testimonial injustice, contributing to gaslighting. While social circumstances were extensively discussed, the medical setting was not addressed. In this dissertation, I will

explore gaslighting in a medical context and analyze how patriarchal influences contribute to discriminatory situations that lead to gaslighting of women.

These five frameworks converge on several key insights about gaslighting. Gaslighting erodes a person's autonomy regarding their experiences by imposing an external interpretation that induces skepticism about perceptions for which they should possess first-person authority (Barnes, 2023). Fricker's idea of testimonial injustice shows how bias can make people unfairly discount a speaker's testimony, and identity power shows whose voices are seen as credible. Gaslighting is not intrinsically sexist; however, it often transpires within gendered power dynamics, especially when women confront discriminatory conduct (Abramson, 2014). Moreover, intentional harm is not always necessary; even individuals with good intentions may perpetrate gaslighting by consistently undermining another person's authority over their own experiences, leading to epistemic injustice (McKinnon, 2017). These insights form the foundation for understanding how gaslighting manifests in medical contexts, which I examine in Chapter Two.

CHAPTER TWO

MEDICAL GASLIGHTING AND ITS ORIGIN

When examining the scenario within a medical context, we may observe the intricate dynamics of the connection between the individual responsible for causing harm (perpetrator) and the individual who has experienced harm (victim), as they pertain to the medical professional and the patient. The concept of medical gaslighting refers to the phenomenon whereby healthcare professionals, such as doctors or medical practitioners, inaccurately dismiss a patient's health issues, either by asserting that the patient is not genuinely unwell or by attributing their physical ailment or symptoms to psychological causes (Fraser, 2021.)

Identifying and detecting instances of medical gaslighting can pose challenges due to its intangible nature, which lacks a discernible physical manifestation. Individuals may fail to perceive instances of gaslighting comments due to their situational nature, resulting in a swift and unnoticed psychological manipulation. In addition to the aforementioned points made by Dr. Stern, it is possible that the perpetrator engaging in gaslighting may lack awareness of this manipulative behavior, while the victim may remain oblivious to the impact of such actions. This phenomenon has the potential to continue as a recurring pattern of manipulation and control, which poses significant challenges in terms of discontinuation. In order to formulate a resolution, it is paramount to establish a consensus regarding the precise nature of the issue at hand. Concerning medical gaslighting, the challenges that ensue in addressing this phenomenon revolve around the task of defining the act of medical gaslighting itself. In order to effectively

identify instances of medical gaslighting, it is extremely important to establish a clear and concise explanation of the phenomenon. Furthermore, it is essential to develop the ability to discern occurrences of medical gaslighting and recognize the individuals who are most commonly subjected to such experiences.

Furthermore, women have described experiencing gaslighting as a result of their healthcare providers dismissing the severity of their symptoms and attributing them to anxiety. Hale highlights the significant disparity in the experiences between men and women when interacting with their healthcare providers, underscoring the prevalence of such experiences among women as opposed to men. The occurrence of discriminatory rates of medical gaslighting can be attributed, in part, to cultural expectations and the influence of gender roles. The article produced by Northwell Health, a group of women's health experts ranging from researchers to gynecologist, osteopathic doctors, psychologists and many more, provides a concise summary of the role of gender in the process of diagnosing medical conditions.

Whether it's heart disease labeled as anxiety, an autoimmune disorder attributed to depression, or ovarian cysts chalked up to "normal period pain," many women's health issues are likely to be misdiagnosed or dismissed by doctors as something less critical. One study published in *Academic Emergency Medicine* found that women who went to the emergency room (ER) with severe stomach pain had to wait for almost 33% longer than men with the same symptoms (Katz Institute for Women's Health, n.d.)

However, the origin of the preconceived notion that women's illnesses and symptoms have been ascribed to their reproductive organs remains ambiguous.

Furthermore, it is worth examining the societal inclination to perpetuate the notion of women as the weaker sex. It is a prevalent occurrence to witness women consistently being attributed symptoms that they experience to anxiety or depression. However, the

underlying reasons for this phenomenon warrant investigation. The analysis of the core cause may be traced back to ancient Greece, which served as the foundation for medicine in a patriarchal culture throughout our history and continues to persist in contemporary times.

Patriarchy, meaning "the rule of father", but for women, this can mean many other things. Who are the women that this patriarchal society is impacting? In this paper I will go over what patriarchy means to women as well as what a woman means to a patriarchy. Elinor Cleghorn (2021) describes what warrants being a woman in *Unwell Women*. Cleghorn connects historical medicine with modern-day society and acknowledges the difference between biological sex and gender identity. As for the beginning of medicine, this was not always the case. Cleghorn explains further what a woman currently is and what a woman previously was

Of course, not all women have uteruses, and not all people who have uteruses, or who menstruate, are women. But medicine, historically, has insisted on conflating biological sex with gender identity. Over centuries, medical knowledge about the organs and systems marked "female" have been imbued with patriarchal notions of womanhood and femininity...We understand, today, that our biology does not determine our gender identity...Today, gender myths are ingrained as biases that negatively impact the care, treatment, and diagnosis of all people who identify as women. (Cleghorn, 2021, p. 13)

As Cleghorn would refer to it as a man-made world in her book "Unwell Women," most women found themselves having to navigate through a patriarchal society that often marginalized and oppressed them. But what does patriarchy mean for men? In the third century BCE, ancient philosopher Aristotle, described women to be "the female body as the inverse of the male body, with its genitalia 'turn'd outside in.'" (Cleghorn, 2021, p. 12). This perspective has been perpetuated throughout history and continues to shape societal attitudes toward gender roles and power dynamics. Women are not their

own entity. Women are perceived as "faulty, defective, deficient" as Cleghorn puts it, and we see this throughout medical histories (Cleghorn, 2021, p. 12).

Cleghorn did not independently create the perception of women in ancient Greece; Jean-Baptiste Bonnard (2014) examines this through ancient Greek medical literature, highlighting gender inequity and misconceptions. Bonnard is a historian who specializes in science history, ancient history, and the history of medicine. Bonnard discusses how ancient Greek physicians and biologists compared male and female bodies from early embryonic stages continuing through fetal development in his essay "Male and Female Bodies According to Ancient Greek Physicians". He emphasizes that "The difference between male and female bodies, whether described as radical (difference in nature) or relative (greater or lesser degree of perfection), is always presented in these texts by reference to the male body, compared with which the female body is thought of in terms of incompleteness or inversion" (Bonnard, 2014, p. 15). While Cleghorn and Bonnard use different terminologies, similarities can be found in phrases such as "turn'd outside in" and "incompleteness or inversion." Both researchers focus on the birth of medicine in ancient Greece and its representation in the medical literature known as the "Hippocratic Corpus." (Cleghorn, 2021, p. 12; Bonnard, 2014, p. 15).

The "Hippocratic Corpus" is considered to be one of the first books of science containing a wide variety of medical discourse explaining disease without blaming or insinuating the Gods (Cleghorn, 2021). It is a significant historical document that has shaped the field of medicine. The "Hippocratic Corpus" is attributed to the Greek physician Hippocrates, who is recognized as the father of medicine in the Classical Era of the fifth century BCE, he was the first physician to separate medicine from Greek

mythology and consider new theories that disease arose from a misalignment in the body.

Hippocrates was a serious man when it came to medicine with a strict set of values and rules:

he invented the patient case study, writing careful notes about the symptoms and course of a person's illness and prescribing herbal recipes as treatments. He vowed to treat all illnesses, in all people, to the best of his ability and to never abuse the body of any man or woman. Whether his patient was freeborn or enslaved, he promised to do no harm: Hippocrates's oath became the cornerstone of patient ethics, and it is still sworn by medical graduates today. (Cleghorn, 2021, p. 27)

The "Hippocratic Corpus" is so fundamental to the history of medicine that it's still acknowledged in today's modern society. This is the same "Hippocratic Corpus" that was created under the notion that women were defined by the uterus and that anything regarding their health was directly linked to this reproductive organ. This outdated belief has led to a lack of understanding and recognition of women's overall health and well-being. Cleghorn emphasizes that the period during which this was created is important, as she explains in *Unwell Women*:

The Hippocratic Corpus was written at a time when most women had few, if any, civil or human rights. In the patriarchal social order of ancient Greece, girls were the property of their fathers, and women of their husbands. They had no ownership over land, property, money, or even their own bodies. (Cleghorn, 2021, p. 27)

Women were looked down on when the first books of science were being constructed. Women's sole purpose was to give birth because women in this time period were constituted by their reproductive organs, the only thing that deemed them useful to men. This is the role patriarchy played when it came to women's healthcare, the rule of father deemed women unworthy of equality in politics, wealth, and education, therefore translating that to medicine (Cleghorn, 2021). Since men were the only doctors and

physicians in society it was their duty with the sacred rules of “Hippocratic Corpus” to figure out what ails a woman's body. This led to a lack of understanding and empathy towards women's health issues. Set in place was the predetermined notion that a woman's body is surrounding her uterus thus every disease and sickness was also attributed to her uterus. Dissecting a human cadaver was forbidden in Ancient Greece, this led to many inaccuracies regarding the anatomy of women (Staden, 1992). This lack of understanding contributed to the stigmatization and mistreatment of women's bodies in ancient Greece, Cleghorn mentions this in *Unwell Women*, explaining their logic as such:

Their understanding of female physiology decreed that women’s bodies were overly wet because they had too much blood. They came to this conclusion because women menstruate...Limited knowledge and prevailing social attitudes led to a concoction of theories about the influence of the uterus on every aspect of women’s health. Sometimes it was diseased; other times it caused diseases in different parts of the body, including the mind. It was both a channel and a vessel, and a woman was kept healthy if it was either releasing moisture or being filled with it. The cure for Hippocratic uterine pathologies, from the madness of suppressed menstruation to the horrors of womb suffocation, was as much social as it was medical: marriage, ideally by the age of fourteen, regular sex with one’s husband—who was usually around the age of thirty—and multiple pregnancies. (Cleghorn, 2021, p. 28)

With a localized focus on the womb, Cleghorn argues, men were hyper-fixated on contributing all medical efforts to "restore" its "natural state", if it's bleeding then fill it up with the "male seed", if a woman was convulsing and in an epileptic state then it must mean her womb has traveled up and past all her organs and was then suffocating her (Cleghorn, 2021, p. 62). Every aspect of a woman's health was dedicated to her womb, the same womb that was governed by men in a patriarchal society. The same patriarchal values that male physicians contributed to the “Hippocratic Corpus”, an "ancient" book of scientific values that is not so ancient. The Hippocratic oath is alive and well, viewed as an ethical code used by doctors to this day (Britannica, 2023). This sparks the

question, are women safe from suffering, medically speaking, are women safe from what most women suffered in the past under domineering patriarchal societies? Is science still profoundly influenced by the rule of father, if parts of the Hippocratic oath are still thriving what does that mean for the modern-day woman?

It is crucial to avoid the misconception that everything is negative and that the Hippocratic Corpus is too controlling in modern society, as this is not true. My primary objective in including patriarchy in this discussion is not to give up or suggest that there is no hope for women's health. Rather, I wish to highlight the imbalance and partial nature of the situation. Although some doctors still employ the Hippocratic Oath during their white coat ceremony, despite its abundance of medical misunderstandings and detrimental behaviors for women, nevertheless, it has contributed to medical progress in society. Despite misconceptions about women's health and anatomy in ancient Greece, there is evidence of women participating in medicine. "Agnodike and the Profession of Medicine" tells the story of Agnodice in early ancient Athens, who disguised herself as a man to practice medicine under gynecologist and physician Herophilus (King, 1986). Women were not allowed to practice medicine during this era, society only started to accept the concept of women practicing medicine once Agnodice's deception was revealed (King, 1986).

I want to highlight the path women had to go to start being involved in the field of medicine. It is intriguing that women were historically excluded from opportunities to become doctors and treat patients. Angodice was only caught because her colleagues suspected she had been seducing her female patients due to her remarkable effectiveness in healing them. In ancient Greece, it was more plausible for a male doctor, in this case

Angodice, to be accused of seducing her patients due to skepticism about her being a woman that had the ability to understand the female anatomy as a woman. After proving her gender and receiving support from her patients during the investigation, it was acknowledged that women could pursue a career in medicine (Jex-Blake, 1886, p. 13-14). Consequently, the patriarchal system permitted free-born women to study medicine (Jex-Blake, 1886, p. 13-14). This indicates that there is potential for improvement in women's health, even though the influence of patriarchy on social structures is beginning to affect the medical field. If a patriarchal society can persuade physicians, in ancient Greece, that women are incapable of practicing medicine, it raises questions about the impact on the Hippocratic Corpus.

Upon conducting a thorough examination of the environmental and sociological circumstances that influenced the development of Hippocrates' oath, it becomes evident that a significant number of women are experiencing significant suffering. The presence of a patriarchal system that upholds the Hippocratic oath as a significant factor in judicial proceedings, even while doctors are opposing violence against doctors, demonstrates the enduring relevance and significance of this oath (Indla & Radhika, 2019). This patriarchal derived oath still holds a place in modern medicine and is potentially harmful to women's rights, well-being, and existence. Research shows that “Women are driven to desperate measures in their attempts to conform to unrealistic physical expectations. These psychological issues lead to intense physical harm and can even prove fatal in extreme cases.” (Gupta et al., 2023).

1. Patriarchy Influences on Hysteria, Iatrogenesis, and Misogyny

The “Hippocratic Corpus” has been impacted by patriarchal ideologies, leading to the distortion of women's healthcare and the perpetuation of enduring consequences that persist in contemporary society. According to Cleghorn's account, “From classical medical theories about women’s diseases and the earliest whisperings of hysteria to the professionalization of gynecology, the birth of public health, and the development of biomedicine, patriarchal ideologies have clung insidiously to medical culture, practice, and knowledge” (Cleghorn, 2021, p. 23).

1.1 Hysteria

In addition to the enduring influence of patriarchy, it is important to acknowledge the historical significance of the “Hippocratic Corpus” on male physicians, particularly in relation to the introduction of the term "hysteria." This term originated from the Greek belief that this condition was specific to women and originated from disorders of the uterus. Hippocrates, Plato, and Aretaeus established a historical context by portraying the various impacts of hysteria-related disorders on the bodily and emotional well-being of women, according to Cleghorn (2021, p. 47). This analysis from a historical standpoint highlights the pervasive impact of patriarchal norms on women's health and the field of medicine in ancient societies. Although the word "hysteria" was not originally coined by ancient Greek physicians, its etymology from the Greek word *hysteria*, meaning uterus, serves as a poignant reminder of the pervasive gender biases that have influenced medical discourse over the course of history.

It is posited that in medieval history, a segment of males who adhere to extreme patriarchal norms may also exhibit a profound manifestation of misogyny, characterized

by an intense hatred towards women and girls. The behavior was encouraged and radicalized by the prevailing patriarchy of the time, which constantly marginalized women. This influence was so widespread that even women internalized many misogynistic beliefs. Men were predominantly scholars during this era, limiting the historical evidence available to what was published. Cleghorn highlights Francesco degli Stabili, a prominent physician in thirteenth-century Italy, as an influential physician exhibiting sexist tendencies. Stabili's significant impact on the advancement of medicine during this period is also acknowledged. Additionally, he was known as Cecco d'Ascoli, and in order to foster and propagate his animosity towards women among his peers and followers, d'Ascoli composed encyclopedic poetry pertaining to celestial and terrestrial matters. The verses selected by Cleghorn serve as a manifestation of his sentiments towards women: "Women's bodies are inferior to men's / they menstruate every month because / they are by nature imperfect beings" and "A woman has less faith than a wild beast / proud, greedy, stupid, crazy and aloof / a poison that infects the body's heart." (Cleghorn, 2021, p. 35).

Despite the origins of hysteria being rooted in impure motivations and its enduring negative consequences for women, it is important to acknowledge the inherent validity of the concept of hysteria. The genuine meaning of hysteria, as provided by the Merriam-Webster dictionary, pertains to "a psychoneurosis marked by emotional excitability and disturbances of the psychogenic, sensory, vasomotor, and visceral". This definition brings focus to some of the most captivating instances of widespread occurrences. In 2006, an outbreak occurred among teens in Portugal, which was commonly known as the "Soap Opera Virus" or the "Strawberries with Sugar" virus. This

outbreak caused significant disruption and perplexed researchers due to the absence of a discernible explanation. The authorities were unable to identify a specific infection that may be attributed to the many symptoms exhibited by these adolescents, which ranged from respiratory issues, disorientation, and skin rashes to the extent of requiring hospitalization. Ultimately, it was determined that these adolescents had exhibited identical symptoms to those portrayed on a widely watched television drama, "Strawberries with Sugar", leading to a phenomenon known as mass hysteria (Boissoneault, 2017).

Gaining an understanding of the origins of hysteria holds significant importance, as it may assist us in understanding why some medical professionals disregard symptoms experienced by women. This phenomenon is observed when medical professionals diminish a woman's experience of pain or her plea for assistance by attributing it solely to her perceived weakness and inclination for theatrics. Scholars and professionals argued long ago, the characterization of women as the embodiment of hysteria significantly amplifies the challenges associated with substantiating the authenticity of their symptoms, establishing the plausibility of their self-diagnosis, and dispelling any notions of hypochondria.

In the present discourse, Ashley Laderer (2023) elucidates the transformation of the terminology pertaining to hysteria, whereby the term "hysterical" has emerged as a derivative. Laderer expounds upon the historical diagnosis of hysteria, which encompassed a diverse array of physiological and psychological manifestations, spanning from emotional outbursts to amnesia, convulsions, and paralysis. Historically, it was commonly believed that the condition exclusively impacted individuals of the female

gender. Historically, men have been prone to categorize women as “hysterical” when they displayed behaviors, mental health issues, or physical symptoms that deviated from societal norms (Laderer, 2023). From an external perspective, it is evident that women in previous eras encountered challenges in contesting medical diagnoses of hysteria, striving to demonstrate that their symptoms were not solely attributable to their reproductive organs. Presently, women continue to face the task of substantiating the authenticity of their symptoms to medical professionals, endeavoring to dispel notions of exaggeration or hysteria.

1.2 Iatrogenesis

Iatrogenesis is another phenomenon that needs to be included when I aim to gain a deeper understanding of medical gaslighting. A brief background on the term iatrogenesis: It originates from the Greek language, specifically meaning "brought forth by the healer.". This encompasses the adverse effects that patients may encounter due to the interventions performed by healthcare practitioners. The noted side effects are sometimes referred to as adverse drug reactions (ADR) (Peer & Shabir, 2018) as to the World Health Organization (WHO), “Iatrogenesis is any noxious, unintended, and undesired effect of a drug, which occurs at doses used in humans for prophylaxis, diagnosis, or therapy.” (Peer & Shabir, 2018, p. 309). The aforementioned experts comprise a diverse group of healthcare professionals, including physicians, surgeons, psychiatrists, psychologists, therapists, and others (Davis, 2020). Iatrogenesis may occur either directly or indirectly as a result of the implementation or omission of medical measures. Medical gaslighting can be classified as a manifestation of iatrogenesis, as it indeed inflicts harm upon patients and originates from their healthcare providers. The

resemblance between these two terms becomes apparent, while medical gaslighting may or may not involve the use of deceptive tactics, iatrogenesis is not intentional. However, both can have a profound impact on a patient's mental and emotional well-being.

The topic of iatrogenesis has been a subject of ongoing discourse, albeit not widely embraced. In her publication titled "Sickness Unto Death: Medicine as Mythic, Necrophilic and Iatrogenic", Dr. Denise Donnell Connors (1980) undertakes a comprehensive analysis that draws upon multiple academic disciplines, such as sociology, philosophy, psychology, and political science. The primary objective of this examination is to explore the medical ramifications pertaining to women's health. According to Connors, conducting a thorough analysis of the profession of medicine is essential for effectively addressing the problems associated with the medicalization of society and the increasing evidence of iatrogenesis specifically affecting women. According to Connors, iatrogenesis pertains to occurrences of death and disease resulting from the interventions and practices of medical practitioners. The subsequent sections present the perspectives of several disciplines regarding the interrelationships between iatrogenesis and the mistreatment of women. We can employ Renee Dubos work, "Mirage of Health", reconsidered by Ian Tait to illustrate the sociological perspectives and norms that underpin medical practice.

complete and lasting freedom from disease is but a dream. The medical profession seems to have turned this dream into a nightmare. Instead of offering health, physicians offer medically induced paralysis, dependence on machinery, invasive diagnostic procedures ("invasive" procedures are distinguished from "noninvasive" procedures when in reality the distinction is between visible and invisible invasion), unnecessary surgery and medication—until the patient's torment eventually lies in not being able to die. (Tait, 1982, p. 485)

Tait (1982) examines the impact of medical intervention and the implementation of medical procedures recommended by healthcare practitioners, which aligns with the undesirable outcomes previously defined as iatrogenesis. The aforementioned negative consequences encompass the potential for dependence on pain medication, emotional and psychological dependence on medical devices, and unnecessary procedures leading to a prolonged need for physical rehabilitation. However, what are the specific ways in which women are adversely affected by this phenomenon? In her work, Connors delves deeper into the association between women and the topic at hand by including an additional perspective derived from a research investigation on the “Risk of Localized and Widespread Endometrial Cancer in Relation to Recent and Discontinued Use of Conjugated Estrogens”

For as long as the present system of patriarchal medicine has existed, women have been the primary targets of iatrogenesis. The so-called first wave of feminism crested in this country at the same time that the field of gynecology was receiving professional recognition. The "second wave of feminism" has coincided with an escalation of unnecessary and abusive gynecological intervention, including unnecessary surgery, prescription of controversial drugs (DES, Depo-Provera and birth control pills), sterilization abuse of black and third-world women, etc. (Connors, 1980, p. 41)

It is vital to comprehend the significant detrimental impact that physicians are exerting on women's reproductive capabilities and lifespan. Equally crucial is the analysis of society reactions to this issue and the degree to which it is being acknowledged within our environment. In a relevant study at the time, Connors acknowledges with commentary:

there is a refusal to acknowledge the evidence of medical morbidity, in this case, specifically, refusal to acknowledge the reality of estrogen-related deaths. As usual, we are told that there isn't enough evidence, that the link-up between drugs

and death has not been proved. Clearly, no matter how many women die, it still will not be proven to those who do not want to know. (Connors, 1980, p. 42)

This discussion aims to establish the historical prevalence of iatrogenesis, which has been observed since ancient times and has continued to be a topic of concern in contemporary society. In support of this assertion, I would like to present a scenario that exemplifies the occurrence of medical gaslighting, iatrogenesis, and the implicit incarnation of misogyny, which is further exacerbated by the historical patriarchal structure in ancient Greece. The following scenario given is by Shirley Davis for the Complex Post-Traumatic Stress Disorder Foundation:

You are a woman and go to the emergency room with a severe cough and the ER doctor listens intently at first and acts nice. However, the physician sees on your record that you have a mental health condition or that you have complained about this same problem before. Suddenly, the physician begins to act differently, perhaps growing curt with you or telling you nonsense such as you need to drink more water or lose weight and the cough will go away. You leave the hospital feeling ashamed and embarrassed with your self-esteem badly bruised. You feel deeply frustrated and a fool forever approaching a medical person for help in the first place. You also may question yourself and your perceptions asking yourself, "Is it all in my head?" You have been medically gaslighted and the doctor has committed iatrogenesis. (Davis, 2020)

The present scenario encompasses the phenomenon of medical gaslighting, the consequences of iatrogenesis, and the subliminal presence of misogyny that categorizes women as hysterical. The initial disregard of her symptoms and the presence of biased attitudes towards her medical history initiate the gaslighting treatment. The patient is currently reassessing her choices over getting medical care for a cough that the doctor deems as inconsequential. The initial recommendation of "increasing water intake or losing weight" can be perceived as a subpar prescription, indicating the development of a diagnostic process that may ultimately result in iatrogenic treatment (Davis, 2020). This

phenomenon can be interpreted as a gender-based microaggression, influenced by misogyny and stereotypes surrounding women's health issues, particularly those pertaining to weight and emotional well-being. Ultimately, the patient's departure from the hospital is characterized by the enduring effects of the manipulation that attributes her symptoms to psychological factors. This situation engenders a considerable sense of shame, potentially resulting in a reluctance to seek medical assistance in the future. Consequently, the patient's encounter with the healthcare system has left a lasting traumatizing impression.

1.3 Misogyny

Exploring the historical underpinnings of misogyny may provide predictable results, given the etymology of the term itself can be traced back to ancient Greece, a civilization that significantly influenced contemporary medical practices. The article titled "Misogyny, Feminism, and Sexual Harassment" in the *Industry Psychiatric Journal* provides a concise overview of the origins of misogyny and societal attitudes towards women during its inception.

The term "misogyny" is derived from the Ancient Greek word "mīsoḡuniā" which means hatred towards women. Misogyny has taken shape in multiple forms such as male privilege, patriarchy, gender discrimination, sexual harassment, belittling of women, violence against women, and sexual objectification.[1,2] The roots of misogyny can be traced back to ancient Greek mythology. According to Hesiod before women came into existence, men were coexisting peacefully as companions to Gods until Prometheus decided to steal the secret of fire from the God which angered Zeus. Zeus punished mankind with an evil thing for their delight called Pandora, the first woman who carried a box which unleashed all evils such as labor, sickness, old age, and death. (Chaudhury et al., 2017, p.111)

Despite Hippocrates' significant contributions to the field of science, particularly in his recognition that sickness could be attributed to bodily imbalances rather than the

Gods intervention, it is important to acknowledge that he held certain beliefs that are regarded as misogynistic and offensive from a contemporary perspective. For instance, he subscribed to the notion that sickness in women was linked to their reproductive organs, specifically the womb, which he believed could become tainted and required the introduction of male seed to alleviate ailments. Regardless of departing from ascribing illnesses to divine causes, the renowned figure known as "the father of medicine" maintained specific gender biases and beliefs pertaining to the female anatomy. This observation suggests that while Hippocrates made significant advancements in the realm of medical knowledge, his viewpoints were nonetheless influenced by the prevalent societal norms and biases of his time. The discussion here highlights the persistence of misogynistic notions in contemporary culture, despite the significant achievements in modern science and the lack of abandonment of medical myths and fallacies. It is noteworthy to acknowledge that contemporary culture continues to exhibit patriarchal characteristics, hence drawing parallels to the ancient Greek patriarchs in terms of perpetuating stereotypes and gender biases against women.

The interconnectedness of hysteria, iatrogenesis, and misogynistic narratives lies in the underlying assumption of the inherent propensity of women to experience pain, which further perpetuates concealed forms of misogyny within the realm of contemporary women's healthcare. Medical professionals may sometimes dismiss women's pain as being overly emotional or "hysterical," and may even recommend weight loss as a solution, which can lead to a delay in receiving appropriate medical attention and treatment. This can have long-lasting negative effects on the patient's health, creating a situation of iatrogenesis and potentially impacting their overall well-

being. The field of medical sciences, despite its persistent gender bias, continues to uphold the belief that women should endure significant levels of pain, particularly during childbirth, since it is perceived as a natural means to promote women's overall well-being.

In the delivery room, where women performed their sacred duty of bringing new life into the world, women were still suffering because of medicine's misogynistic insistence on the necessity of pain...“ The “torture of bearing children” was a punishment forced on women in a society that held the female sex responsible for all the world's sin. Medicine then claimed that obeying the “natural law” of childbearing was the only way for women to obtain “health and happiness. (Cleghorn 2021, p. 130)

The Retrievals Podcast

An example of one medical practice that did not take women's pain experience seriously is in the podcast titled "The Retrievals", which delves into the firsthand accounts of women who underwent egg retrieval procedures at Yale University's fertility clinic during the year 2020. During this period, a nurse engaged in the unlawful act of substituting vials containing opioid pain medicine with saline solution. As a consequence, the women undergo the complete process of egg retrieval without the administration of pain medication, leading to the women experiencing intense and distressing agony. The podcast showcases several individuals who share their own medical narratives regarding the experience of being disregarded. These accounts shed light on the emotional impact of having their credibility questioned, as well as the resulting self-doubt in their perception of their own experiences.

During the post-operative discussion, a patient named Allison recounted her conversation with the nurse who possessed knowledge regarding the anticipated level of pain Allison would experience. This knowledge was based on the nurse's involvement in Allison's illicit getting of fentanyl and subsequent administration of saline solution.

Next thing I remember is waking up in the recovery room. And I was in quite a bit of pain, a lot more pain than I ever would have expected for an egg retrieval. And Donna was my nurse. And I remember asking her if it's normal to be in that much pain. And she looked at me and said, "Yes." (Burton, 2023)

Allison was promptly subjected to gaslighting by her nurse, Donna, who possessed knowledge that Allison's current level of extreme pain was not typical. The primary factor enabling Donna to persist in this behavior for an extended duration was the fact that even though, "Some of the patients screamed out in the procedure room. Others called the clinic from home to report pain in the hours that followed.", the medical personnel's assumption that these women were either encountering a typical post-procedural discomfort displayed a deficiency in empathetic concern (Burton, 2023). According to another patient, Esha, she expressed her dissatisfaction with the lack of empathy displayed by her physician in response to her distressing encounter during her postpartum visit, stating, "After I delivered, I went in for my six-week postpartum visit to meet with my doctor. And it somehow came up in conversation that I was part of this suit that was going on. And she looked at me and she said: "Well, what's the big deal? I mean, you ended up pregnant." (Burton, 2023). This is one example of how the absence of empathy and consideration for women's pain and suffering is deeply ingrained within our societal framework of patriarchy and misogyny, to the extent that even female healthcare professionals exhibit harmful biases towards women.

Despite the clinic establishing an anticipated level of moderate discomfort or pain, they persisted in disregarding the women's reports of experiencing severe suffering. The podcast host, Susan Burton (2023), provided a firsthand account of the patients' experiences and elucidated her perspective on the underlying reasons behind the neglect of women's pain symptoms.

One of the things that was so interesting about this series was the way that pain had been normalized around this egg retrieval procedure at this clinic. I came to see the fact that doctors and nurses at this clinic almost expected that patients would feel some pain. That was one of the reasons that the nurse was able to hide what she was doing for so long. And when we talk about pain being ignored, we often think of like going to a doctor and saying, I'm feeling this pain and the doctor dismissing us. But not treating pain adequately in the first place is another way of dismissing pain, another way of saying, it doesn't matter. (Burton, 2023)

If an examination were conducted on the long-term consequences of this particular pain and the failure to recognize the suffering endured by these women, it is probable that iatrogenesis would emerge as a contributing factor. The catalysts in these scenarios extend beyond mere dismissal by healthcare professionals. Each time these women encounter such experiences, they are left with enduring memories and traumatic responses, stemming from the denial of their agency and the deprivation of their bodily autonomy. The individuals in question had experienced a distressing episode in their lives when they saw a sense of detachment from their fertility clinic, as their expressions of discomfort were either disregarded or, in some instances, challenged.

While there have been significant advancements in healthcare since ancient Greece, modern-day society still witnesses the mistreatment of women through various forms of abuse. Gender-based microaggressions are among the ways in which such

mistreatment is perpetuated. The statement "You're prettier when you smile" might be identified as a conventional gender microaggression directed at women. According to Algner and Lorenz (2022), the phenomenon under discussion serves to promote detrimental gender stereotypes and sustain discriminatory practices. What are the implications when it begins to permeate deliberately into areas such as women's healthcare and overall welfare? The aforementioned phenomenon may result in a systematic neglect of the rights and needs of the individuals in question. The language used in various contexts ranges from expressions such as "thank you, sweetheart" or "you throw like a girl" to instances where healthcare specialists assert that "she's too hysterical" or "women tend to exaggerate their symptoms." The occurrence wherein healthcare providers employ direct and hurtful language to ignore or discredit an individual's views and concerns is sometimes referred to as a pragmatic act.

2. What is a pragmatic act? Defining Pragmatics

A pragmatic act refers to a deliberate action that is executed with the intention of achieving a desired outcome, often employing subtle or implicit meanings. According to Jacob Mey's (2001) work titled "Pragmatics: An Introduction", pragmatic acts refer to the deliberate and strategic use of language with the aim of accomplishing particular objectives. The process can encompass the manipulation of the contextual framework, tone, and substance of language in order to effectively communicate a specific message. The topic of pragmatics has been a subject of scholarly discussion for a considerable period of time, as evidenced by the establishment of international conferences beginning in Viareggio in 1985 and the ongoing activities of the International Pragmatics Association (IPrA) (Mey, 2001). Discussions pertaining to the delineation of pragmatics

arise when considering the application of pragmatics to acts of manipulation and imperceptible forms of intimidation. The delineation of pragmatics is a multifaceted and continual discourse, nevertheless it is imperative to grasp the intricacies of pragmatics to proficiently employ it in diverse settings. Mey explains:

Unfortunately, the definitions that have been offered...do not delimit pragmatics either clearly and neatly, or to everybody's satisfaction. Many authors confine themselves to a strictly linguistically oriented definition...alternatively they resort to a definition that, while incorporating as much societal context as possible, necessarily remains vague as regards the relation between pragmatics and the other areas of linguistics. (Mey, 2001, p.7)

The other areas of linguistics that Mey is referring to are: "semanticism (pragmatics inside semantics), pragmaticism (semantics inside pragmatics), and complementarism (semantics and pragmatics complement each other, but are otherwise independent areas of research)" (Mey, 2001, p. 7).

It is noteworthy to acknowledge that the concept of pragmaticism originated within the field of linguistics and was initially delineated only through a "syntax-only" framework. However, the discourse surrounding a novel paradigm of the language user was subsequently initiated by philosophers (Mey, 2001). Within the framework of semantic structure, it is now possible to precisely delineate speech activities. The emergence of this novel paradigm has facilitated a more intricate comprehension of language and its function in influencing human communication. In summary, the concept of words possessing significance based on their syntax and semantics has undergone development. In contrast to a word's veracity being contingent upon its definition or syntactic position, the semantic value of a word is presently ascertained by the contextual

surroundings in which it is employed. The context is acknowledged as the "active pragmatic character" of the language user (Mey, 2001, p.7).

This implies that the semantic interpretation of a term is not static but rather contingent upon the contextual circumstances in which it is employed. This leads us to the topic of gender-based microaggressions within a patriarchal environment.

3. What is gender-based microaggression?

Firstly, it is key to deconstruct the concept of a microaggression. As to the definition provided by the Merriam-Webster Dictionary, a microaggression refers to a remark or behavior that discreetly and frequently without conscious awareness or deliberate aim, conveys a prejudiced stance towards an individual belonging to a marginalized group, such as a racial minority. An illustration of a microaggression targeting individuals from racial minority groups can be observed when individuals who visually appear as minorities are inquired about their country of origin or place of birth. Despite being a citizen born in the United States, individuals of certain appearances are often automatically presumed to be non-natives of the country. According to Wiley and Sons (2010), such behavior has the potential to be degrading and may result in the individual feeling disconnected from their native country.

The notion of a gender-based microaggression bears resemblance to the manifestation of discrimination directed at an individual's gender. According to the Royal Pharmacy Society, gender-related microaggressions can be categorized as a manifestation of discriminatory behavior and sexism, microaggressions, which are seemingly innocuous infractions, encompass purposeful or unintentional statements or behaviors

that are aimed towards individuals belonging to marginalized groups, hence conveying disrespect and injustice. It is worth noting that women frequently encounter such occurrences.

The previously mentioned expressions, "you look prettier when you smile" and "thank you, sweetheart," may be perceived as affectionate and complimentary based on the connotations associated with the terms prettier and sweetheart. Upon deconstructing the active pragmatic character present in this context, one might discern elements suggestive of condescension and the reduction of individuals to objects, alluding to gender-based microaggressions. The pragmatic actions that occur regularly represent only superficial interventions in the challenges that women encounter in their everyday lives. Gender-based microaggressions extend beyond mere interpersonal exchanges of trivial remarks, since they exert a substantial influence on women's healthcare (Periyakoil et al., 2020, p. 451).

The research investigation conducted across both private and public medical schools revealed that female individuals experienced a higher incidence of microaggressions in comparison to their male counterparts. The educational institutions examined in this research encompassed the Stanford University School of Medicine, University of Rochester School of Medicine, Harvard Medical School, and Medical University of South Carolina. According to the study conducted by Periyakoil, the research involved the analysis of a total of 68 videos that portrayed instances of microaggressions, along with an additional set of 34 control videos for comparison purposes. The videos were displayed in a random manner. According to the research study, the frequency of gender-based microaggressions experienced by women was found

to be significantly greater compared to men in 33 out of the 34 videos analyzed. However, no significant gender disparities were observed in the control videos (Periyakoil et al., 2020, p. 451- 452).

Despite the fact that the research was conducted within esteemed medical institutions, the results indicate that gender microaggressions are neither contingent upon the intellectual capacity of the healthcare professional nor are they confined to a particular geographical setting. Medical schools and hospital faculty are often regarded as institutions that attract individuals with exceptional intellectual capabilities and a robust ethical compass. The occurrence of gender microaggressions towards women who hold genuine membership in these facilities serves as evidence that microaggressions can manifest in any setting. An additional observation that may be made is that this study defined the microaggressions into six distinct themes: "encountering sexism, encountering pregnancy- and child care–related bias, having abilities underestimated, encountering sexually inappropriate comments, being relegated to mundane tasks, and feeling excluded/marginalized." (Periyakoil et al., 2020, p. 450). These findings highlight the pervasive nature of gender microaggressions and their alignment with patriarchal norms.

Gender-based microaggressions exemplify the detrimental effects of pragmatic acts. Furthermore, this observation highlights the inherent difficulty in identifying pragmatic acts, as they often go unnoticed. After careful examination of the preceding arguments, it is evident that instances of mistreatment directed against women, such as gender-based microaggressions and the “Hippocratic Corpus”, have been observed from ancient times within patriarchal civilizations and continue to endure in modern society. It

has been determined that women are more susceptible to experiencing detrimental pragmatic actions, primarily due to men's tendency to uphold power dynamics in relationships as a result of persistent patriarchal structures. This prompts inquiry into the consequences of a pragmatic act taking place within a medical context. The inherent flexibility of pragmatic acts is evident in its capacity to exert influence in various contexts. Pragmatic acts within an office environment have the potential to impede the growth and acknowledgment of women, hindering their professional advancement and acknowledgement of accomplishments. Similarly, pragmatic acts in academic and research settings can serve as barriers, limiting women's access to various opportunities.

4. The ramifications when a pragmatic act is observed within a medical context.

The consequences now extend beyond frustrations and hurdles for women, spanning to the matters of life and death. The phenomenon can be referred to as medical gaslighting. The present discourse revolves around the extent to which patriarchal pragmaticism influences the recognition, or lack thereof, of women as being particularly endangered to medical mistreatment, manipulation, and neglect in relation to their overall health and well-being. This phenomenon is commonly referred to as medical gaslighting.

According to a recent poll conducted by Mira Fertility, 72% of millennial women in the United States had a sense of being medically gaslighted by their medical professionals (Hale, 2023). The survey, which involved 2,000 adult participants, sheds light on the perceptions and experiences of this particular demographic. A comprehensive analysis of the survey data reveals that a majority of women, namely over 65%,

expressed a perception that their healthcare providers exhibited a tendency to overlook their concerns by dismissing their symptoms and disregarding the severity of those symptoms (Hale, 2023). Moreover, a majority of the female participants in the survey, specifically two-thirds, reported receiving a diagnosis from their healthcare providers, attributing their symptoms to stress. Consequently, this misdiagnosis resulted in inadequate medical attention and treatment. Furthermore, it was shown that almost 50% of women were advised that their problems may be alleviated simply by adjusting their body weight. This observation reaffirms the necessity for implementing more comprehensive and sophisticated strategies for tackling women's health concerns.

Additionally, the study proceeds to document the factors that other minority groups saw as influencing the extent of medical gaslighting experienced by them. The findings indicate that a significant proportion of female participants (35%) claimed that their encounters with medical gaslighting were exacerbated by their gender, a rate that is twice as high as that reported by male patients (16%) (Hale, 2023). Furthermore, the participants made reference to factors such as race, ethnicity, identity, and sexual orientation, in addition to gender. This study was written by Shelby Hale (2023) and medically reviewed by Katerina Shkodzik, M.D., OB-GYN.

The theoretical framework pertaining to gaslighting has recently been subject to criticism by a collective of psychologists. In their scholarly paper titled "You Think I'm Insane: An Integrative Review and Novel Theoretical Framework for Studying the Phenomenon of Gaslighting," the collaborative group stipulates that medical gaslighting can be classified as a kind of emotional abuse, as it has the capacity to inflict direct emotional and psychological distress. The authors provided additional clarification,

"Gaslighting is a form of psychological manipulation that causes a victim to doubt their sense of reality, usually leading to a loss of agency (i.e., confidence and sense of self) and emotional and mental instability." (Klein et al., 2022, p. 2)

The Scientific Advisory Board noted in their most recent medical evaluation in 2017 that psychological abuse is particularly difficult to identify. The failure to recognize medical gaslighting can have serious consequences that endanger an individual's life, including the escalation of anxiety and the erosion of confidence in one's own perception of reality. As suggested in Theo Dorpat's *Gaslighting, the Double Whammy, Interrogation, and Other Methods of Covert Control in Psychotherapy and Analysis*: "Gaslighting often evokes disturbing emotions, low self-esteem, and cognitive dyscontrol by causing the individual to question his own abilities for thinking, perceiving, and reality testing. Along with the emergence of self-doubt and diminished self-esteem, they also may develop confusion, anxiety, depression, and in a few cases, psychosis." (Dorpat, 1996, p. 33-34)

According to Dorpat's (1996) analysis, the symptoms listed above can have a substantial impact on an individual's overall well-being and their capacity to engage in routine activities. Long-term anxiety and depression have the potential to induce physiological changes in the brain. Dr. Michael Amiel has observed that depression, in particular, can lead to an increase in cortisol levels within the hippocampus, hindering the neurogenesis process. The atrophy of neural networks is intricately linked to the diminished functionality of the affected region. In addition to anxiety, research has revealed that pathological anxiety and chronic stress have detrimental effects on the structure and functioning of the hippocampus and prefrontal cortex. These effects may

contribute to an elevated susceptibility to neuropsychiatric disorders such as depression and dementia (Mah, 2016).

Despite the significance of this topic, there appears to be a significant disparity between the frequency of experiences and the level of research dedicated to it. The discussion surrounding medical gaslighting is sometimes considered a taboo topic, particularly due to the greater prevalence experienced by women compared to men (Femtech Insider, 2023). The phenomenon of medical gaslighting, characterized by the minimization of women's feelings and distress by healthcare practitioners, elicits a deep sense of indignation and outrage (Pollock, 2023). According to Weckesser (2023), empirical research suggests that physicians have a tendency to interpret women's pain as intrinsic and hence neglect to give it adequate attention. The persistent impact of the ideas given in the “Hippocratic Corpus” is evident in the ongoing endorsement among medical professionals of the belief that pain experienced by women is an inherent outcome of the existence of the uterus. As mentioned, failure to address untreated symptoms might result in the emergence of enduring health difficulties, encompassing significant psychological and emotional determinants stemming from their disregard and inadequate consideration.

The reliance on conversations alone is no longer sufficient; there is an urgent need for appropriate insight in the issue of women experiencing decline in their worth as individuals because of medical gaslighting. It is imperative to furnish individuals with the requisite assistance and resources to surmount these obstacles and restore their sense of self-esteem. With this dissertation, I aim to contribute to that.

CHAPTER THREE

LITERATURE on PATIENT EXPERIENCES with BEING GASLIGHT in a MEDICAL CONTEXT

In her article, Stephanie Booth (2018) examines several strategies aimed at mitigating gender-based disparities in medical care. Booth examines many cases of gender-based medical gaslighting, elucidating the experiences encountered. Booth emphasizes the need of recognizing such occurrences and provides strategies for mitigating and confronting gaslighting. Booth delves into the experiences of Deborah J. Cohan as she navigates her interactions with her primary care physician. Cohan was enduring severe agony and suffering in her abdominal region, to such an extent that she was unable to maintain an upright position or engage in prolonged standing. Furthermore, she experienced discomfort whenever she consumed food or engaged in excretory activities. Cohan experienced insomnia and persistent anxiety for her well-being due to her deteriorating health. During the consultation with her physician, she was abruptly dismissed and advised to seek pain medication and chiropractic treatment. Cohan's physician exacerbated the situation by dismissing her belief that she required a consultation with a gynecologist. The doctor adamantly asserted that Cohan lacked knowledge on the topic and expressed unwavering confidence in the efficacy of the proposed treatment plan, which included heat, ice, rest, and further medications.

The contrast between contemporary medical practices and the treatment of female patients by physicians during ancient Greece is a subject of considerable interest. It is

apparent and conspicuous that Cohan's expresses skepticism regarding her personal judgment of her own well-being. It is sometimes asserted that physicians possess superior knowledge, but to what extent are they truly acquainted with an individual's body compared to the individual themselves? Cohan, who has resided within her physical form during her whole existence, has been encountering severe deviations from the usual. However, even these conspicuous irregularities fail to persuade a medical professional of the validity of her subjective perspectives. At this juncture, the emergence of uncertainty within a patient gradually infiltrates their cognitive processes. Cohan experiences a growing inclination to question the accuracy of her perception of pain, pondering whether it is indeed an irrational feeling originating only within her consciousness. The strategy mentioned above is frequently employed towards patients, particularly those who identify as women, in order to undermine their self-assurance with the objective of silencing them.

The intensity of the agony escalated to such an extent that Cohan sought medical attention in the emergency room, where she subsequently received a secondary diagnosis of "uterine fibroids," which refers to benign tumors that develop within the uterus. Cohan had a combination of astonishment and profound disappointment upon receiving the diagnosis, primarily stemming from the absence of her uterus. Further adding to her distress was the undeniable fact that her uterus had been surgically removed at the same hospital hardly a year prior. Once again, the medical practitioners expressed their firm belief that Cohan's assertions were incorrect. They pointed out that not only was this particular treatment well-documented in the hospital records, but they also attempted to persuade Cohan that they possessed a greater understanding of her medical background

than she did herself. Consequently, this led her to doubt her own vision of reality. The realization that even the medical records themselves do not possess inherent persuasive power is evident. Despite the doctors having documented these records, they were insufficient to convince them of their own fallibility and the patient's accuracy. Cohan observed an unmistakable pattern in her experiences, wherein her symptoms and excruciating pain were initially disregarded, and subsequently, her medical records were not accorded due credibility. The medical practitioners expressed skepticism, suggesting that she may have misinterpreted her condition and potentially confused it with a different medical treatment. She began to recognize the emerging realization that the speaker's identity holds greater significance than the content of their speech.

The healthcare providers at the emergency room persisted in proposing a diagnosis of uterine fibroids, so extending the diagnostic process and impeding the accurate determination of her medical condition. The doctors seeing Cohan believed that her condition is unlikely to cause significant harm to her overall health. However, the actuality was somewhat more serious. The participation of Cohan's obstetrician-gynecologist was essential in order to permit a thorough diagnostic that leads to more significant results. Cohan's diagnosis unveiled the existence of a medical condition referred to as "ovarian torsion," characterized by the abnormal twisting of the ovaries from their typical anatomical orientation. Cohan's diagnosis exemplifies a case of iatrogenesis occurring in real-time, when the patient's medical treatment has led to a decline in their health. This specific illness is commonly recognized as a medical emergency and, if not expeditiously attended to, can result in the necrosis of ovarian tissue and have detrimental effects on an individual's reproductive capacity. Cohan's

relief from suffering was contingent upon the intervention of her obstetrician-gynecologist (OBGYN). The sole recourse for addressing ovarian torsion is surgical intervention. Unfortunately, Cohan endured a prolonged period without medical attention due to her physicians' gender biases, as they erroneously attributed her symptoms and ailment to her uterus. There are numerous underlying indications of misogyny reminiscent of ancient Greece, as evidenced by the persistent attribution of a woman's ailments to her uterus. The patriarchal belief in question is considered to be a core tenet that has persisted within society without significant abatement.

Consider the potential consequences that Cohan might have faced had her obstetrician-gynecologist not intervened to protect her bodily autonomy. The repercussions of such a scenario could have been difficult to fathom. The prioritization of patients' well-being and the advocacy for their rights are imperative responsibilities for healthcare personnel in order to safeguard their safety and overall welfare. Stephanie Booth establishes a connection between these aforementioned concerns and the contemporary "Me Too" movement. She highlights the impact of the #MeToo movement in shedding light on allegations of sexual harassment and assault, while also drawing attention to an additional disconcerting gender-related transgression: the tendency of healthcare professionals to occasionally disregard, inadequately address, or incorrectly diagnose women's health matters. Booth also incorporates the insights of G. Thomas Ruiz, MD, the lead OB-GYN at Memorial Care Orange Coast, who addresses the issue of gender-based biases among physicians against women. Undoubtedly, many gynecological illnesses, such as endometriosis, pose significant challenges in terms of accurate diagnosis. However, it is not solely limited to matters of women's health that

certain healthcare experts tend to diminish in importance. According to a study published in the journal *Intensive Care Medicine* in April 2021, there exists a disparity in the provision of intensive care unit (ICU) therapy for women, irrespective of the severity of their underlying medical conditions. The research revealed that there was a notable prevalence of underutilization of intensive care unit (ICU) services among females aged below 45 years.

A study published in the September 2021 issue of *Clinics in Chest Medicine* presents findings indicating that male patients demonstrate greater rates of admission to the intensive care unit (ICU) and consumption of its resources as compared to female patients. The research findings also indicate that this phenomena is similarly found within the wider medical system, as men, particularly those in younger age groups, demonstrate a greater consumption of hospital services and are more susceptible to involvement in accidents in comparison to women. According to Erin Jackson, a healthcare attorney and the founder of Inspire Santé, a nonprofit organization dedicated to addressing pelvic pain, "Because of the ubiquity of the message—that pain is a normal part of womanhood or girlhood—we have a systemic, societal problem where we all, doctors included, aren't good at sorting out the normal from the abnormal for women's health,". Consequently, this systemic problem hampers our collective ability, including that of medical professionals, to effectively discern between normal and abnormal manifestations of women's health. Jackson goes on to elaborate on the notion that women's genuine grievances regarding symptoms or illnesses are often dismissed as trivial, and there exists a lack of confidence in women's ability to possess authoritative knowledge about their own bodily experiences and autonomy, "Women's veracious complaints of symptoms or

illness may be labeled whiny, and we don't trust women to be the experts in their bodies' experiences and autonomy."

The matter under consideration transcends the mere utilization of bad terminology that carries negative connotations. The phenomenon of medical gaslighting, despite its ostensibly innocuous conversational character, can elicit significant distress and unease. In the section titled "Being Told That I Was Fine Was Terrifying" within Booth's work delves into a more extensive examination of Erin Jackson's prior interactions with healthcare providers. Over the course of ten years, healthcare practitioners continually provided Jackson with reassurances that her pelvic pain, which was characterized by symptoms of "stabbing, burning, and tingling," did not necessitate any cause for alarm. As per Jackson's account, she encountered distressing symptoms such as cramps, vulvar puffiness, and lower back discomfort. Nevertheless, she did not get any medical diagnosis or referral for psychological assessment. "Being told I was fine was terrifying." Once again, parallels emerge between the experiences of Cohan and Jackson. Both individuals endured excruciating pelvic pain and encountered dismissive attitudes from their healthcare providers, who attributed their symptoms to normal menstrual cycles or the natural functioning of the uterus.

In a state of urgency, Jackson sought counsel from a substantial number of medical professionals, "double-digit". Numerous others asserted that her physical condition was in optimal state, reassuring her that her discomfort was just attributed to severe menstrual cycles, or advising her to enhance her stress management techniques. Jackson expressed that she experienced an unprecedented level of fear during her visit to the emergency room. She perceived that due to the doctor's lack of attentiveness, her

medical concerns were not adequately addressed, leaving her with a sense of helplessness and limited alternatives for seeking medical assistance. Following the successful identification of a healthcare professional who acknowledged the legitimacy of her suffering and subsequently referred her to a specialist in pelvic floor physical therapy, she is felt a complete alleviation of pain. It is extremely unfortunate that in order to finally be heard, Jackson needed to seek over ten different doctors opinions.

The feasibility of adopting such a self-focused approach is not universally accessible, as it relies on fortuitous circumstances such as possessing insurance coverage that encompasses multiple healthcare providers, having convenient transportation options to reach various medical facilities, and maintaining a stable income and career that allows for regular scheduling of doctor appointments. The paramount and urgent concern associated with the utilization of a strategy, including multiple consultations with physicians until one feels adequately understood, pertains to the extent of time that may be allocated without jeopardizing one's overall well-being. Similar to the narrative presented by Cohan, she experienced severe discomfort that hindered her from scheduling appointments at intervals spanning an extended duration. Consequently, Cohan lacked the opportunity to deliberate and select the most suitable healthcare professional, particularly given the exigency of her required procedure, which could no longer be postponed. This prompts an additional inquiry: what are the implications for women in lower socioeconomic circumstances when their healthcare provider fails to heed their concerns? How can these individuals effectively address instances of medical gaslighting, considering potential constraints such as limited time availability and lack of medical insurance assistance?

The article by Booth explores several strategies and methodologies that women might employ to prevent falling victim to gaslighting, as well as effective approaches to counteract such manipulation when encountered. Booth initially asserts the importance of establishing a strong rapport with a healthcare provider. You should not be looking for someone you want to have drinks with. That is not the goal, according to Dr. Bohn, the objective is “want someone who is honest and direct” However, it is desirable to have an individual who possesses the qualities of honesty and directness, as well as actively engages in attentive listening during conversations. Identifying instances of gaslighting in real-time can be particularly challenging; nonetheless, Booth (2018) provides valuable insights and strategies to preemptively mitigate its occurrence. Both Cohan and Jackson, as previously indicated, received accurate diagnoses only after being endorsed by a trusted physician with whom they had a strong rapport. Furthermore, Booth emphasizes the need of prioritizing your priorities. Dr. Bohn emphasized that physicians experience significant levels of pressure in their professional roles. There is an excessive number of patients in care, while the available time to attend to them is insufficient. If a patient arrives at a scheduled session with a comprehensive list of 15 inquiries, healthcare practitioners may have challenges in addressing each query within the allotted time frame. Instead, direct your attention towards a select number of your most pressing worries. And with some facilities it is possible to submit your inquiries in advance, and appropriate measures will be taken to address your issues.

Finally, in spite of the obstacles encountered in the context of gaslighting, Booth advocates for women to express their agency and advocate for their own interests. Dr. Ruiz suggests that individuals who harbor skepticism towards an initial viewpoint should

consider seeking a second perspective. In specific circumstances, it may be imperative to assertively solicit a consultation with a healthcare practitioner who possesses expertise in the field of women's health. Furthermore, it is not imperative to entirely abstain from male healthcare providers. Dr. Ruiz asserts that the proportion of insensitive female obstetrician-gynecologists (OB-GYNs) is equivalent to that of their male counterparts. The primary objective is to identify a healthcare professional that exemplifies the ability to actively listen and displays authentic empathy towards your concerns. However, it is of equal significance to highlight the perpetuation of misogynistic behaviors within the healthcare industry. Engaging in discourse regarding this matter serves to enhance awareness and provide women with the necessary knowledge to anticipate and navigate such situations.

Another case of medical gaslighting in women:

Hypermobility Ehlers-Danlos Syndrome (hEDS) is a complex condition that exerts its influence on multiple physiological systems by affecting the integrity of connective tissues. This condition is characterized by the presence of chronic pain and fatigue, along with a variety of neurological, cardiovascular, and gastrointestinal symptoms. The aforementioned attributes contribute to the bias that many professionals harbor towards individuals with hypermobile Ehlers-Danlos syndrome (hEDS), leading them to perceive these individuals as "difficult patients."

A background information on Halverson's (2021) and Berglund's (2010) prior investigation concerning the obstacles encountered by patients with hEDS in obtaining a diagnosis, a significant number of participants in interviews expressed acute

psychological distress arising from the perceived hostility and lack of interest exhibited by their healthcare providers. The ethical implications of trauma arising from clinical visits were a cause for concern, as it raised medical apprehensions due to the potential consequences of trauma symptoms, such as nonadherence (Kronish et al., 2012), psychiatric comorbidities (Kessler, 1995), and a decline in overall health status (Ouimette et al., 2004).

According to Halverson (2023), those who have been diagnosed with hypermobile Ehlers Danlos Syndrome frequently experience psychological suffering as a result of the seeming hostility and lack of participation displayed by their clinicians. It is very common for clinicians who are unable to see any issues with a patient's complaints to instantly conclude that the patient is either lying or exaggerating their symptoms. Women who are experiencing symptoms connected with discomfort, often pain that can be attributed to their uterus, are more likely to experience this treatment as seen in the stories associated with Cohan and Jackson mentioned earlier. However, hEDS is not a sickness that exclusively affects women; therefore, it is fascinating to observe how medical professionals perceive a condition that is as real as it is invisible to both women and men with the same symptoms. Within the scope of the research carried out by Halverson (2023), a total of twenty-six individuals were selected for participation and then interviewed in greater detail. The study's major purpose was to get an understanding of the factors that contribute to the development of trauma and to investigate the many approaches that could be utilized for the management of trauma in real-world situations. According to Halverson (2023), it has been demonstrated that patients lose trust in both the healthcare staff and the healthcare system when they have a string of negative events

that have contributed to the accumulation of these experiences. Additionally, this can play a role in the development of acute anxiety when that individual is contemplating going back to the clinic for additional medical attention. According to Halverson (2023), this condition is referred to as "clinician-associated traumatization." The individuals who took part in the interview described the repercussions of this traumatization as more severe health outcomes, despite the fact that they could have been avoided.

Within the framework of this investigation, Halverson offers a more in-depth investigation of the notion of medical trauma. According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), which was published by the American Psychiatric Association in 1994, Halverson (2023) uses the definition that includes life-threatening medical illness as a potential catalyst for post-traumatic stress disorder. In this particular instance, the term "medical trauma" is used to refer to this condition. More elucidation is provided by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), which was published in 2013. The incident that may be considered a traumatic event was limited to a medical occurrence that was "abrupt, unforeseen, and had the potential to cause death." Having intrusive memories of the traumatic event is something that a significant number of people who have had medical trauma report experiencing. These individuals also describe feeling physically and emotionally over-aroused, avoiding and emotionally detaching themselves from things that make them feel uncomfortable, and having these feelings. There are severe kinds of post-traumatic stress disorder (PTSD) that are comparable to this circumstance. It is fascinating to observe the various similarities that exist between the symptoms of medical trauma and those of medical gaslighting. These similarities suggest that medical

gaslighting ought to be recognized as a medical condition or condition that should be included in the DSM-V. We have seen documented instances throughout medical history when patients had lost the ability to have self-confidence, or where self-identifying women no longer felt secure going to the emergency room. These situations occurred when a patient was medically gaslit which was when they are being treated. Certain circumstances, such as medical trauma, are responsible for planting the seed of uncertainty in a patient, which in turn causes the patient to hesitate before seeking medical assistance. This long delay in receiving the proper medical care can result in a life of agony or even death.

It was determined by the outcomes of the research conducted by Halverson (2023) that a total of twenty-six individuals were able to successfully engage in an interview. According to earlier research (Demmler et al., 2019; Voermans et al., 2009), the sample was predominantly comprised of persons who identified as White (N = 24) and female (N = 22). This closely aligns with the demographic distribution that was observed in the community of people who had been diagnosed with hEDS. A range of ages, from 19 to 60 years old, was represented among the participants, with the average age being 39 years old. The duration of the in-depth interviews ranged from 26 minutes to 90 minutes, with an average of 51 minutes being spent on each session. There is one interview that stands out to me and demonstrates how much of a bad influence one doctor made by being overconfident and misogynistic. This interview was of a mother speaking on behalf of her and her daughter's experience. Since her daughter was a young adolescent with a hearing impairment, her mother made sure that she received the

appropriate treatment and response. During the course of her interview, she describes the manner in which the results were discussed with both of them.

The doctor strolls in, pompous, with five med students. He sits down in his chair and says, 'She's faking it.' I'm like, 'Excuse me?' He's like, 'She's completely faking it.' Now [my daughter's] crying in this chair with these five med students all looking at her, proclaiming based on her age and her sex – because she was female and at the time, she was like 13 or 14 – that it was typical for them to fake it. I looked at him, and I'm like, 'We've been dealing with this for over a year. She wears hearing aids; she's had multiple tests. You don't get it. We've had hearing tests at three different places, and they all come in all the same.' He was just adamant. [...] 'She's faking it, and she just needs to stop.' [...] I never went back to him. He then also called the organization associated with the school for the deaf that advocates for kids with hearing loss. [...] He went and told them that she was faking it. I don't even know what would possess someone to be that vindictive and evil! (Halverson, 2023)

The actions of this physician not only had a negative impact on her daughter's access to suitable educational support and accommodations, but also had an influential effect on the attitudes and approaches of his colleagues (medical students) in the medical field towards the treatment and care of adolescent female patients. The acts of the physician had a negative impact on the likelihood of her daughter obtaining either of these outcomes. During a subsequent interview, a patient recollected a specific event from their own viewpoint.

I was probably seven or eight at this point, and the dentist wanted to pull teeth because my mouth was overcrowded and he was doing the numbing, and I kept saying it was hurting and that I could feel it. But he didn't believe me. And then he got angrier and angrier. He called me a liar. He dragged me into the waiting room where my mom was. And then he finally gave me laughing gas, and that worked fine. [...] But yeah, it traumatized me. (Halverson, 2023)

In the given case, the response provided by the dentist to the patient's complaint of persistent pain might be identified as an instance of medical gaslighting. Several concerns were raised, including the patient's observation that the doctor failed to provide the necessary dosage of numbing injections or struggled to accurately position the numbing agent. The credibility of a child, perhaps seven or eight years of age, may not possess sufficient strength to warrant a dentist's belief in the information they provide. This viewpoint presents an additional aspect to be taken into account. It is crucial to acknowledge the approach adopted by the dentist in addressing the patient's reported pain. Instead of simply expressing disagreement with the patient, the dentist endeavored to exhibit visible signs of anger. This phenomenon bears resemblance to the cognitive processes observed in persons who experience medical gaslighting, wherein they tend to recall instances of disagreement with the perpetrator. The dentist displayed signs of animosity towards the patient, aiming to coerce her into compliance with the dentist's perspective. This was evident when the dentist resorted to attempting to embarrass the patient by escorting her to the waiting room in the presence of her mother and other patients, while accusing her of dishonesty. This phenomenon can be understood as a strategic approach employed to either persuade the patient to regard their discomfort as

incongruous or to induce a sense of guilt, leading them to acquiesce to the doctor's recommendations in order to avoid being perceived as bothersome.

Halverson's (2023) examination of adverse effects highlights the identification of iatrogenesis in individuals who have gotten substandard healthcare from their providers. According to Halverson (2023), a significant proportion of the participants, specifically 81% of the total number of participants, indicated that they had encountered adverse health consequences as a result of receiving insufficient care at the clinic. The primary rationale for these adverse results was attributed to the physicians' restricted understanding of EDS and their insufficient recognition of the patients' treatment-related apprehensions. The aforementioned interviews provide evidence of instances in which both patients attempted to seek assistance or articulate their symptoms, only to be met with significant disregard or even subjected to bullying. Halverson (2023) emphasizes the account of a female participant who reported an occurrence involving a healthcare practitioner prescribing medication for the treatment of a sinus infection. The administration of said medication resulted in a heightened state of relaxation in her connective tissue, subsequently leading to episodes of nocturnal dyspnea. The term "paroxysmal nocturnal dyspnea" (PND) refers to a respiratory distress that people experience while they are sleeping, typically after one or two hours.

Physicians have the potential to mitigate these issues by avoiding the incidents mentioned above, which would depend on their improved understanding of the medical complexities associated with EDS or their willingness to attentively acknowledge the concerns expressed by their patients. Another interviewee recounted an instance in which they were involved in a sleep study and required the utilization of adhesive pads. The

physicists' lack of meticulousness and attentiveness resulted in the emergence of enduring scars. Another alarming occurrence pertaining to hypermobile Ehlers-Danlos syndrome (hEDS) involved a participant who revealed experiencing two occurrences of spinal bleeding as a result of insufficient clotting during spinal taps. According to Halverson, the aforementioned outcome is frequently observed in individuals with hEDS, although it is also an avoidable event. This example shows a potential outcome that a clinician with a thorough understanding of hypermobile Ehlers-Danlos syndrome (hEDS) or who is open to accepting the legitimacy of a patient's non-visible symptoms could have predicted and avoided.

The aforementioned stories demonstrate how insufficient professional comprehension, dismissive communication, and inadequate recognition of patient-reported issues can result in adverse outcomes for individuals with hypermobile Ehlers-Danlos syndrome (hEDS). These incidents exemplify the potential for iatrogenic harm resulting from inadequacies in provider understanding, while highlighting therapeutic interactions where patients' perceptions and symptoms are trivialized, examined, or disregarded. These interactions extend beyond a singular medical error, illustrating how relationships and frameworks within healthcare institutions influence the recognition and validation of patient perspectives. Academics are progressively conceptualizing these linkages via the lens of medical gaslighting. Examining this topic provides a valuable perspective on how patients' authentic experiences may be overlooked in medical environments. This chapter introduces the concept of medical gaslighting and situates it within the theoretical framework behind this research.

PART B
FIRST-PERSON ACCOUNTS of GASLIGHTING

CHAPTER FOUR

METHODOLOGY and MEMOIRS

Medical gaslighting is not a new phenomenon that people are experiencing; rather, we've just begun to acknowledge and understand it. This dissertation is meant to understand the lived experiences of people with medical gaslighting. As stated previously, I want to gather, analyze, and provide evidence of the indiscernible phenomena that are challenging to pinpoint, that people talk about but are hard to prove.

Through reading the various theories on the characteristics of gaslighting, I am seeking clarity and deep understanding of gaslighting through theoretical perspectives and the lived experiences of people who encountered this phenomenon. My dissertation is designed to be articulated with confidence. Gaslighting is a genuine phenomenon, as demonstrated and argued by various scholars, despite its deceptive nature, it is not insurmountable.

Additionally, another phenomenon that stands to be just as important, as it is prevalent, is women at a disproportionate rate experiencing poor medical treatment by their medical professionals (Khan et al., 2024, p.11.) This is demonstrated by the memoirs that will now take center stage in my dissertation. Before I introduce the memoirs, followed by an in-depth analysis, I would like to be mindful of the rawness that is to be felt with gaslighting; the memoirs may showcase real-life experiences that demonstrate that experiences with gaslighting will vary widely from person to person. Vicariously reading the memoirs, assists readers to recognize the severity of the impacts

that follow a person who experiences gaslighting in a medical context. There is something so intimate about medicine when our bodies need treatment, the vulnerability, as well as the anxiety of looking to someone else for help with their own body, can feel comparable to submission.

Positionality through Self-Reflection

It pains me to read cases of women facing medical gaslighting, let alone young girls being exposed to this sort of treatment from an early age. However, it also brought me comfort in the reality that I am not the only one to whom this happened. We must discuss our experiences to encourage those around us and protect those who have started encountering this.

From my perspective, beginning at the age of 10 years old, I often encountered being medically gaslit, which became a crucial part of my understanding of the world. However, my perception shifted when I started expressing dissatisfaction regarding the increasingly bothersome nature of my notably elevated heart rate. I distinctly recall experiencing dissatisfaction and disappointment because my physical limits impeded my complete engagement in activities that brought me enjoyment. At that point in time, I attained an understanding of the profound influence exerted by my elevated heart rate on my day-to-day existence. It fostered a resolute determination to identify a resolution, enabling me to lead a life unencumbered by these persistent physiological limitations.

Thus began my warpath as a young woman seeking medical professional help in trying to receive a diagnosis. This course of action took me over ten years of retentive battling against doctors, swallowing down the self-doubt, and tenaciously chasing after a diagnosis to finally be told that what I was experiencing was not made up in my head and

that I was not crazy. In those ten years of life, I have been thrown through the wringer, forcing me to "mature" faster than my peers. Safeguarding and advocating for my narrative fell upon me, as I would distort it vehemently, for the bearer of that responsibility was far too great and complex for me to grasp at such a young age fully.

As someone who has experienced gaslighting within a medical context, I can provide a firsthand account of the demoralizing and detrimental effects it had on my well-being. The personal account of my experiences has been marked by significant mistreatment, to the extent that even after receiving a formal diagnosis, I retain a strong reluctance to engage in conversations with medical practitioners. It anguishes me to acknowledge that even when I am being treated appropriately, I will always have that shred of doubt in the back of my mind, reliving the moments from the past when I was being told, "you're just being pessimistic" or hearing the pediatric cardiologist, in a hushed tone, whisper to my parents outside the door of my patient room "she just has anxiety her heart is fine." Even after years of rigorous biomedical courses throughout my educational journey and years of training under and working with medical professionals, I still doubt myself.

That is why it is more consequential than ever to recognize and address the root cause of these endangering conversations, which predominantly involve young girls and women. Although emotional trauma is mostly overlooked by society, maybe because emotional trauma not at all visible to the naked eye and does not maintain physical attributes, we must focus on both the underlying health issues and lifelong detrimental

impacts medical gaslighting has caused as well as the emotional trauma it has burrowed deep in patients.

To fully understand the serious emotional and psychological effects of medical gaslighting, we must carefully think about how to interpret and share these experiences. Because emotional trauma is sometimes hard to see and hard to document using standard medical frameworks, we need to use an approach that puts lived experience first and makes sure the research technique is clear when we look at these stories.

Therefore, reflecting on my own positionality as a quality procedure is fundamental to responsible and insightful humanities research (Finlay, 2012) . Reflection encourages self-awareness, transparency, ethical conduct, and a deeper understanding of the complexities involved in the research process and the interpretation of social phenomena through a humanities' lens. By explicitly considering my place in the research, both individually and together with my dissertation committee, also as a form of triangulation, I aim to produce more credible, meaningful, and ethically sound findings, and provide the reader with context while they interpret my dissertation work.

This work employs memoirs as a vital interpretative medium, facilitating the lived experiences of those subjected to medical gaslighting to elucidate the psychological, relational, and epistemic dynamics intrinsic to these interactions. The memoirs are my vehicle for gaining a deep understanding of gaslighting as a pervasive form of psychological manipulation that can, when intertwined with medical practices, lead to misunderstandings and a distortion of reality for patients. This phenomenon often becomes obscured in translation, complicating the communication between healthcare providers and patients. Although medical gaslighting is the focus, I aim to understand the

mystic cunning ploy that invites itself to conversations with or without an invitation. Gaslighting presents significant challenges in identification, largely due to the inherent dynamics between the individual affected and the manipulative strategy employed. My primary question is how gaslighting arises and where it comes from, according to the scholarly resources and memoirs included. And how can the memoirs provide us with an increased understanding of the manipulative strategies involved, so that, eventually, they equip women and others encountering the phenomenon with insights that will help them cope with and respond to it. This is where the concepts I introduced earlier of projective identification, applications of gaslighting, testimonial injustice, identity power, intentionality and epistemicism gain further depth and color: through the narratives about everyday experiences with gaslighting as presented in the memoirs.

As for the memoirs, I concentrate on women within the medical field who do not rely on strong emotional responses stemming from a sequence of distressing events, but women who have experienced numerous incidents that underscore the persistent and demeaning narrative of distrust directed towards them. It is an important detail to have these experiences entail both women and men healthcare professionals to show that mistreating women is the norm irrespective of gender.

To gain that understanding, I carefully selected three memoirs. The choice of memoir is deliberate, as first-person narratives provide direct access to the subjective experience of gaslighting. These accounts reveal the experience of doubting one's own reality, the psychological impact of repeated dismissal, and the process of reclaiming one's narrative. First, *The Lady's Handbook for Mysterious Illness* by Sarah Ramey, published in 2021. Another memoir that provides me with access into the experiences

with gaslighting is Lisa Lynch's (2010) *The C-Word*. Finally, Porochista Khakpour's (2018) *Sick*. I employed several interconnected selection criteria. All three memoirs center on women navigating serious illnesses while being dismissed, disbelieved, or invalidated by medical professionals, making medical gaslighting the central theme and providing concentrated examples of institutional gaslighting in healthcare settings. The selection was also driven by the various types of illnesses represented. While Ramey and Khakpour deal with conditions that were difficult to diagnose or not well-understood—such as chronic illness and Lyme disease—Lynch has a clear cancer diagnosis. This distinction allows for examination of how gaslighting manifests differently when illness is "visible" versus "invisible," revealing important patterns in how medical professionals may respond to ambiguous versus clearly defined conditions. Gender dynamics were another crucial criterion, as I wanted all three authors to be women. This focus enables concentrated analysis of how gendered assumptions in healthcare contribute to gaslighting, particularly the ways women's pain is often minimized or their symptoms dismissed as psychological rather than physical. The contemporary timeframe of these works, published between 2010 and 2021, ensures they reflect relatively recent medical culture and participate in contemporary discourse around patient advocacy and systemic healthcare issues.

Additionally, Khakpour's Iranian-American perspective brings important intersectional dimensions to my analysis, adding layers of cultural and potentially racial factors to medical gaslighting. The different illness trajectories—cancer, chronic autoimmune conditions, and late-diagnosed Lyme disease—offer me varied contexts for understanding how gaslighting operates across different medical scenarios, while the

literary quality and accessibility of all three memoirs ensure they balance compelling personal stories with broader systemic critique. Before moving to the analysis in the next chapter, I will now introduce each memoir.

It is important to acknowledge the limitations inherent in the selection of memoirs analyzed in this dissertation. The three narratives examined are all published works written in English by women who had the opportunity, resources, and platform necessary to share their experiences publicly. Two of the memoirs are set within the United States' healthcare context. In contrast, the third is set in the United Kingdom—two countries whose publishing infrastructures, literacy rates, and relative protections for freedom of expression create conditions that make it more feasible for individuals to document and disseminate their personal experiences. These geographical and linguistic contexts may therefore introduce a form of selection bias, as the voices represented are those of individuals who were able to access publishing avenues and reach an English-speaking readership.

As a result, the experiences of individuals who encounter medical gaslighting but lack similar social, economic, or institutional access, including people from non-English-speaking regions, marginalized communities with limited publishing opportunities, or individuals whose stories remain undocumented, are not represented in this study. Consequently, this dissertation does not aim to produce broadly generalizable conclusions about medical gaslighting. Rather, it seeks to engage deeply with the perspectives presented in these three memoirs and explore the interpretive insights they offer. In line with Robert Stake's concept of naturalistic generalization, the goal is to

provide rich analysis that allows readers to recognize patterns or resonances and determine for themselves how these insights may apply to other contexts.

The Lady's Handbook for Mysterious Illness (2021)

Sarah Ramey is not an average college student; she comes from a prominent background as a Harvard student, with both of her parents being esteemed physicians. Immediately, one would assume the true luck and protection Sarah's healthcare has as both of her parents are well-versed in the healthcare world. Indeed, physicians will take Sarah more seriously than other girls at 18 years old because of her parents' background and her being highly educated. Unfortunately, this could not be further from Sarah's reality. Sarah Ramey's introduction from her memoir *The Lady's Handbook for Mysterious Illness* dives into her suffering battle with doctors and the agonizing pains that she has to undergo to have a proper diagnosis.

The C-Word (2010)

Lisa Lynch's memoir titled *The C-Word* is her sharing of her journey, although she hates to call it a journey, through the horrors of fighting for her diagnosis of breast cancer and what her treatment process looked like at the age of 28 years old. Lisa's memoir slips in and out from her blog posts to her carefully crafted reflections on her past pains and experiences that led up to her diagnosis. Lisa proactively visits her doctor in response to a lump in her breast only to be told it is nothing she has to worry about and to enjoy her holiday as it is a cyst that will go away on its own. Unbeknownst to Lisa and her doctor, it is cancer. Being shrugged off by her doctor, "The concern didn't even

stretch to my GP. 'Yep, I'm sure it's a cyst,' she said. 'It'll have disappeared by the time you're back from your holiday.' Lisa does as she is told and enjoys her holidays under the assumption this "cyst" will go away (Lynch, 2010, p.13).

Lisa is initially told to wait eight weeks for a needle biopsy as the doctor is not too concerned due to her young age and no family history of breast cancer; thanks to Lisa's discomfort, she cuts her 8-week follow-up appointment to 48 hours. Her follow-up appointment with the biopsy needle stick wasn't any better. After this, an entire train of events of misinformation, misdiagnosis and dismissal.

Sick (2018)

The third memoir I analyze is written by Porochista Khakpour, an Iranian-American woman who has Lyme disease and many other health issues resulting in chronic illness. In her memoir *Sick: A Memoir*, Porochista explores the frustrations and detrimental effects of being misdiagnosed and dismissed by medical professionals. Through her essay, Porochista talks about the emotional and psychological toll her illnesses took on her health and well-being. She breaks down how there are multiple portions to one's suffering, ranging from healthcare professionals being dismissive and demeaning to not feeling in control of your own body, and how societal attitudes toward illness, primarily chronic conditions in women's health that are invisible and often these critiques leave her feeling misunderstood and minimized.

CHAPTER FIVE

ANALYSIS of MEMOIRS

This chapter five delves deeper into the three memoirs through a thematic analysis of the narratives. Ultimately, it results in three major findings, which I will present at the end of this chapter.

The Lady's Handbook for Mysterious Illness

Sarah Ramey divides her memoir into three parts:

Part One

The diagnosis begins with a visit to the emergency room, uncovering the symptoms of "peeing broken glass" as an easily treatable UTI, urinary tract infection; no alarm bells ringing as Sarah is brushed off to have this resolved in a matter of days, expect this is not the case, her future did not consist of days nor week of sufferings, but excruciating months that do not plan on tapering off anytime soon (Ramey, 2021, p. 12).

Thus begins Sarah's induction to "a secret society of sorts that no one—not even the members—has heard of. We don't look alike, we don't dress alike, and we're from all over. There is no secret handshake, no meeting place, no cipher. We are the women with mysterious illnesses, and we are everywhere." (Ramey, 2021, p. 13). Now, fast forward six months, and Sarah is still struggling with her pain and discomfort; she visits the top of the top urologist in Washington, D.C., under her parents, who are "both top-notch physicians", discretion, and immediately she is given a solution to her so far untreatable and undiagnosed struggles (Ramey, 2021, p.13). With the utmost confidence, Sarah's

“top-notch” urologist tells her that he needs to rip her urethra, as the muscle spasms she was experiencing were the root of her problems; he dismissed her previous diagnosis of an infection, claiming that it was long gone. Dr. Damaskus, Sarah's urologist, emphasizes to her that this is "the only option" and tells her the procedure is to be done "right there, that day, in the office." (Ramey, 2021, p. 13-14).

Back to the present, Sarah follows through with the ripping of her tissue; she describes the procedure as "It was a blinding pain that no amount of lidocaine would dull. He peeked over the paper blanket and asked if I thought he had gone enough notches. I was crying too hard to do anything but nod. He went one more notch." (Ramey, 2021, p.14).

Sarah is sent home; instead of being relieved from her symptoms, she brings new ones home. By the following day, Sarah is in intolerable pain; her mother sees her and rushes her to the hospital; come to find out, Sarah goes septic. After narrowly dodging death, doctors flock to her room, all of them concluding, “‘Strange,’ my doctors murmured, making notes. ‘How very strange.’” (Ramey, 2021, p.14). With a lack of diagnoses and failed attempts at getting better, Sarah finds her health declining; she fast-forwards to 17 years later in her life when she has become well known for her undiagnosable and untreatable symptoms. She explains how close the reality is to us all of knowing a woman out there with a mysterious illness, and she even alludes to the fact that we may be that woman; we do not know it yet. Thus comes her creation of the word "WOMI, a woman with a mysterious illness." (Ramey, 2021, p.17). Sarah is determined to classify what is happening to her and other women, and if she must take matters into

her own hands, then so be it. She continues her memoir, referring to herself and other women finding themselves in similar shoes as being a WOMI.

Sarah primarily focuses on introducing her symptoms due to her symptoms being vague and changing from one day to the next, as well as defying the norms of medical conditions, resulting in frustrations and a lack of understanding. As her condition worsens, Sarah visits various healthcare professionals to find answers about what is plaguing her daily life. Unsurprisingly, it is just theory after theory and creative ideas as to what *might* be happening to her. Sarah digresses about the impersonal nature of the medical system she is met with and how determinantal it affects her hopes for healing. Sarah emphasizes that the inability to obtain a proper diagnosis has now begun to impact not only her personal life but her professional life as well; it is affecting her relationships, leaving her feeling isolated and entirely alone since it feels almost impossible to communicate what it is she is experiencing as no one around her understands what it feels like to be tormented by an illness so severe yet invisible. As part one ends, Sarah leaves off with her proactive efforts to find a solution and how she begins to consider turning to alternative medicine, self-help strategies, and even online communities. Part one concludes with the desperation and lack of hope accompanied by a WOMI, perfectly describing how one WOMI may feel.

Part Two

Sarah begins to show her desperation growing and her pleas for help increasing; her symptoms are not showing any signs of stopping and only worsening as her pain intensifies. This leads her to seek out even more drastic and unconventional experimental treatments in the hope of solving her declining health. But Sarah begins to describe in

depth how her relationships are genuinely taking a hit from her health and feelings of alienation from friends and family who struggle to understand what she is going through; she is met with an apparent lack of empathy and almost a twinge of frustration and annoyance from those dear to her as she is feeling the stress of her health condition. This pushes her to find a means to an end as Sarah keeps coming up blank through her explorations of conventional medicine, she begins addressing alternative and holistic therapies. As her story progresses, we begin to have insight into Sarah's inner life, her reflection of her self-identity that the passage with the nature of suffering brings her. Slowly, we begin to see the psychological and emotional impact dealing with a mysterious illness can truly bring someone, as well as the self-discovery one might go through when searching for meaning in one's resilience. Sarah proceeds to describe the coping mechanisms she relies on when going through the motions of a battle against a deceptive ailment in the body. With a bit of self-reflection, Sarah offers the raw truths of finding different ways to communicate her experiences to others to ensure more effective outcomes and adjust her expectations so as not to be disappointed every time a new therapy fails her. In part two, we see a clear emphasis on Sarah accepting and facing the challenges of not having a precise diagnosis despite her efforts to remediate her symptoms, noting that her condition remains medically elusive.

Part Three

Sarah's focus is on deepening challenges, highlighting the ongoing struggles she faces with her illness that defies any clear treatment or remedy, and how this resistance will forever impact her physically, psychologically, and spiritually. Sarah, unfortunately, finds herself victim to the adverse effects of an untamable illness's damages on her

relationship with her family and now even doctors. Medically, professionals who cannot fulfill their role of diagnosing Sarah show their frustrations and impatience, but through all this, Sarah is still able to find newfound support and even sympathy from other women alike, or as Sarah says, other WOMI's. These testimonials leave Sarah with a lot of time to reflect on her personal growth; with the realities of a mysterious illness, Sarah has grown a deep philosophical understanding of suffering, resilience, and the feelings associated with the search for meaning in the experiences of fighting a mysterious invisible illness. Sarah begins to investigate new insights into the nature of her conditions, what it means to gain perspectives from others, what it is like to inquire about new treatments and the behavior towards those seeking new treatment. A big part of Sarah's self-growth relates back to her acknowledging the forever uncertainty of her condition, finding how to fulfill her life despite lacking so much clarity in regard to her health and finding the strength to cope with ongoing unpredictability. The last send-off Sarah gives in her memoir is strong; while she has never been able to get a definitive resolution or cure for her mysterious illness, Sarah is unwavering in her acceptance of her situation. Acceptance is not submission, and Sarah clarifies that in her final remarks.

A closer look

In the early stages of Sarah's memoir, an interesting statistic about the National Institutes of Health and the disparities between men and women suffering from illnesses is mentioned.

“Eighty-five percent of fibromyalgia patients are women. Eighty-five percent of multiple sclerosis patients are women. Ninety percent of Hashimoto’s patients are women. Eighty percent of chronic fatigue syndrome patients are women. Seventy-five percent of Lyme patients are women. Ninety percent of lupus patients,

women. Seventy-five percent of all autoimmune patients are female. And for the true mystery illnesses, the disparity is even greater—often 8:1, 9:1. This should give anyone pause—not simply because there are so many diseases affecting women these days, not simply because that discrepancy is very large, but for a more serious reason:

No one seems to notice.” (Ramey, 2021, p. 28)

These statistics are compelling as they acknowledge that women are the majority to suffer from these illnesses, but they are not the only one’s suffering; the larger issue is the massive difference in at what rate women are suffering versus men. Sarah emphasizes one of the most significant points in this dissertation that seems to constantly go overlooked, or at least unrecognized, is that the gap at which women are suffering is too large to go unanswered. An even larger point that Sarah is coming to may be related to Cleghorn and that is, is the disparity in the rates at which women are suffering autoimmune diseases due to the lack of knowledge and fundamental understanding of the female body? Sarah noticed the trend of women in lieu of men being patients from these illnesses at higher rates to be true for both autoimmune and mysterious illnesses.

To comprehend Sarah's memoir is to digest the dynamics at play. The no room for questions solution Dr. Damaskus is imposing on Sarah, leaving her to believe there is no reason to question since this is the only option and leaving her to think there is also no time to ask questions or time to figure out another solution as this procedure will happen right at the moment of discovery. The urgent "right there, that day, in the office." it is almost as if her urologist is removed from her reality of suffering and not concerned with how she feels and what this procedure may do to her (Ramey, 2021, p. 13-14). It all feels very manipulative and a bit careless, the coldness of giving a diagnosis without genuinely engaging with the young patient who is frightened and uncomfortable with the idea of

ripping her urethra, yet pushing his authoritative identity as the more trustworthy speaker to pressure into doing this procedure.

Not only was she subjected to the severity of the pain that she was not mentally prepared for, but the fact that he asked her if it was enough, and while she was showing a clear display of her tremendous pain and nodding in agreement that it felt to be enough; Dr. Damaskus still pushed forward with an additional notch. "I was crying too hard to do anything but nod. He went one more notch." (Ramey, 2021, p.14). When reading this line, it felt too similar to a striking instance of the dismissal previously described, the almost rhetorical questioning on the doctor's behalf, such as his way of asking if the pain was too much and if he had done enough but then continued without an answer is to emphasize his clear indifference towards her face that was contorted in pain. This dynamic is a bit crueller than one where the speaker is intentionally setting out to gaslight the patient; this was a clear display of a regular user of their identity power. Dr. Damaskus, as introduced by Sarah, the top urologist located in Washington D.C., must have credibility to not only operate instinctively on Sarah the way he did but to attain the influence in society that leads patients and doctors alike to believe that he knows what is best for a young woman that has had many contradicting diagnoses before coming to see him. Sarah intended to show how little her voice rang in the ears of the healthcare professionals in that office, for not one of them could step in and see how she felt about such an invasive and harmful procedure that lacked substantial grounds for cause. The briskness of everything from the moment Sarah walks into the doctor's office to her going septic and being looked at as if she were an animal on display at the zoo shows the lack

of empathy and power her identity holds, for she is a WOMI, and that took precedence over everything else.

The C-Word

In her memoir, Lisa Lynch, the author of *The C-Word*, narrates on how she was misinformed, left in the dark, and felt like a sitting duck when a nurse spoke to her:

“We’re running a bit behind, but we’ll do your mammogram as soon as the room’s free,’ said the nurse, crouching in front of us and resting her hand on my knee.

‘She just touched my leg,’ I whispered to P.

‘I’ve never met her. What’s all that about?’

Even the waiting room was confusing to me. I didn’t even realise I was scheduled for a mammogram.” (Lynch, 2010, p.17).

Without her knowledge, Lisa was set up for a mammogram following her biopsy, and at the mammogram appointment, she had to wait in agonizing anxiety with no directions or explanation as to what was happening around her. Lisa and her husband Peter had waited for hours until they could be seen.

Her raw look at the realities one may face when being dismissed and misunderstood by medical professionals who are meant to preserve and promote your health contributes to your downfall, which is one experience too many women are seemingly having. The healthcare system has failed Lisa as her illness was misdiagnosed, causing a delay in proper treatment. First, she finds her initial assessments do not relate to the severity of her symptoms, let alone address the seriousness of her condition. The diagnosis she received was much less severe, causing not only a delay but also a lack of acknowledgment of Lisa's rapidly declining condition. Lisa breaks down the medical

inefficiencies and bureaucratic challenges within the medical system that contributed to her delay in receiving a proper diagnosis.

It is bad enough that it takes weeks on end for one symptom to get a proper look at by doctors due to the limbo of never-ending follow-up appointments, but Lisa also emphasizes how she felt her healthcare provider did not take her seriously. There was a constant lack of urgency despite Lisa's growing symptoms of pain; she felt invalid in her experience and was not taken seriously. This is something that should be escapable by now, the miscommunication through lack of explanations on the doctor's behalf is all the more common as it is avoidable; yet again, Lisa was not given the actual audience she deserved, Lisa found it became more and more challenging to advocate for herself stripping her of her authority over her own experiences.

In addition to the constant back and forth of misdiagnosis, Lisa finds it familiar to be faced with a lack of empathy from most of the medical professionals who she sought help from. Her doctors and specialists fail her in fulfilling their roles of genuinely caring about her health and wellbeing, giving her the automatic glance of a hysterical woman crying out from anger rather than actual pain or someone who is exaggerating because they want attention.

“P and I introduced my folks to the professor and nurse who we’d seen the previous Tuesday.

‘Oh, it is good that you’ve got your parents around you,’ said the nurse as she shook my dad’s hand. ‘Long may it continue,’ she added enigmatically, as my mum clocked her meaning. ‘I’m sorry to keep you waiting, Lisa,’ she said, turning to me, ‘but Prof wants to see the easy ones first; he’d like to spend a bit more time with you.’ (Lynch, 2010, p. 25).

When Lisa is constantly being met with a dismissive attitude, she too begins to doubt herself; it is only natural for a person who is looking to the professional for help yet is being met with abrasiveness to second guess if the problem indeed relies on them. Again, this contributes to a delay in diagnosis. Lisa often experiences interactions with impersonal attitudes; her doctors were almost entirely detached from her situation, and pleas were brushed aside. This began to have an impact on her emotional and psychological wellbeing as she was not being adequately addressed. Doctors separated Lisa from her treatments as they were more focused on the clinical aspects behind her procedural treatment attributes, almost as if to objectify her to her symptoms. As if this is not bad enough, paired with the dismissive and impersonal nature of her doctors, Lisa finds limited emotional support; she felt no professionals would support her, beginning to feel isolated and frustrated as to why she was entirely alone in her experiences of suffering.

Lisa could not understand why she kept being met with a lack of empathy. She is the patient; she is the one who is suffering from her symptoms; her tentmate and the healthcare professionals who are meant to rectify her situation are entirely disregarding the validity of what was happening in real-time, almost as if her narrative on her medical journey was invalid. As if the lack of empathy wasn't enough, her doctors weren't communicating correctly with her. Lisa highlights that her symptoms were not fully understood or communicated effectively between one doctor and another; it is like a vicious game of tennis where the dialogue between providers would go back and forth with no actual goals being met. In addition to understating her symptoms, doctors did the same for the implications of her treatments; time and time again, Lisa found her

healthcare professionals glazing over the side effects of her treatments and the difference the treatment options may do to her and again, leaving Lisa uninformed and frustrated. On top of the constant miscommunication, there also tends to be a lack of follow-up; Lisa mentions instances where the follow-up communication after appointments was next to none; even when she received results, she would not receive follow-up calls or appointments to sit down and explain the results to her, almost as if no one was looking them over. This led Lisa down an arduous path, putting her in a position of being unable to make challenging decisions for her future treatments. It is bad enough that her results weren't being followed up with, but what makes it even more difficult for Lisa to be able to understand what going on with her entirely is health is she is getting conflicting results, one doctor will tell her one result with a specific course of action while another doctor was telling her to do an utterly conflicting procedure, she finds herself navigating in the dark with no assistance and constant back and forth.

This brings the memoir to a more significant part of Lisa's experiences; this is a broader systemic issue within healthcare systems worldwide; women, most of the time, are finding themselves victims to the inefficiencies and impersonal approach of healthcare professionals. Lisa shared details on the fragmented care she encountered, including the lack of coordination between different healthcare departments. First, she touched on the lack of doctor-to-doctor communication, but it is an even more significant issue than that. Lisa noticed that this lack of communication even spread to the entirety of departments, leading to delays in obtaining various specialist outlooks on her condition and depriving Lisa of different specialist treatments and services they could have offered her. It was a daunting domino effect that chased her around every corner; Lisa could not

avoid it, and her pleas and worries of the lack of communication could not be proactively avoided as she was being dismissed a majority of the time, and on the short chance that Lisa was not dismissed the doctors did not have efficient communication with different departments so by the time she was given a chance it was already a long delay in treatment. Outside of the realm of doctors, Lisa noticed the healthcare system itself to have many flaws, the amount of time it would take to request a referral, actually obtain it, and then have it processed, adding this on top of insurance approvals her time just kept running, and the delay of treatments only increased.

Towards the end of her memoir, Lisa reflects on her experiences with cancer, the challenges she was met with, and how these same challenges have changed her outlook on her perspective of her life and health. She fully acknowledges the emotional and psychological toll this journey had taken, highlighting both the difficulties she underwent as well as the new insights she was able to gain. Lisa ends her memoir with an undertone of empowerment for women to advocate for themselves when it comes to standing up for themselves against the powerful healthcare system one woman may face. She shares how she learned to navigate the medical challenges she was put up with and emphasizes the value and persistence in the face of adversary backlash. To complete her memoir with all-around acknowledgments, Lisa does not forget to recognize those who supported her during her struggles with her health and the healthcare system and her loved ones who supported her voice and validity throughout this all.

A closer look

Lisa's experiences show the unfortunate side of testimonial injustice; throughout all her doctor's appointments, she was never allowed to narrate her health. Lisa denied

validity when reporting her symptoms; doctors went as far as to tell her that she was so stressed out and had so much anxiety that it caused her not to understand what she was feeling and led to her misunderstanding her symptoms as something more serious. Her testimony is approached similarly to the injustices read in Harper Lee's novel "To Kill a Mockingbird"; However, Lisa's testimony is not facing scrutiny due to her race; her experiences are met with skepticism because she is a seemingly healthy-appearing patient that also happens to be a woman. Of course, this is not finite, but the trends commonly documented throughout Abramson's and Booth's depictions of women being targets of medical gaslighting through their testimonials facing injustice. The parallels throughout Abramson's coverage of the screenplay for Pat and Mike dissect the projective identification at play, Collier, who has projected his insecurities onto Pat due to her golfing success, thus leading to Pat falling victim to a case of gaslighting. Doctors are unsure of Lisa's symptoms in the medical context. Discovering remedies that conflict with other doctors can be a way of projective identification, almost as a way to save face as to why their diagnosis opposes another. Lisa is pushed to believe that her doctors are right while she is misinterpreting her symptoms, leading to the invalidation of her medical narrative.

Booth strays into Deborah J. Cohan's harrowing journey of doctors telling her that her excruciating abdominal pain is fine and she is misinterpreting her symptoms only to come and find out that she was indeed not. Cohan's pain impacted her day-to-day lifestyle; she could not eat, sleep, or sit upright, and with these symptoms reported, her credibility was reduced to a patient who does not understand what their symptoms are and is in need of a gynecologist appointment. The parallels between Cohan and Lisa are

as such, both were not given the validity to be trustworthy candidates therefore discrediting their testimonies, both suffered from a delay in the correct preventative measurements to treat their illness due to doctor's discourse of not deeming these candidates as credible sources, as a result at one point in time this led to both women doubting themselves and suffering from the effects of being medically gaslit.

It is nonsensical to think that someone could be dying, yet the priority of our medical system is to obtain referrals, specific diagnostic panels run, and follow-up appointments that you again need a referral for; all of this contributes to delaying a proper diagnosis even further. Lisa shows corruption within the medical system and outside the doctor's office in her memoir. In addition to medical gaslighting, the undertones of patriarchy lying beneath the fundamentals of medicine would be the very system under which medicine is practiced. Similarly, to Erin Jackson's experiences described by Booth, Jackson had to seek double digits worth of opinions on her diagnoses; who has the time and privilege for that, not the majority of women? It takes referrals, appointments in advance that may require paid time off, and family care in place of some mothers who may need multiple *second opinions* to ensure that they are receiving the proper care, not to mention the feasibility of traveling from one place to another. This is quite literally a race against time; for some patients, time is a privilege that, unfortunately, is not on their side. Some illnesses do not show mercy to allow women the time and research it may take to achieve the correct diagnosis, and the sad fact is the medical system put in place does not aid comfort to those who fall victim to time trial.

Sick

Porochista Khakpour teaches at both Bard College and Sarah Lawrence, electing two days a week to both schools. It is early in the year 2016, and throughout her time managing work, she talks about her experiences and daily challenges in juggling Lyme disease relapses, being in a car accident, and helping her anxiety-filled students navigate life through the most recent Paris attacks and rise of Islamophobia. She emphasizes that she herself has anxiety and feels lost yet holds these emotions back as she finds this to be her responsibility and duty to help her students.

One of her earliest essays consists of an email that she sent out to her friends due to her fear of the impending doom of a Lyme relapse.

“dear some of my closest nyc friends who are in town currently or might be soon,
i am getting more and more ill very fast. i’m scared at the moment. in case you don’t know, i’ve had a late stage lyme relapse but this one feels very intense. rapidly things are going downhill.
i’m trying not to be extra alarming online—some important work stuff i want to be well enough for—while also letting people know some things are off.
i have various lyme communities and that’s the way to reach them.
but also i don’t want to drop out as last time i became completely disabled that way—i need to stay engaged
but i’m scared
at points in the day i don’t know where i am exactly. at night it somewhat clears.
i’ve been falling again a lot. etc. very faint, very dizzy. getting a cane.
having trouble with reading and writing.
it’s very reassuring to be around people when I’m confused. alone it is very hard.
i’m not totally sure what i’m asking. it’s hard to ask for help here because what can you do even? i don’t have the imagination to know what is help right now completely
but some things maybe would you mind occasionally checking in on me?
i might not be able to text back very effusively as i’d wish but perhaps briefly—it doesn’t mean i am mad, it just means i can’t think. i’m also worried something will happen to me and cosmo will just be alone.
also if anyone had the time and was interested in being a passenger in my car with me? i have 2.5 more weeks of classes.

for now i think i can drive. or was able last week. but i go to bard twice a week (weds and thurs) and sarah lawrence mon
i have nice offices at both if you wanted to work there too and even hang out with cosmo?
or if you were ever in harlem? just walking with me to the dogpark? i'm not that deep in harlem, just 120th.
or perhaps riding the subway with me? (i tend to avoid subways alone when relapsing)
i might even drive cross country if i find i can't take cosmo with me on a plane to the west during break. just will do the southern route slowly. if anyone wanted a free ride there too!
i'm also happy to pay anyone for their time. not meant to be insulting! just meant to say i value your time.
basically just the presence of others around me right now is helpful i think (tho i also have a lot of work to do so i can't take breaks perhaps study dates?)
all my friends are busy people who do work i love so i'm hesitant to ask. also you all have your own shit right now.
i will not be mad at all if you can't deal with this right now! i'm embarrassed to ask frankly. i thought to write people individually but i didn't want you to feel the burden like you were the only one!!
basically i am very bad at this.
and sorry for chaotic nature of this email. hard to express myself.

love p" (Khakpour, 2018, p. 13-15).

Porochista shows her way of communicating her relapses to her friends and how she downplays the severity and anxiety that comes with it through her essays, almost seeming as if she is embarrassed by what she is about to endure and afraid to cause trouble. It emphasized that all through her battling of Lyme relapses, her doctors and healthcare professionals have vast differences in opinions, the understandings and beliefs of symptoms vary to no point end, and Porochista finds herself suffering from the symptoms that are not so common, leading her to feel even more ashamed of herself.

Surrounding her essays, Porochista offers her outlook on her previous experiences, almost as a way to digest what she has just discussed; she recognizes her patterns of shying away from her realities of needing support as she was never given

much growing up. In her chapter titled "On Being a Bad Sick Person," she begins to confess what leads her to believe she is not good at *being sick*. First is her avoidance of accepting the fact she is ill from a very young age; when you are a kid and sick then you stay home from school, and as Porochista put it, "School was a place to get away from home and home was where the problems were." (Porochista, 2018, p. 193). In turn, this results in Porochista feigning feeling well whenever she is sick, showing the readers her unhealthy relationship with when she feels ill; this is where the insecurities begin, only to be met with an unsupportive and unhealthy relationship with her health care professionals that she would later reach out to for support during her Lyme relapses.

She continues to explain "With Lyme disease, certain diets are recommended. It's been long believed that sugar, dairy, and gluten can exacerbate Lyme symptoms." (Khakpour, 2018, p. 193), again alluding to her book's opening remarks that Lyme disease is wildly misunderstood and that general medicine does not have a full grasp of the capabilities it holds on the human body. It is clear throughout her memoir that Porochista is her most prominent critic; she feels guilty for simply wanting to live an average life; she wants to be healthy, not be a burden to others, and to feel proud of herself.

A closer look

In almost every chapter of Porochista 's memoir, she brings up how she does not feel at home and how she is not comfortable in her own sick body; at one point, she even states, "I can't recall a time when I felt my parents' home was my home. Part of it was their own fault—I remember being single digits and echoing my father's constant refrain that we were in America only temporarily....My parents always called me a wanderer

and poked fun at my comfort with a sort of homelessness" (Khakpour, 2018, p. 78), she also mentions in her chapter "On Support" that her family was not always a part of her support system, with the mixture of feeling alienated and ostracized as well as not supported or believed by her parents it allows room for the conversation of, not everyone is medically gaslit by medical professionals. Instead, in this situation, this may have been a lifelong case of epistemic abuse, therefore turning into gaslighting and having an impact on her diagnosis and the severity of the symptoms to come, allowing Porochista to become more susceptible to medial gaslighting.

It is essential to see how, from a very young age, Porochista hated the thought of feeling ill. Whether it was due to how the symptoms made her think or the predicaments being sick would put her through, she never felt comfortable being honest about being ill. Fast forward to her essays showcasing her email when reaching out to her friends, she already feels like a burden; as teeth-clenching as it is to ask for help, Porochista made sure to pave the way for her friends to cop out of helping her during her time of need. I believe this sense of guilt and embarrassment attached to being sick has led Porochista's relationship with healthcare professionals off to an abysmal start. Having no faith in herself, we see Porochista exhibiting self-blame behaviors as she constantly reminds the readers throughout the book that she, too, is at fault. Although this behavior may come from the results of gaslighting, in Porochista's case, she has developed this from a young age, but what is important to note is that no doctor thought to mention to her that none of this is her fault. Indeed, some habits or choices made on Porochista's end are not beneficial to her health, but with that said, her outlook on herself is too harsh as she states the following:

“Another part of it is the thrill of the sick person making herself sicker. If you know a part of you is always dying, taking charge of that dying has a feeling of empowerment. My body goes against me often, so what if I put it through that myself? At times, in the composition of this book, I snuck a cigarette or two, a reward for some paragraphs or pages. I watch the smoke, I watch the ash, I watch my fingers curl around them in familiar ways, I take in the smell and the stench like the most familiar ambiance of my upbringing. This is me, I tell myself.”
(Khakpour, 2018, p. 195)

It is a fact that drugs, alcohol, cigarettes, and other toxic stimulants are harmful to your body. With that being said if you were to smoke a cigarette here and there or have drinks while out with friends, you are not solely responsible for the detrimental effects of your Lyme’s disease; the same goes for eating junk food and not sticking to a strict diet of no carbs, low sugar, low fat. Porochista recognizes the negative consequences of her actions. Still, she words it in a way that almost seems like she is at fault for her entire health problems, and what is noticeable throughout her essays and reflections is that not once did a doctor tell her the opposite. Taking advantage of the epistemic advantages one holds over Porochista, learning of her occasionally unhealthy choices and allowing her to believe that those choices are entirely at fault for her relapses or that the new symptom she has developed and that modern medicine does not comprehend had to at some point and time stem from the cigarette she smoked last month as a reward for finishing a chapter she was writing.

PART C
CONNECTING INSIGHTS

CHAPTER SIX

SYNTHESIS and DISCUSSION

Central Themes and Synthesis

The analysis of each memoir reveals three main themes, leading to an interconnected synthesis that I will now present and discuss before moving on to a chapter about the complex traumatic effects of medical gaslighting.

Theme A: The Gendered Disparity and Systemic Neglect of Women's Pain

Across these memoirs, a central finding emerges: the institutional disregard for women's health and pain operates not as isolated clinical failures but as a systematic pattern reflected in both statistical realities and interpersonal encounters. This disregard and *failure to notice* functions at multiple epistemic levels, silencing women's testimonies while simultaneously impoverishing the conceptual frameworks needed to understand their conditions.

Ramey makes this dynamic visible by foregrounding epidemiological data that ought to provoke urgent institutional response: 75–90% of autoimmune and "mysterious" illness patients are women. Yet this overwhelming demographic disparity is met with what she describes as societal indifference: "No one seems to notice." This silence is not mere oversight but reflects compounded forms of epistemic injustice. Women experience

testimonial injustice when their reports of pain are systematically doubted or minimized in clinical encounters—their credibility deficit operates as a structural feature of medical interaction. Simultaneously, they suffer hermeneutical injustice: the very frameworks for understanding these conditions remain underdeveloped precisely because of structural gender bias in medical research, nosology, and clinical training. When the conceptual resources to interpret and communicate an experience do not exist—or exist only in impoverished form—patients are left inarticulate even to themselves, unable to make their suffering intelligible within available medical vocabularies.

The failure to notice becomes, over time, an institutional habit of disbelief. Physicians' overreliance on gendered stereotypes—that women are "anxious," "hysterical," or "emotional"—actively shapes diagnostic behavior, functioning as cognitive shortcuts that preemptively close down clinical inquiry. These stereotypes are not simply individual prejudices but circulate as shared professional common sense, encoded in clinical training, case discussions, and informal medical culture. They constitute what Fricker identifies as 'identity power': the power of social imaginaries that define what it "means" to be a woman in medical spaces. These shared assumptions constrain how both doctor and patient imagine illness itself. The woman patient enters the clinical encounter already positioned within a hermeneutic structure that renders her testimony suspect and her symptoms illegible. Even her own self-interpretation may be colonized by these dominant frameworks, leading her to doubt her perceptions or attribute her suffering to psychological rather than physiological causes.

In summary and transitioning to my next main finding, I propose Ramey's narrative reveals that the disparity in women's suffering is not simply biological but profoundly epistemic—rooted in gendered systems of knowledge production and credibility distribution. The institutional disregard for women's health is maintained through interlocking mechanisms: the systematic devaluation of women's testimony, the underdevelopment of conceptual resources for understanding conditions that predominantly affect women, and the circulation of identity-based stereotypes that foreclose diagnostic possibility. What appears as clinical indifference or incompetence is better understood as the predictable outcome of epistemic structures that render women's bodily knowledge marginal and their suffering invisible.

Theme B: The Erasure of Women's Medical Narratives Through Testimonial Injustice

Closely related to the first main finding is the idea that the memoirs convey the experiences of encountering testimonial injustice. Lisa Lynch's *The C-Word* offers a harrowing anatomy of testimonial injustice as it operates in clinical practice, demonstrating how the systematic devaluation of women's self-reported symptoms functions not merely as dismissal but as epistemic violence. Her narrative traces the mechanisms through which medical authority actively erases women's bodily knowledge, replacing patient testimony with gendered assumptions about feminine unreliability.

Lynch's doctors often invalidate her experiences, attributing her physical symptoms to stress or anxiety rather than investigating potential organic causes. In doing so, they suggest that her own emotions distort her perception of reality—that her psychological state renders her an unreliable narrator of her bodily experience. This pattern of dismissal exemplifies Fricker's analysis of how credibility deficits arise from identity-based prejudice rather than from any genuine assessment of epistemic competence. The gendered assumption at work is that women systematically misinterpret their bodies, conflating somatic sensation with emotional distress, and thus require medical authority to distinguish "real" symptoms from imagined ones. Lynch is not simply disbelieved about particular facts; her capacity for self-knowledge itself is called into question on the basis of her gender.

This dynamic, along with the other memoirs, also reveals how testimonial injustice operates through identity power: the patient enters the clinical encounter already positioned as epistemically suspect, her gender marking her testimony as inherently less credible than comparable reports from male patients. The physician need not harbor conscious bias; the credibility deficit is structured into the interpretive frameworks through which women's symptoms are received and assessed. What might be investigated as potentially serious in a male patient is reflexively psychologized in a female one—a pattern that persists even when controlling for symptom presentation and severity.

Lynch's experience also illuminates how projective identification can function institutionally, extending beyond individual psychodynamics to become a structural

feature of medical practice. When doctors encounter diagnostic uncertainty—symptoms that do not readily fit available categories or that challenge their clinical confidence—they may unconsciously project this professional insecurity onto the patient. The implication becomes that if the physician cannot diagnose a symptom, it must not be genuinely physiological; it must be psychosomatic, imagined, or exaggerated. This projection serves a defensive function, preserving medical authority by relocating the "problem" from the limits of medical knowledge to the unreliability of the patient's testimony. The physician's epistemic anxiety is transmuted into a judgment about the patient's psychological state, transforming a gap in medical understanding into evidence of feminine instability. This may also emerge in subtle pragmatic acts, as described previously.

The memoirs reveal how pragmatic acts frequently take the form of gender-based microaggressions—those "seemingly innocuous infractions" that "encompass purposeful or unintentional statements or behaviors" conveying disrespect and injustice to marginalized groups. Lynch's experience demonstrates this clearly in her interactions with medical staff. The nurse's gesture of crouching before her and touching her knee while delivering ambiguous information—"Long may it continue," referring to parental support—functions pragmatically on multiple levels. On the surface, it appears solicitous and caring. Pragmatically, it infantilizes Lynch, positioning her as a child needing parental presence rather than an adult patient deserving clear information. Similarly, when the nurse tells Lynch that the professor "wants to see the easy ones first" and will "spend a bit more time with you," these functions pragmatically to reframe Lynch's

cancer as her personal difficulty rather than a medical challenge. The "easy" patients presumably have straightforward cases; Lynch is positioned as complicated, burdensome—the implication being that her case requires extra effort not because of medical complexity but because of something about her. This shifts responsibility from the medical system's failure to diagnose her cancer promptly to Lynch's own problematic presentation.

The consequence of sustained testimonial injustice is profound and extends beyond the immediate clinical encounter. Lynch begins to internalize the disbelief directed at her, doubting her own capacity to interpret pain and distinguish genuine symptoms from anxiety-driven misperceptions. This internalized uncertainty represents the psychological hallmark of medical gaslighting—a phenomenon where epistemic injustice becomes embodied as self-distrust. The patient is not simply denied belief by others; she begins to lose faith in her own perceptual and interpretive capacities. Her bodily knowledge, continually invalidated by medical authority, comes to seem unreliable even to herself. This erosion of epistemic self-trust constitutes an internalized form of testimonial injustice, one that persists even in the absence of explicit dismissal and that can make future medical advocacy profoundly difficult. When a patient no longer trusts her own testimony, she becomes complicit in her own erasure.

My analysis shows gendered testimonial injustice operates not only as external disbelief but as an internalized epistemic injury that erodes the patient's trust in her own body. The systematic devaluation of women's self-reported symptoms functions as both

immediate dismissal and long-term psychological damage, producing subjects who doubt their capacity for self-knowledge. What begins as identity-based credibility deficit becomes, through repetition and institutional reinforcement, a fundamental alienation from one's own bodily experience—a form of epistemic violence that leaves lasting traces in the patient's relationship to herself.

Theme C: The Internalization of Gaslighting and the Formation of Self-Blame (Epistemic Abuse)

Another main finding relates to the psychological and cultural layer to understanding epistemic injustice in medical contexts, demonstrating how the internalization of medical gaslighting transforms into profound self-blame. Khakpour's 'Sick', for example, reveals that sustained dismissal does not simply occur at the level of individual clinical encounters but becomes incorporated into the patient's own framework for understanding her body and suffering. From childhood, Khakpour internalizes feelings of alienation, "homelessness," and unbelonging—experiences rooted in her family's displacement from Iran and the ongoing dislocations of immigrant experience. These early formations create fertile ground for epistemic vulnerability. When epistemic confidence has been compromised from the outset by experiences of cultural marginalization, the additional burden of medical dismissal finds a psyche already primed to doubt its own perceptions.

By adulthood, her Lyme disease unfolds against this backdrop of lifelong unbelief. Doctors exploit her existing doubts, reinforcing that her relapses and persistent symptoms stem from personal failings. Rather than investigating the complexities of chronic Lyme disease or acknowledging the limits of medical understanding, physicians redirect attention to Khakpour's behavior and choices. This dynamic exemplifies what scholars term 'epistemic abuse'—the exploitation of someone's self-doubt and lack of epistemic authority to maintain hierarchical control. By locating the source of her illness in her personal failings rather than in organic disease processes, doctors preserve their own authority while deflecting responsibility for diagnostic uncertainty or treatment failures. The patient's vulnerability—her pre-existing tendency to doubt herself—becomes a tool through which medical power is maintained.

This also brings us back to how identity power operates at complex intersections of gender, ethnicity, and illness. As an Iranian American woman presenting with a "mysterious" condition that defies straightforward diagnosis, she becomes an archetype of the "unreliable narrator of her own suffering." Her gender already positions her as epistemically suspect within medical frameworks that historically pathologize women's testimony; her ethnic difference adds another layer of Otherness that complicates how her body and its symptoms are read; and her medically contested illness aligns her with long-standing cultural narratives about hysteria, malingering, and psychosomatic complaints. These identity categories converge to produce a particularly acute credibility deficit, where multiple systems of prejudice compound to render her testimony maximally dismissible.

Hence, sustained medical gaslighting becomes self-reinforcing, creating an internalized structure of doubt that persists even beyond individual clinical encounters. The language of guilt and moral failure, demonstrate the risk of adopting the very frameworks that have been used to dismiss victims of gaslighting, coming to see her suffering not as something happening 'to' oneself but as something one has caused through insufficient discipline, poor choices, or characterological weakness.

This internalized gaslighting serves a paradoxical psychological function. By accepting responsibility for her illness, the authors seem to regain a precarious sense of coherence and control. If their suffering results from their own failings, then perhaps they can fix it through better behavior, stricter self-management, more perfect adherence to medical advice. Self-blame, however painful, offers the illusion of agency in a situation that might otherwise feel helpless. When the medical system cannot or will not provide answers, aligning with the oppressor's narrative—accepting that the problem lies within oneself—becomes a way of maintaining psychological stability and the hope of eventual relief.

Synthesis: Interconnected themes

The three memoirs examined reveal a systematic architecture of epistemic injustice in medical contexts, operating at institutional, interpersonal, and psychological levels. While each narrative foregrounds a distinct dimension of harm, together they

demonstrate how gendered medical dismissal functions as an interlocking system that spans from knowledge production to internalized self-doubt.

Gendered disparity and institutional neglect exposes the foundational level at which epistemic injustice operates—in the very structures of medical knowledge production itself. The overwhelming prevalence of women among autoimmune and "mysterious" illness patients reveals not simply a biological phenomenon but a hermeneutical failure: the frameworks for understanding these conditions remain underdeveloped precisely because of systemic gender bias in research priorities, diagnostic categories, and clinical training. Identity power operates here at its most structural level, shaping what counts as worthy of medical attention and what remains epistemically obscure. The institutional neglect of conditions that predominantly affect women reflects broader patterns in which women's experiences are deemed less significant, less urgent, and less deserving of conceptual elaboration.

The erasure of women's testimonies demonstrates how this structural bias manifests in clinical encounters, where testimonial injustice systematically diminishes women's credibility. The pattern of disbelief is not random but follows identity-based prejudices: gendered assumptions that women misinterpret their bodies, conflate physical symptoms with emotional distress, or exaggerate minor sensations. Projective identification compounds this dynamic, as physicians unconsciously transfer their own diagnostic uncertainty onto patients, suggesting that symptoms they cannot explain must be psychosomatic rather than organic. This interpersonal dimension of epistemic injustice

transforms the clinical encounter into a site where women's embodied knowledge is actively erased, replaced by medical narratives that privilege professional authority over patient testimony.

Finally, internalized gaslighting and epistemic abuse reveal the deepest psychological consequences of sustained dismissal. When testimonial injustice is repeated across multiple encounters and institutional contexts, it becomes internalized as self-doubt and self-blame. Epistemic abuse exploits pre-existing vulnerabilities—particularly among those already marginalized by intersecting identity categories—to shift responsibility for diagnostic failures onto patients themselves. The result is a form of epistemic self-surveillance in which patients adopt the very frameworks used to discredit them, narrating their suffering through vocabularies of personal failing rather than medical legitimacy. This internalization represents the culmination of systemic gaslighting: the patient becomes complicit in her own epistemic erasure, aligning with dismissive narratives to regain a precarious sense of coherence and control.

These three major insights were inductively developed through an analysis of the three memoirs. They are not merely parallel but interconnected, forming a cascading structure of harm. Institutional neglect creates the conditions for testimonial injustice by leaving certain conditions conceptually underdeveloped and clinically poorly understood. Testimonial injustice, repeated across encounters, creates the conditions for internalized self-doubt and epistemic abuse. Each level reinforces the others: structural bias

legitimizes interpersonal dismissal, which produces psychological injury that further undermines patients' capacity to assert their own knowledge claims.

Together, these three memoirs reveal that medical gaslighting is not merely an interpersonal phenomenon—a matter of individual physician bias or poor communication—but a systemic structure perpetuated through institutionalized gender bias, the systematic discrediting of women's testimony, and the internalization of disbelief as self-blame. In each memoir, identity power underpins the epistemic structure of harm: women's embodied knowledge is dismissed not because of any genuine assessment of epistemic competence but because dominant cultural scripts dictate who counts as a credible knower of pain. These scripts position women as inherently unreliable narrators of their bodily experience, prone to emotional exaggeration, psychological confusion, or attention-seeking behavior.

Medical Gaslighting as Medical Trauma

The experiences described across the three memoirs closely align with clinical definitions of medical trauma. Research suggests that medical gaslighting can create distressing encounters that may result in lasting psychological harm for patients. An interview conducted by Kristen Ballard with clinical health psychologist Dr. Melissa Geraghty provides a concrete illustration of how medical gaslighting can lead to trauma. Dr. Geraghty explains that she was "born with a rare neural tube defect that was not discovered until 2019 when I started to become paralyzed" (Ballard, 2024). Despite repeatedly seeking medical care, her symptoms were dismissed, leading her to question her own credibility: "I then second-guessed myself, thinking that maybe I had verbalized

my symptoms in a way that came off as overdramatic, when in reality I was just listing the symptoms" (Ballard, 2024). The experience ultimately produced lasting anxiety about seeking care again, demonstrating how dismissive medical encounters can produce what she later identified as "medical trauma" (Ballard, 2024).

This example reflects broader clinical understandings of trauma within medical contexts. The International Society for Traumatic Stress Studies (ISTSS) defines medical trauma as the mental and physical reactions that occur in response to pain, injury, serious illness, medical procedures, or distressing treatment experiences. Similarly, the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 2000) describes trauma as a psychological condition resulting from exposure to a deeply distressing or life-threatening event. The American Psychological Association (APA) defines trauma as an emotional response to catastrophic events such as accidents, sexual assault, or natural disasters (American Psychological Association, n.d.). Although these definitions often emphasize external events, medical trauma may also originate from internal illness or distressing interactions within healthcare environments, as demonstrated in Dr. Geraghty's experience.

Clinical mental health counselor Michelle Flaum Hall proposes a more specific framework for understanding medical trauma within healthcare settings. Hall defines medical trauma as "a trauma that occurs from direct contact with the medical setting, and develops through a complex interaction between the patient, medical staff, medical environment, and the diagnostic and/or procedural experiences that can have powerful psychological impacts due to the patient's unique interpretation of the event" (Hall &

Hall, 2016, p. 19). Importantly, Hall emphasizes the psychological and subjective dimensions of these experiences rather than focusing solely on physiological responses to illness or injury.

Hall (2016) organizes and analyzes the concept of "medical trauma" by dividing it into five subsections: (1) direct contact, (2) medical setting, (3) complex interaction, (4) psychological impacts, and (5) patients' unique interpretation (Hall & Hall, 2016, pp. 19-20). Direct contact centers the patient's personal experience with healthcare systems. The medical setting encompasses a wide range of environments where healthcare interactions occur, from hospitals and surgical centers to outpatient clinics and routine examinations. These encounters involve complex interactions among multiple factors, including healthcare professionals, institutional environments, and medical procedures. These interactions may produce significant psychological impacts, affecting patients' mental health, sense of self, relationships, and overall well-being. Finally, each patient's unique interpretation shapes how medical events are experienced and understood, meaning that similar clinical encounters may be perceived very differently depending on the individual.

Hall and Hall's (2016) framework highlights that medical trauma does not arise solely from illness or treatment itself but from the broader relational and institutional dynamics of healthcare. Physician behavior, organizational practices, and the interpretation of patients' symptoms all shape how individuals make meaning of their medical experiences. When patients encounter dismissal, disbelief, or inadequate communication, conditions frequently associated with medical gaslighting, these

interactions can contribute to traumatic outcomes. The following section builds on this framework by examining how patterns of dismissal, distrust, and unequal access to medical knowledge contribute to women's experiences of medical trauma.

CHAPTER SEVEN

THE MULTIFACETED IMPACT of GASLIGHTING

This chapter discusses the traumatic impact of gaslighting on people's mental health, self, relationships and other aspects of their experience. As the previous chapter presented, the memoirs demonstrate that epistemic injustice in medical contexts operates through multiple, mutually reinforcing mechanisms. The memoirs show at the psychological level, sustained dismissal becomes incorporated into patients' self-understanding, producing epistemic self-doubt that persists even in the absence of immediate external gaslighting. At the interpersonal level, identity-based prejudice produces credibility deficits that silence women's testimony and replace patient knowledge with medical assumptions. This unfolds within the contexts of hospitals and other institutions where gendered bias may even shape research agendas and conceptual frameworks, leaving conditions that predominantly affect women epistemically impoverished.

What emerges is a portrait of epistemic violence as systematic and structural, even though my insights are based on three analyses of individual memoirs. Contextualizing these with the findings of the literature review, demonstrates the harm done to women in medical contexts is not reducible to isolated cases of physician misconduct but reflects patterns in how knowledge is produced, whose testimony is credited, and which bodies are deemed capable of authoritative self-interpretation. Understanding medical gaslighting as systemic rather than interpersonal is crucial for

developing adequate responses: individual physician education, while necessary, cannot address structural biases in medical knowledge production, and individual patient empowerment cannot overcome institutional patterns of dismissal. Only by recognizing the full architecture of epistemic injustice—from knowledge production to clinical encounter to internalized self-doubt—can we begin to envision structural remedies adequate to the scope of the harm.

Medical Posttraumatic Stress Disorder

Returning to the memoirs, Lynch's experience demonstrates how delayed diagnosis itself functions as a traumatic stressor. The eight-week wait she was initially given for follow-up—later shortened only because of her persistent advocacy—represents time during which cancer progressed untreated. The trauma here is not merely the disease but the institutional indifference that allowed it to advance. Her confusion at the mammogram appointment, not knowing why she was there or what was happening, exemplifies how lack of clear communication compounds medical trauma. Patients experience not only physical vulnerability but informational vulnerability, unable to understand or prepare for what is happening to their bodies.

Khakpour's memoir reveals how chronic, recurring medical encounters can produce cumulative trauma. Unlike a single catastrophic event, her Lyme disease relapses create repeated cycles of symptom emergence, medical consultation, dismissal, worsening symptoms, and crisis. Each cycle reinforces the previous one's psychological damage. Her desperate email to friends, written while cognitively impaired and terrified,

captures the acute psychological distress of medical trauma in real-time. The trauma is not solely the disease but the predictable pattern of disbelief and abandonment she has learned to expect from medical systems.

The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 2000) defines trauma as exposure to an event that produces intense fear, helplessness, or distress. Women experience posttraumatic stress disorder (PTSD) at higher rates than men, with lifetime prevalence estimates of approximately 10–12% compared to 5–6% for men (Novotney, 2023). This disparity is often attributed to higher rates of interpersonal trauma experienced by women. The World Health Organization estimates that roughly one-third of women worldwide experience physical or sexual violence during their lifetime (World Health Organization, 2021), and the Centers for Disease Control and Prevention reports that approximately one in four women in the United States has experienced rape or attempted rape (Centers for Disease Control and Prevention, 2022).

These experiences can influence later medical encounters. Survivors of sexual violence, for example, may experience re-traumatization during invasive procedures such as childbirth (Blanchfield, 2022). Studies indicate that nearly 45% of first-time mothers report childbirth as traumatic (Blanchfield, 2022). Together, these findings demonstrate how trauma may originate both outside and within medical environments and help explain why women experience higher rates of PTSD following medical events.

Hall (2013) distinguishes between primary and secondary crises that may trigger trauma following medical events. Primary crises refer to traumatic events directly linked to medical experiences, such as heart attacks, strokes, childbirth complications, ICU

hospitalization, or serious diagnoses. Secondary crises are broader psychological consequences that may occur before or after a medical event, affecting domains such as relationships, work, physical health, and spiritual well-being. Individuals already experiencing stress across these domains may be more vulnerable to traumatic responses to medical procedures, particularly when additional risk factors, such as lower socioeconomic status or poorer baseline health, are present (O'Connor et al., 2011; Seligman, 2011). Thus, empirical studies illustrate how medical procedures themselves can generate traumatic responses. In a study of 500 women who underwent obstetric or gynecological procedures, 100 participants described their experiences as “terrifying” or “very distressing,” and 30 met the diagnostic criteria for PTSD (Menage, 1993). Notably, 14 of these women had no prior psychological conditions, suggesting that the medical experience itself served as the primary source of trauma.

Secondary impact

Ramey's search for meaning in unexplained suffering represents an existential quest. Why her? Why this collection of symptoms? Why the medical system's inability to help? Her creation of the WOMI category and her memoir itself represent attempts to make meaning from suffering that medical systems render meaningless (mysterious, unexplained, strange).

Lynch confronts mortality at 28, facing cancer when she expected decades of healthy life. The preventable nature of the delay in diagnosis adds existential outrage to existential fear, it should not be this way, it did not have to be this way. Her anger at the system coexists with her need to navigate that same system for treatment. And

Khakpour's existential struggle is most explicitly articulated. Her reflections on not feeling at home in her body or the world, her descriptions of illness as a form of alienation, her attempts to understand what she did to deserve this suffering, all represent existential grappling with chronic illness complicated by medical dismissal. The absence of clear answers about cause, course, or cure leaves her in existential limbo.

After having discussed the primary impacts of gaslighting, discerning secondary crisis where trauma is caused, is much more elusive and challenging. These effects can be classified as existential crises and spiritual crises, especially patients with diverse religious beliefs or lack thereof at risk, as the memoirs demonstrated.

Furthermore, it is worth examining the collective impact of medical trauma and medical gaslighting on our state of awareness, self-perception, and interpersonal connections, in addition to the two secondary crises previously described. I extensively discussed the prevalence of medical procedures and their ability to alter an individual's body. Many treatments for women, such as a hysterectomy, have a significant impact on their reproductive health and permanently alter their bodies. However, I did not discuss the implications of these physical changes on individuals' daily lives and the resulting mental impact caused by the disruption of their lifestyle.

Impact on Self and Relational

Ramey's description of isolation captures the dynamic of impact on one's self and relational identity. She notes that as her symptoms worsen and defy explanation, relationships become strained. Friends and family who initially offered support grow

frustrated or skeptical. Without medical validation for her experience, she lacks social permission to be ill in ways that others recognize. The WOMI identity she constructs represents both the reality of marginalization and an attempt to create alternative validation structures when mainstream medical and social recognition is unavailable.

Lynch's account emphasizes how medical dismissal creates relationship asymmetries. When doctors tell her the lump is nothing to worry about, she must either accept their authority (and thus invalidate her own concern) or maintain her concern (and thus position herself as irrationally anxious). Either choice creates relational tension—with medical providers who she challenges, with partners or family who she may burden with unvalidated worry, with herself as she navigates competing interpretations of her experience.

Khakpour's email to friends requesting support captures the excruciating vulnerability of asking for help when one's suffering has been consistently dismissed. Her repeated apologizing, her offering to pay friends for their time, her insistence that she will not be offended if they cannot help—all this reflects internalized shame about needing assistance. Medical dismissal teaches patients that their needs are unreasonable, their suffering suspect. This lesson extends beyond clinical encounters to contaminate all requests for support.

One's perception of oneself, commonly referred to as identity, is a crucial aspect of both self-confidence and personal development (Johnston, 2012). Stevens (1990) defines the Self as the fundamental essence of our being, capable of influencing and sustaining our psychological development throughout our lifespan. Individuals often

engage in self-reflection when their self-identity is challenged due to a painful experience. Following a distressing surgical intervention, an individual who previously exhibited confidence and self-sufficiency may subsequently realize that they have become more reliant and submissive, and that their level of self-assurance has diminished. This shift in self-perception may potentially have further consequences in several domains of life, including interpersonal connections and professional trajectories.

Medical treatment-induced trauma can also impact interpersonal interactions. As stated by Walsh, Manuel, and Avis (2005), the quality and frequency of current connections can undergo changes that either foster greater closeness or lead to a gradual drift apart. Individuals who have experienced a distressing childbirth may experience a sense of uncertainty over their own sexual identity, leading to increased susceptibility to emotional and physical intimacy within their personal and relational spheres. Subsequently, it is likely that the nature of communication will shift from being transparent and sincere to being cautious and reserved (Gottman & Silver, 1999), leading to the relationship itself becoming a cause of strain and suspicion. Undoubtedly, the distress or unease resulting from a medical catastrophe can significantly impact individuals' relationships, potentially precipitating a crisis in those partnerships.

Depression

A plethora of studies have been published regarding the correlation between depression and medical trauma and anxiety. Hall (2013) cites a study involving 51 individuals who had been in the intensive care unit (ICU). The study found that 31% of

these individuals exhibited symptoms indicating the presence of anxiety and sadness. These results were obtained nine months after their initial admission in the ICU, indicating the long-term impact of experiencing the ICU on persistent mental diseases (Hall, 2013). This was already present in an older study conducted in 2001 found that 47% of the 80 adults who were treated and released from the intensive care unit (ICU) exhibited clinically significant levels of anxiety and depression. Additionally, 15% of the participants satisfied the complete criteria for post-traumatic stress disorder (PTSD).

Another example of a study conducted in 2012 by Wade examined 157 adult patients who had been discharged from the ICU. The research revealed that 46.3% of the patient's experienced depression, while 44.4% experienced anxiety three months after their discharge. Furthermore, a meta-analysis of 14 studies utilizing the Hospital Anxiety and Depression Scale (HADS) revealed that the average prevalence of individuals meeting the complete criteria for depression was 28%. Although the majority of studies examining depression and anxiety in ICU patients encompass various age groups, few studies have also indicated the presence of depression in older adult survivors (Vest, Murphy, Araujo, & Pisani, 2011). Overall, research has demonstrated that having experience in intensive care is a significant risk in the development of depression. These studies did not link this risk with medical gaslighting, but they do show that people are at increased risk of developing depression or anxiety. While most studies primarily investigate the emergence of melancholy and anxiety in critical care settings, alternative research explores the psychological ramifications of life-threatening conditions such as cancer and heart attacks. A study conducted on 405 oncology patients revealed that 135 of them experienced both depression and anxiety, while 174 individuals experienced

depression alone (Brown, Kroenke, Theobald, Wu, & Tu, 2010). In a study conducted by Schleifer et al. (1989), it was discovered that out of 171 patients who had experienced a heart attack, 45% had symptoms of either major or moderate depression immediately after the incident. Additionally, 33% of the patients still met the criteria for depression 3-4 months later. The statistics clearly indicate that depression and anxiety frequently coexist with severe medical conditions and procedures. Once again, these studies did not connect with the presence or impact of medical gaslighting.

Physical.

A dynamic of invalidation and power imbalance appears in Sarah's experience during her in-office procedure with Dr. Damaskus. As he continued what she described as an increasingly aggressive intervention, Sarah told him that he had gone far enough. Despite her clear expression of distress, the procedure continued, leaving her feeling powerless and unheard. The physical trauma that followed ultimately resulted in sepsis the next morning. For Sarah, the most destabilizing aspect of the experience was that it occurred under the care of a physician regarded as "top-notch." Much like the accounts described by Lynch and Khakpour, her suffering was not only physical but relational: her attempt to assert her own bodily limits was overridden by medical authority. This incident highlights how dismissal within clinical encounters can escalate from emotional invalidation to tangible physical harm, reinforcing the broader pattern in which professional reputation and institutional credibility might outweigh patient testimony.

Medical procedures inherently involve modifying or restoring the physical body. Patients receive instruction on optimal physical recovery and rehabilitation techniques.

However, in some cases, a traumatic experience may result in physical limitations that require significant modifications to their daily activities (Kratz et al., 2010). For example, someone may discover that they are incapable of ascending a set of stairs within their own residence owing to physical alterations, which may need them to move to a different property. The same physical constraint may impede their ability to participate in previously enjoyed activities, such as afternoon running or swimming. Both events possess the capacity to exert a substantial influence on an individual's mental and emotional well-being, perhaps overwhelming them and leading to feelings of melancholy or unease.

Occupational

Ramey's repeated medical consultations, alternative treatments, and inability to maintain stable employment create economic precarity. While her family's medical connections provide some access advantages, they do not protect her from the financial consequences of having a poorly understood, inadequately treated condition. Lynch's delayed diagnosis likely worsened her prognosis and definitely complicated her treatment, with attendant costs in time, money, and physical suffering. The medical system's inefficiencies—the need for referrals, the waits for appointments, the miscommunications between departments—add logistical burdens on top of the disease burden.

Khakpour's need to maintain employment while experiencing severe cognitive and physical symptoms creates impossible conflicts. She must appear functional to keep her teaching positions, but doing so requires expending energy reserves she does not

have, potentially worsening her condition. Her email to friends asking for help with basic tasks such as getting to work or walking her dog reveals how medical dismissal forces patients to cobble together informal support systems because formal systems (healthcare, disability accommodations, workplace modifications) are unavailable or inadequate.

The memoirs document how medical gaslighting produces concrete economic and occupational harm. When patients cannot obtain proper diagnosis and treatment, they may be unable to work. When they seek multiple medical opinions (as all three authors do), they incur financial costs. When chronic conditions go unmanaged, disability accumulates.

CHAPTER EIGHT

CONCLUSION

Medical gaslighting stands as a significant adversary within the contemporary healthcare landscape. The aforementioned memoirs illustrate the experiences of three distinct women, each encountering medical gaslighting in unique contexts, varying in age, historical period, and geographical location. It is important to clarify that this is not a certainty for women; this phenomenon, which remains largely elusive due to its concealed characteristics, presents a complexity that is challenging to navigate for them, for health professionals, healthcare administrators and for scholars-researchers, too. The unpredictability of its manifestation, whether driven by malicious intent or not, underscores the intricacy of the concept, making its practical application all the more daunting. All individuals, regardless of their role or identity, may encounter the phenomenon of medical gaslighting: patients, healthcare professionals, and all those involved. Education bears the duty to discern prevalent patterns, pinpoint the groups most impacted, and foster understanding to dismantle the biases that may perpetuate gaslighting.

This concept must be extended to the global context, acknowledging that the phenomenon of medical gaslighting occurs even within highly progressive and advanced healthcare systems, such as in the United States, as illustrated in Sarah Ramey's *Unwell Woman*, where research and education have achieved unprecedented levels. Ramey engaged in dialogue with and received assistance from cutting-edge healthcare organizations, originating from a family with distinguished medical credentials. Lisa

Lynch was obtaining her healthcare in the United Kingdom, where it is asserted that women experience greater access to medical services. Nonetheless, Lynch encountered a misdiagnosis, as her complaints were dismissed based on the assumption that being 28 years old with no familial history suggested little cause for concern, leading to an oversight of her pain tolerance. Envision this scenario in a nation with minimal healthcare infrastructure, one that is still in the process of creating its governmental and healthcare frameworks, characterized by an absence of standardized educational systems with established criteria, and existing educational institutions that do not incorporate medical gaslighting as a criterion for instruction. Medical gaslighting is, in fact, not a novel phenomenon. It is an indelible presence that will mark the old medicine, the new medicine, and the present. Despite medical breakthroughs, gender, or financial status, medical gaslighting is a human behavior driven by individual experiences and information deficits, hence shaping one's perspective of reality.

To transition from acknowledgment to action, it is inadequate to merely identify medical gaslighting as a widespread and persistent issue; we must also comprehend its functioning in real time. If medical gaslighting is ingrained in human interaction— influenced by bias, authority, fear, and uncertainty—it will manifest not only in hospitals and clinics but also in the nuanced psychological dynamics that govern those interactions.

The next three scenarios are fictional case studies that show how these dynamics work, especially written for people most at risk of experiencing medical gaslighting: patients, but I have added useful guidelines for health professionals to help prevent it and suggest

possible responses when patients feel medically gaslit. These scenarios aim to teach patients, clients, and health professionals how to spot warning signs, understand the underlying dynamics, and develop effective ways to respond and protect their sense of reality by showing how gaslighting patterns play out in everyday clinical conversations. I distinguished three main ways that medical gaslighting can happen in each scenario: projective identification, testimonial injustice, and overt power play. Storytelling makes the abstract concept useful by turning theory into tools for recognizing, resisting, and protecting oneself.

Scenario 1 Elena's Story: Projective Identification

Elena had been living with severe fatigue, dizziness, and pain that came and went without warning. After months of inconclusive tests, her physician, Dr. Rowan, began to sound impatient.

"You seem anxious," he said one morning. "Maybe this is just stress. You need to relax."

Elena flushed with embarrassment. She hadn't mentioned feeling anxious, but now she wondered if she was. Each appointment left her uneasy — as though she were the problem, not her symptoms. Dr. Rowan, once attentive, had grown distant. When she described new pains, he sighed and said, "You really focus on your body a lot, don't you?"

After a particularly frustrating visit, Elena noticed something: Dr. Rowan often appeared uncomfortable when he didn't have clear answers. He'd tighten his jaw, look away, and change the subject. It dawned on her that her uncertainty might be echoing his own.

When he couldn't solve her case, he projected his frustration and helplessness onto her — labeling her as “anxious” or “overly focused” to preserve his image as competent and in control.

At her next appointment, Elena brought her partner for support and calmly presented a summary of her symptoms, test results, and prior notes. When Dr. Rowan began to interrupt, she said, “I understand that my case is complex. But uncertainty doesn't mean these symptoms aren't real.”

Her tone was steady. Dr. Rowan looked momentarily startled — as if she had reflected something back to him that he wasn't ready to see. He shifted in his chair, finally saying, “Let's look at this again.”

Elena left that day still without answers, but no longer doubting her sanity. She recognized that part of what had made her question herself wasn't just disbelief — it was his discomfort projected into her. Seeing that pattern gave her clarity and power.

Guidelines from Elena's Story: recognizing signs of projective identification in medical gaslighting

It can be hard to spot projective identification in medical gaslighting because it often happens in small ways during clinical interactions. An emotional change that feels strange or out of proportion is one of the first signs. After an appointment, you might feel more guilt, shame, or self-doubt than you did before. These feelings can come on slowly, which makes it hard to figure out where they came from.

Another sign of recognition is when a clinician's discomfort with uncertainty is reframed as a problem that is your fault. Instead of admitting that current medical knowledge is limited or that your symptoms are complicated, the provider may suggest in a subtle way that your reactions are too emotional or unstable. In this situation, real questions about your health may be turned into anxiety, exaggeration, or obsessive worry. You may start to feel like you are to blame for the doctor's lack of clear answers over time, taking on responsibility for a problem that is not yours.

Being aware is the first step in responding to projective identification. Quietly naming the dynamic to yourself can be a strong first step. Realize that the anger, defensiveness, or confusion in the room may not be coming from you, but from the clinician.

Practical safeguards can also make it less likely that things will get distorted. Having written records of symptoms, timelines, and past consultations gives the conversation a clear starting point. When possible, having someone you trust there can help make things clearer and hold you accountable even more.

Staying grounded in your own life is just as important. "I know this may be hard to understand, but these symptoms are real" is an example of a statement that supports both the complexity of medicine and the truth of your situation. When you start to doubt yourself, stop and ask yourself, "Whose feeling is this—mine or theirs?" This reflective practice stops you from unconsciously taking on someone else's anxiety or defensiveness.

Finally, look for professionals who can work together and deal with uncertainty without blaming anyone. Providers who are honest about their limits, encourage conversation, and respect what patients have to say make environments that are less likely to lead to projective dynamics.

When clinicians keep dismissing, ignoring, or psychologizing your concerns without properly assessing them, intervention is needed. It is also important to do something if you often leave appointments feeling confused, ashamed, or silenced, especially if you notice that you are taking on feelings that do not seem right or that you do not understand. Patterns that keep happening, not just one-time misunderstandings, are a sign that the dynamic may be bad. When you know these times, you can ask for a second opinion, switch providers, or be more assertive about your care.

In this story, Dr. Rowan's projective identification manifests as the unconscious projection of his own helplessness and professional insecurity onto Elena. Clinicians are humans, too, and even though they are trained to deal with uncertainty, by framing her as *anxious* and *difficult*, they may act like the physician in the scenario: safeguarding their identity as competent — yet inducing patients in the very feelings (confusion, self-doubt, anxiety) that they disown. This scenario exemplifies the psychodynamic roots of gaslighting, where emotional projection and power imbalance combine to distort shared reality.

Practical Guidelines for healthcare professionals: lessons from Elena's story

Elena's experience highlights the significance of healthcare providers recognizing and managing their own emotions during patient care. When patients exhibit discomfort,

annoyance, or defensiveness during appointments, providers should consider whether their own feelings stem from uncertainty, fear of error, or other internal pressures rather than the patient's behavior. Validating patients' experiences is crucial, and healthcare providers should avoid presuming that complex or unclear symptoms, which do not align with typical conditions, are fabricated or stem from anxiety or emotional issues without conducting a comprehensive assessment. It is important to acknowledge the patient's experiences. Even a straightforward statement like "I do not have a clear explanation at the moment, but I take your symptoms seriously" can foster trust and reduce the likelihood of imposing your own worries on the patient. Even though health care providers expressing their uncertainties during consultations may risk simplifying medicine and unintentionally transferring their own anxieties to patients, the memoirs indicate that patients prefer honesty and transparency over overreliance on certainty.

Scenario 2 Janelle's Story: testimonial injustice and power play

Janelle was a 35-year-old Black woman who began experiencing heart palpitations, fatigue, and shortness of breath. When she went to the emergency department, the doctor glanced briefly at her chart before saying, "You're too young for heart problems. Maybe it's anxiety or caffeine."

Janelle tried to explain that she rarely drank caffeine and that her mother had died of a cardiac condition in her forties, but the doctor was already typing notes, barely looking up. He handed her a prescription for anti-anxiety medication and told her to "get more rest."

Weeks later, Janelle returned—this time with chest pain so severe she could barely speak. A different physician admitted her immediately and discovered a serious heart condition that had been developing for months. The cardiologist looked surprised and said softly, “This should have been caught earlier.”

Janelle felt a mix of anger and grief. She realized that the first doctor hadn’t just missed her symptoms—he hadn’t believed her. His assumptions about her age, gender, and race had quietly determined the credibility of her words. He had heard “anxious Black woman” instead of “patient in distress.”

For a long time, Janelle blamed herself for not insisting harder, for not being more assertive. But as she began to read about testimonial injustice, she recognized what had really happened: her credibility was unjustly deflated by bias. The problem wasn’t that she hadn’t spoken clearly—it was that her voice had been filtered through someone else’s prejudice.

When she later joined a patient advocacy group, Janelle began keeping a copy of her medical records and encouraged others to do the same. “You have to protect your story,” she told new members. “Sometimes the system doesn’t listen—but that doesn’t mean your experience isn’t real.”

Guidelines from Janelle’s Story: Recognizing Medical Gaslighting through Testimonial Injustice

Medical gaslighting based on testimonial injustice often shows up as patterns of downplaying and reinterpreting. Instead of looking into your symptoms on their own

terms, you might use stereotypes to explain them. For instance, people might say that their physical problems are caused by "anxiety," "stress," or "perceived attention-seeking" without doing enough clinical research. Over time, this reframing can make people less likely to take your concerns seriously.

Another important sign is a big gap in credibility. You might notice that people are skeptical, interrupting, or doubting your explanations, but they believe what doctors or even family members say without question. In these instances, authority seems to be unevenly shared, and your voice does not carry as much weight as evidence.

Testimonial injustice can also make people feel like they are responsible for what happened. You might think, "Maybe I didn't explain it well enough," or "Maybe I'm overreacting." At the same time, implicit bias based on gender, race, age, or other identity markers may affect how your words are understood, remembered, or even written down in medical records. The distortion does not always happen in a clear way; it can be hidden in tone, chart notes, or clinical assumptions that change your story in a subtle way.

To fix testimonial injustice, you need both practical and mental strategies. Writing things down is an important first step. Keeping written records of your symptoms, medications, test results, and even copies of your visit notes make an independent record of what happened. Written proof can make it less likely that something will be misinterpreted or left out.

Having a trusted witness come to appointments with you could also change the power dynamics. Having someone else there can back up your story and stop people from

being rude. Use neutral but firm language when talking to providers to show that you are the expert. Statements such as "I'd like this noted in my record" or "Could you explain why this explanation doesn't match my symptoms?" hold people accountable without making things worse.

It is also important to understand that testimonial injustice is a systemic problem. Recognizing that credibility gaps frequently arise from overarching cultural biases aids in depersonalizing the experience. The issue is not a personal communication failure; it signifies systemic patterns regarding the valuation of knowledge. Looking for patient advocacy groups or groups of people who have had similar experiences can help restore credibility and rebuild the self-trust that repeated rejection may damage.

When symptoms are regularly described as "all in your head," especially if they have not been thoroughly evaluated, it is time to do something. It is also necessary to take action when objective evidence, such as lab results or imaging, is ignored, downplayed, or misrepresented. If you feel like you have to go above and beyond to prove your credibility or legitimacy to get care, this is a sign of an unhealthy relationship. In the same way, you should not ignore bias when identity-based assumptions seem to affect how your symptoms are understood.

In Fricker's terms, the injustice here is both dyadic (doctor and patient) and structural, since it operates through identity power—socially shared imaginaries about who is believable and who is not. Janelle's eventual empowerment through documentation and community mirrors the restorative response to epistemic injustice: reclaiming her credibility and narrative authority.

Practical Guidelines for Healthcare Professionals: lessons from Janelle's story

Janelle's story shows how bias and testimonial injustice may change how patients are treated and make them less trusting, especially women of color. Healthcare professionals can counteract these biases by rigorously evaluating their own perspectives and reflecting on how age, gender, or ethnicity may inadvertently affect their perception of signals. One way to protect patient integrity is to ensure this patient's documentation is accurate, thereby reducing the risk of errors or missing information in medical records. Medical records must accurately reflect the patient's story, objective results, and any conversations about symptoms.

As a clinician, clearly explain the reasons for diagnoses and treatment plans, encourage questions, and clear up any confusion to help everyone understand better. Being open and involving patients by allowing them to bring a trusted family member, friend, or advocate to their sessions can help build trust, ensure that all their issues are heard, and protect them against bias. Using simple and clear language, such as asking for a correct report or more information, encourages professional responsibility and reduces conflict. Clinicians can ultimately interact with patients in an even more humble and meaningful manner by acknowledging that trust deficits often stem from systemic issues rather than individual failings, actively challenging prejudices, and creating a professional space where patients' opinions are heard, understood, and valued.

Scenario 3 Priya's Story: Identity Power

Priya was 28 when her migraines became unbearable. They came with dizziness, light sensitivity, and sudden bouts of nausea that sometimes left her unable to work. After months of enduring them, she visited a neurologist.

He listened for a few minutes before smiling politely. “You’re young, you’re working long hours, probably staring at screens too much,” he said. “Try reducing stress. Maybe meditate or take fewer painkillers — sometimes they make headaches worse.”

Priya nodded, uncertain. She was indeed working long hours, but something about the headaches felt deeper, more insistent. When she tried to explain, the doctor interrupted gently, “You women are always so hard on yourselves. Don’t overthink it.”

That line stayed with her: You women.

At home, she began doubting her body. Maybe she was exaggerating. Maybe she was weak. Her friends reassured her that doctors knew best. Still, she felt unseen — as though her youth and gender had scripted her into a role: the “stressed young woman” whose pain was emotional, not physical.

Months later, a new doctor — a woman in her forties — ordered an MRI after noticing subtle neurological signs. The scan revealed a small but serious vascular issue pressing near Priya’s optic nerve. It was treatable, but only because she had persisted.

When she thought back to the first appointment, she realized it wasn’t just that the first doctor hadn’t believed her — it was that he couldn’t see her outside the stereotype his imagination supplied. Her gender and age had quietly shaped the limits of her credibility.

His identity power, rooted in a shared social conception of who young women are and how they should feel, had determined what kind of patient she was allowed to be.

Now, Priya keeps a record of every appointment. She tells her story openly when friends doubt their symptoms: "You don't need to be perfect to deserve belief. Sometimes you're fighting an idea, not just an illness."

Guidelines from Priya's Story: identifying signs of identity power in medical gaslighting

Medical gaslighting based on identity power often starts with small groups. Instead of concentrating on your symptoms, a clinician might interpret your experience through social identity labels similar to "emotional," "too young," or "overreacting." When you talk to these people, they do not just look at your medical problems based on how serious they are; they also look at them through stereotypes based on your gender, age, class, or other parts of your identity.

Before you even say anything, you might start to feel like credibility has already been given. People hear what you say differently because of who you are, not what you are talking about. The conversation may slowly move away from your health and toward your personality, lifestyle, stress levels, or how you think you are. When this happens, identity-based assumptions take the place of clinical focus, subtly changing how you see your symptoms from medical facts to character traits.

To deal with identity-based gaslighting, you first have to recognize the pattern. Understanding that disbelief may arise from identity assumptions rather than

inadequacies in your explanation aids in averting the internalization of unjust doubt. This awareness sets your credibility apart from the stereotypes that are affecting the interaction.

Documentation is once more a way to protect yourself. Keeping detailed records of symptoms, doctor visits, and repeated rejections can help you see patterns that might not be obvious at first. Using neutral language to set boundaries when talking to the clinician can help bring the conversation back to the medical issue at hand. For instance, saying, "I get your point, but I'm worried about these symptoms in particular," keeps the conversation professional while bringing it back to the main point.

Looking for different medical opinions could also shake up long-held beliefs. Different practitioners may not have the same hidden biases, and a second opinion can help where identity-based dismissal used to be the norm. Lastly, talking about your experiences with other people, either through trusted relationships or support groups, can help you feel like you have epistemic authority again. Collective validation frequently mitigates the isolating consequences of stereotype-based disbelief.

When stereotypes or assumptions about your identity keep coming up in your medical visits, it is time to take action. If disbelief continues despite consistent evidence, transparent communication, or repeated self-advocacy, the issue may transcend mere misunderstanding. It is especially worrying when credibility is linked to gender, age, or how someone expresses their feelings, either directly or indirectly. Persistent identity-based dismissal indicates a systemic issue rather than an isolated erroneous interaction.

This situation shows what philosopher Miranda Fricker (2007) means by "identity power." Identity power is the effect of shared social imaginations that shape what it means to be a "young woman," a "elderly patient," or a "professional," even before any evidence is looked at.

In Priya's situation, the neurologist's authority was bolstered not only by professional hierarchy but also by prevalent cultural stereotypes regarding the emotionality of young women. His identity power worked both actively, like when he called her concerns "overthinking," and passively, by relying on ingrained norms that see women's pain as psychological rather than physical. The outcome was testimonial injustice: Priya's credibility was diminished due to social identity bias.

Practical Guidelines for Healthcare Professionals: lessons from Priya's story

Priya's story shows how important it is to believe patients, even when their symptoms do not fit common demographic patterns or stereotypes. As a clinician, pay close attention and not dismiss concerns as overreaction, emotionality, or stress without first doing a full assessment. Using neutral, focused language can bring conversations back to the medical issue while remaining professional. For instance, you could say, "I understand your point of view, but I am only worried about these symptoms." It is also important to get a second opinion or work with others, since individual biases can cloud judgment. Referrals for further evaluation or interdisciplinary consultation can ensure that care is thorough and prevent identity-based dismissal. Clinicians may find it helpful to know that repeated credibility gaps are often caused by social and cultural assumptions that are built into the system, not by personal failures. Being humble when talking to

patients, actively fighting stereotypes, and creating an environment where everyone's voice is heard all help lessen the power of identity, give patients more control, and make healthcare safer and fairer for everyone.

The gaslighting aspect manifested as Priya started to internalize this rejection. She doubted her own ability to feel her body, her reasoning, and slowly took the stereotype into her own view of herself. Priya fought against both the psychological effects of gaslighting and the epistemic harm caused by identity power by writing down her thoughts and speaking up for herself. By doing this, she turned passive disbelief into active credibility, showing that she was still in charge of her own body.

Medical gaslighting is not a fleeting occurrence or an overstated representation of isolated events. This dissertation has shown that it represents a pervasive relational harm situated at the intersection of psychology, authority, and institutional medicine. It has traced the development of gaslighting from the play "Gas Light" to contemporary psychological theory, and its integration into clinical environments, demonstrating how the distortion or denial of a patient's lived experience can occur insidiously, systematically, and often without explicit malicious intent. But intention does not negate effect. Whether on purpose or by accident, losing a patient's trust in themselves has real effects on their mental, social, and physical health.

The literature suggests that gaslighting compromises an individual's perception and autonomy. When applied to medicine, which is already organized by expertise and hierarchy, the effects are even stronger. Patients are asked to compare what they know to what a professional knows, and when those two things do not match up, the person who is more vulnerable usually has to deal with the doubt. The memoirs examined in this

study illustrate that dismissal is rarely confined to a single appointment; rather, it accumulates, transforming identity, straining relationships, and, in some cases, resulting in delayed diagnoses and medical trauma. The stories of Sarah Ramey and Lisa Lynch, among others, show that even well-known institutions and advanced healthcare systems can be affected. Medical gaslighting persists across geographical boundaries, social strata, and temporal contexts, rooted in systemic inequities and human behaviors, including bias, projection, defensiveness, and the maintenance of power.

The integration of scholarly research with the three memoirs as personal accounts demonstrates that medical gaslighting extends beyond simple miscommunication. It can happen in different ways, for example, when a patient's credibility is unfairly lowered (testimonial injustice), when a clinician unconsciously projects their own worries or assumptions onto the patient (projective identification), or when authority is used to silence dissent (overt power play). Even though these mechanisms are different, they all have the same effect: they make it harder for patients to make their own choices. Education and awareness thus emerge as indispensable instruments of reform — not to delegitimize medical practice, but to strengthen its epistemic foundations. Advancing meaningful progress would then require integrating into medical curricula the critical competencies of pattern recognition, reflexive interrogation of implicit bias, and engagement with the concept through practice. This dissertation asserts that medical gaslighting represents a valid and enduring threat owing to its insidious characteristics. It does well when people are confused, there are strict rules, and they cannot question authority. But it is not permanent. By presenting three scenarios and guidelines for patients and health professionals, I provided ways to break the cycle by giving patients

the words to describe their experiences, encouraging providers to reflect on their actions through specific questions, and ensuring that healthcare systems take responsibility.

Medicine works best when people work together and trust each other. We have to take care of the small things that break trust to keep it. Healthcare can only fulfill its moral duty of listening, validating, and healing without hurting anyone if it does so.

References

- Abellowins. (2021, April 14). *What happens to the brain during depression – Transformations center*. Transformations Treatment Center. <https://www.transformationstreatment.center/treatment/what-happens-to-the-brain-during-depression/#:~:text=Depression%20causes%20the%20hippocampus%20to,of%20cortisol%2C%20the%20amygdala%20enlarges>
- About sexual violence*. (2022). Sexual Violence Prevention. https://www.cdc.gov/sexual-violence/about/?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/sexualviolence
- Abramson, K. (2014). Turning up the lights on gaslighting. *Philosophical Perspectives*, 28(1), 1-30. <https://doi.org/10.1111/phpe.12046>
- Algner, M., & Lorenz, T. (n.d.). *You're prettier when you smile: Construction and validation of a questionnaire to assess microaggressions against women in the workplace*. Frontiers. <https://www.frontiersin.org/articles/10.3389/fpsyg.2022.809862/full>
- American Psychiatric Association, DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™* (5th ed.). American Psychiatric Publishing, Inc.. <https://doi.org/10.1176/appi.books.9780890425596>
- Ballard, K. (2024, April 2). *Medical Gaslighting: The devastating effects of being told your symptoms are not valid*. INvisible Project. <https://invisibleproject.org/medical-gaslighting-the-devastating-effects-of-being-told-your-symptoms-are-not-valid/>
- Barnes, E. (2023). Trust, Distrust, and 'Medical Gaslighting'. *The Philosophical Quarterly*, 73(3), 649-676. <https://doi.org/10.1093/pq/pqad035>
- Blanchfield, T. (2022, January 31). *What is medical trauma?* Verywell Mind. <https://www.verywellmind.com/what-is-medical-trauma-5211358#citation-1>
- Boissoneault, L. (2017, March 6). *How a soap opera virus felled hundreds of students in Portugal*. Smithsonian Magazine. <https://www.smithsonianmag.com/history/how-soap-opera-virus-felled-hundreds-students-portugal-180962383/>
- Bonnard, J. B. (2014). Male and female bodies according to Ancient Greek physicians (L. E. Doherty and V. S. Cuchet, Trans.). *Clio*, (37). <https://doi.org/10.4000/cliowgh.339>

- Booth, S. (2018, September 5). *How to avoid gender-based medical Gaslighting*. Health. <https://www.health.com/mind-body/is-your-doctor-gaslighting-you>
- Brigham and Women's Hospital. (n.d.). *Hysterectomy options*. Boston Hospital & Medical Center - Brigham and Women's Hospital. <https://www.brighamandwomens.org/obgyn/minimally-invasive-gynecologic-surgery/hysterectomy-options#:~:text=Each%20year%20approximately%20600%2C000%20hysterectomies,every%20minute%20of%20the%20year>
- Britannica Encyclopedia. (1998, July 20). *Hippocratic oath*. Encyclopedia Britannica. <https://www.britannica.com/topic/Hippocratic-oath>
- Brown, L. F., Kroenke, K., Theobald, D. E., Wu, J., & Tu, W. (2010). The association of depression and anxiety with health-related quality of life in cancer patients with depression and/or pain. *Psycho-Oncology*, 19(7), 734-741. <https://doi.org/10.1002/pon.1627>
- Burton, S. (2023, August 29). *Podcast 'The Retrievals' reveals painful experiences of female patients are often ignored*. Interview by L. Desjardins. PBS News Hour. <https://www.pbs.org/newshour/show/podcast-the-retrievals-reveals-painful-experiences-of-female-patients-are-often-ignored#:~:text=Yes%20Not%20now-.Podcast%20%27The%20Retrievals%27%20reveals%20painful%20experiences%20of,female%20patients%20are%20often%20ignored&text=A%20new%20podcast%20is%20bringing,egg%20retrievals%20with%20saline%20solution>
- Chaudhury, S., Srivastava, K., Bhat, P., & Sahu, S. (2017). Misogyny, feminism, and sexual harassment. *Industrial Psychiatry Journal*, 26(2), 111-113. https://doi.org/10.4103/ipj.32_18
- Cleghorn, E. (2021). *Unwell women: Misdiagnosis and myth in a man-made world*. Penguin.
- Connors, D. D. (1980). Sickness unto Death: Medicine as Mythic, Necrophilic and Iatrogenic. *Advances in Nursing Science*, 2(3), 39-51. <https://doi.org/10.1097/00012272-198002030-00005>
- Davis, S. (2020, June 8). *Medical and mental health Gaslighting and iatrogenic injury*. CPTSD Foundation. <https://cptsdfoundation.org/2020/06/08/medical-and-mental-health-gaslighting-and-iatrogenic-injury/>
- Davis, S. J. (2022). The enormous problem of medical gaslighting. *MOJ Addiction Medicine & Therapy*, 7(1), 4-5. <https://medcraveonline.com/MOJAMT/MOJAMT-07-00151.pdf>

- Demmler, J. C., Atkinson, M. D., Reinhold, E. J., Choy, E., Lyons, R. A., & Brophy, S. T. (2019). Diagnosed prevalence of ehlers-danlos syndrome and hypermobility spectrum disorder in Wales, UK: A national electronic cohort study and case-control comparison. *BMJ Open*, 9(11), e031365. <https://doi.org/10.1136/bmjopen-2019-031365>
- Dorpat, T. L. (1996). *Gaslighting, the double whammy, interrogation, and other methods of covert control in psychotherapy and analysis*. Jason Aronson.
- Doyle, G. (2023, April). Are You Being Gaslighted? With Dr. Robin Stern. *We can do hard things*[Audio Podcast].
- Femtech Insider. (2023, May 31). *Female Millennials Most Affected by Medical Gaslighting, According to New Research by Mira*. <https://femtechinsider.com/medical-gaslighting-survey-mira/#:~:text=More%20than%20a%20third%20>
- Fraser, S. (2021). The toxic power dynamics of gaslighting in medicine. *Canadian Family Physician*, 67(5), 367-368. <https://doi.org/10.46747/cfp.6705367>
- Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.
- Ganesh, K., & Lazar, A. (2021). The Work of Workplace Disclosure: Invisible Chronic Conditions and Opportunities for Design. *Proceedings of the ACM on Human-Computer Interaction*, 5(1), 1-26. <https://doi.org/10.1145/3449147>
- Gillette, H. (2023, August 3). *What are the types of abuse? Psychological, physical, and more*. Psych Central. <https://psychcentral.com/lib/types-of-abuse#1>
- Gottman, J. M., & Silver, N. (1999). *The seven principles for making marriage work*. Crown.
- Gupta, M., Madabushi, J. S., & Gupta, N. (2023). Critical Overview of Patriarchy, Its Interferences With Psychological Development, and Risks for Mental Health. *Cureus*, 15(6). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10332384/#:~:text=Women%20are%20driven%20to%20desperate,a%20fundamentally%20rigid%20heteronormative%20lens>
- Hale, S. (2023, April 28). *Medical Gaslighting: The truth & hidden dangers - Mira blog*. Mira Fertility. <https://www.miracare.com/blog/medical-gaslighting/>
- Hall, M. F. (2013). The psychological impact of medical trauma: One woman's childbirth story. *Nursing for Women's Health*, 17(4), 271-274. <https://doi.org/10.1111/1751-486x.12045>

- Hall, M. F., & Hall, S. E. (2016). *Managing the psychological impact of medical trauma: A guide for mental health and health care professionals*.
- Halverson, C. M., Penwell, H. L., & Francomano, C. A. (2023). Clinician-associated traumatization from difficult medical encounters: Results from a qualitative interview study on the ehlers-danlos syndromes. *SSM - Qualitative Research in Health*, 3, 100237. <https://doi.org/10.1016/j.ssmqr.2023.100237>
- Indla, V., & Radhika, M. S. (2019). Hippocratic oath:Losing relevance in today's world? *Indian Journal of Psychiatry*, 61(4), 773-775. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_140_19
- International Society for Traumatic Stress Studies. (n.d.). *ISTSS - Public resources*. <https://istss.org/public-resources/friday-fast-facts/fast-facts-medical-trauma#:~:text=Medical%20trauma%20is%20emotional%20and,be%20difficult%2C%20uncomfortable%20or%20frightening>
- Jex-Blake, S. (1886). *Medical women: A thesis and a history* (44th ed.). Verlag.
- Johns Hopkins Medicine. (2019, November 19). *Common surgical procedures*. <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/common-surgical-procedures>
- Johns Hopkins Medicine. (2022, November 16). *Hysterectomy*. <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/hysterectomy#:~:text=About%20half%20a%20million%20hysterectomies,ages%20of%2040%20and%2050>
- Johnston, D. (2012). Mindfulness: A proposed couple-based intervention for the altered self-identity of breast cancer survivors. *Mindfulness*, 3(4), 282-290.
- Katz Institute for Women's Health. (n.d.). *Gaslighting in women's health: No it's not just in your head*. <https://www.northwell.edu/katz-institute-for-womens-health/articles/gaslighting-in-womens-health>
- Kelley, A. (2023, August 21). *3 ways women are impacted by Gaslighting*. Psychology Today. <https://www.psychologytoday.com/us/blog/in-your-corner/202308/3-ways-women-are-impacted-by-gaslighting#:~:text=When%20considering%20race%2C%20women%20of,with%20medical%20gaslighting%20previously%20explored>
- Khan, K., Tariq, N. U., & 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>

- King, H. (1986). Agnodike and the profession of medicine. *Proceedings of the Cambridge Philological Society*, 32, 53- 77.
<https://doi.org/10.1017/s006867350000482x>
- Klein, W., & Bartz, J. A. (2023, June). *A Historical Review of Gaslighting: Tracing Changing Conceptualizations Within Psychology and Psychiatry* [Poster session]. Canadian Psychological Association Annual Convention.
- Klein, W., Wood, S., & Li, S. (2022). *A Qualitative Analysis of Gaslighting in Romantic Relationships*. <https://osf.io/preprints/psyarxiv/cjrpq>
- Klein, w., Wood, S., & Bartz, J. A. (2023). *You Think I'm Insane: An Integrative Review and Novel Theoretical Framework for Studying the Phenomenon of Gaslighting*. University of Toronto. <https://osf.io/preprints/psyarxiv/g55mp>
- Kratz, A. L., Williams, R. M., Turner, A. P., Raichle, K. A., Smith, D. G., & Ehde, D. (2010). To lump or to split? Comparing individuals with traumatic and nontraumatic limb loss in the first year after amputation. *Rehabilitation Psychology*, 55(2), 126-138. <https://doi.org/10.1037/a0019492>
- Laderer, A. (2023, November 16). *The history of hysteria and its link to mental health*. Charlie Health. <https://www.charliehealth.com/post/the-history-of-hysteria-and-its-link-to-mental-health>
- Lynch, L. (2010). *The C-word*. Random House.
- Mah, L., Szabuniewicz, C., & Fiocco, A. J. (2016). Can anxiety damage the brain? *Current Opinion in Psychiatry*, 29(1), 56-63.
<https://pubmed.ncbi.nlm.nih.gov/26651008/>
- McKinnon, R. (2017). Allies behaving badly. *The Routledge Handbook of Epistemic Injustice*, 167-174. <https://doi.org/10.4324/9781315212043-16>
- Martinich, A. and Stroll, . Avrum (2023, December 26). epistemology. Encyclopedia Britannica. <https://www.britannica.com/topic/epistemology>
- Medaris, A. (2022, August 4). *I'm a doctor who's witnessed medical gaslighting. Here's how I try to avoid it, and how patients can advocate for themselves*. Insider. <https://www.insider.com/doctor-mike-how-to-deal-with-avoid-medical-gaslighting-2022-8>
- Menage, J. (1993). Post-traumatic stress disorder in women who have undergone obstetric and/or gynaecological procedures: A consecutive series of 30 cases of PTSD. *Journal of Reproductive and Infant Psychology*, 11(4), 221-228. <https://doi.org/10.1080/02646839308403222>

- Merriam-Webster. (n.d.). *Definition of microaggression*.
<https://www.merriam-webster.com/dictionary/microaggression>
- Novotney, A. (2023, April 13). *Women who experience trauma are twice as likely as men to develop PTSD. Here's why*. <https://www.apa.org>.
<https://www.apa.org/topics/women-girls/women-trauma>
- O'Connor, M., Christensen, S., Jensen, A. B., Møller, S., & Zachariae, R. (2011). How traumatic is breast cancer? post-traumatic stress symptoms (PTSS) and risk factors for severe PTSS at 3 and 15 months after surgery in a nationwide cohort of Danish women treated for primary breast cancer. *British Journal of Cancer*, 104(3), 419-426. <https://doi.org/10.1038/sj.bjc.6606073>
- Peer, R. F., & Shabir, N. (2018). Iatrogenesis A review on nature, extent, and distribution of healthcare hazards. *Journal of Family Medicine and Primary Care*, 7(2), 309-314.
https://journals.lww.com/jfmpc/fulltext/2018/07020/iatrogenesis_a_review_on_nature,_extent,_and.6.aspx
- Periyakoil, V. S., Chaudron, L., Hill, E. V., Pellegrini, V., Neri, E., & Kraemer, H. C. (2020). Common types of gender-based microaggressions in medicine. *Academic Medicine*, 95(3), 450-457. <https://doi.org/10.1097/acm.0000000000003057>
- Pollock, B. (2023, April 11). *Downplayed distress: Gaslighting in women's healthcare*. The Daily Free Press – The Independent Student Newspaper at Boston University. <https://dailyfreepress.com/2023/04/11/downplayed-distress-gaslighting-in-womens-healthcare/#:~:text=Medical%20gaslighting%20in%20women%27s%20healthcare,of%20the%20participants%20were%20women>
- Ramey, S. (2021). *The lady's handbook for her mysterious illness: A memoir*. Anchor.
- Roberge, M., Dupuis, G., & Marchand, A. (2010). Post-traumatic stress disorder following myocardial infarction: Prevalence and risk factors. *Canadian Journal of Cardiology*, 26(5), e170-e175. [https://doi.org/10.1016/s0828-282x\(10\)70386-x](https://doi.org/10.1016/s0828-282x(10)70386-x)
- Roy, D. (2023, March 29). *What is medical gaslighting?* Medtigo.
<https://medtigo.com/blog/what-is-medical-gaslighting/>
- Schleifer, S. J. (1989). The nature and course of depression following myocardial infarction. *Archives of Internal Medicine*, 149(8), 1785. <https://doi.org/10.1001/archinte.1989.00390080059014>
- Scienceblog. (2023, March 21). *When your doctor doesn't believe you: Navigating medical Gaslighting*. <https://www.scienceblog.co.uk/medical-gaslighting/>

- Seligman, M. (2011). *Flourish: A visionary new understanding of happiness and wellbeing*. New York, NY: Free Press.
- Serial Productions, & The New York Times. (2023, June). The Retrievals. <https://open.spotify.com/show/6EvG4iL7sOi8L4UrzLopmE?si=654e0574e03449a8>
- Shapiro, S., Kelly, J. P., Rosenberg, L., Kaufman, D. W., Helmrich, S. P., Rosenshein, N. B., Lewis, J. L., Knapp, R. C., Stolley, P. D., & Schottenfeld, D. (1985). Risk of localized and widespread endometrial cancer in relation to recent and discontinued use of conjugated estrogens. *New England Journal of Medicine*, 313(16), 969-972. <https://doi.org/10.1056/nejm198510173131601>
- Spear, A. D. (2019). Epistemic dimensions of gaslighting: Peer-disagreement, self-trust, and epistemic injustice. *Inquiry*, 66(1), 68-91. <https://doi.org/10.1080/0020174x.2019.1610051>
- Staden, H. V. (1992). The discovery of the body: human dissection and its cultural contexts in ancient Greece. *Yale J Biol Med*, 65(3), 223-241. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2589595/>
- Stanford Encyclopedia of Philosophy. (2022, January 21). *Kant's moral philosophy (Stanford encyclopedia of philosophy)*. Retrieved January 20, 2024, from <https://plato.stanford.edu/entries/kant-moral/>
- Steele, E. (2022, November 8). *When doctors cause harm: Finding causes vs managing symptoms*. Psychology Today. <https://www.psychologytoday.com/us/blog/putting-the-care-back-in-healthcare/202211/when-doctors-cause-harm>
- Stevens, A. (1990). *On Jung*. Princeton, NJ: Princeton University Press.
- Strong, K. (2023, March 25). *Uncovering the dark reality of medical Gaslighting*. Medium. <https://medium.com/change-your-mind/uncovering-the-dark-reality-of-medical-gaslighting-5f05b16e875b>
- Tait I. (1982). DUBOS' MIRAGE OF HEALTH. *The Journal of the Royal College of General Practitioners*, 32(237), 248.
- Timmons, M. (2019, June 26). *Gender Gap in Surgery Costs: Women Pay Less but More Often*. ValuePenguin. <https://www.valuepenguin.com/gender-gap-in-surgery-costs#costs-all>

- Vest, M. T., Murphy, T. E., Araujo, K. L., & Pisani, M. A. (2011). *Disability in activities of daily living, depression, and quality of life among older medical ICU survivors: A prospective cohort study*. *Health and Quality of Life Outcomes*, 9(1), 9. <https://doi.org/10.1186/1477-7525-9-9>
- Violence against women*. (2021) World Health Organization (WHO). <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>
- Voermans, N. C., Van Alfen, N., Pillen, S., Lammens, M., Schalkwijk, J., Zwarts, M. J., Van Rooij, I. A., Hamel, B. C., & Van Engelen, B. G. (2009). Neuromuscular involvement in various types of ehlers–danlos syndrome. *Annals of Neurology*, 65(6), 687-697. <https://doi.org/10.1002/ana.21643>
- Walsh, S. R., Manuel, J. C., & Avis, N. E. (2005). The impact of breast cancer on younger women's relationships with their partner and children. *Families, Systems, & Health*, 23(1), 80–93.
- Waska, R. T. (1999). Projective identification, self-disclosure, and the patient's view of the object: the need for flexibility. *The Journal of psychotherapy practice and research*, 8(3), 225-233.
- Weckesser, A. (2023, September 12). *Women's pain is often not believed – here's how to make your voice heard when seeking help*. The Conversation. <https://theconversation.com/womens-pain-is-often-not-believed-heres-how-to-make-your-voice-heard-when-seeking-help-207866#:~:text=Women%20are%20also%20believed%20to,as%20seriously%20by%20a%20practitioner>
- Whiteman, H. (2015, January 11). *Almost 1 in 5 hysterectomies are 'unnecessary,' study finds*. Medical and health information. <https://www.medicalnewstoday.com/articles/287736>
- Wiley, & Sons. (2010). *Tool: Recognizing Microaggressions and the Messages They Send*[Slideshow].https://academicaffairs.ucsc.edu/events/documents/Microaggressions_Examples_Arial_2014_11_12.pdf

Curriculum Vitae

Sophia Aburmeileh earned her Doctorate in Medical and Health Humanities (DMH) from Caspersen School of Graduate Studies Drew University. One conviction has guided her academic and professional life: that patients deserve to be believed.

Her doctoral dissertation *No One in Your Corner: Medical Gaslighting, Epistemic Injustice, and the Absence of Patient Advocacy* explores the ethical and epistemic dimensions of medical gaslighting, a widespread and often invisible harm in which healthcare providers dismiss, belittle, or psychologize patients' health concerns. By combining philosophical accounts of epistemic injustice with first-person memoirs of women navigating the healthcare system, Aburmeileh shows that medical gaslighting is not just a question of individual physician prejudice, but rather a systemic phenomenon perpetuated by patriarchal structures, gendered power relations, and institutionalized disregard for women's bodily knowledge. Her work calls for structural reform and provides practical tools to help patients and healthcare professionals identify and resist dismissive care.

Aburmeileh, a passionate patient rights advocate, completed her clinical practicum at Morristown Medical Center within the Atlantic Health System where she explored bioethics as it relates to palliative and hospice care and participated in grand rounds and interdisciplinary case discussions on some of the most complex ethical issues in medicine. Much of her basic biomedical research has been on the preservation of autonomy for people with neurodegenerative disease, and she has spent a lot of time working to improve women's reproductive rights and access to health care.

Outside of academia, Aburmeileh has extensive experience as a biological scientist and research scientist in the biotechnology industry. Her background includes

federal quality assurance and leadership in regulatory compliance, donor operations and laboratory science. Her industry work echoes the same dedication to precision, integrity and human welfare that is characteristic of her scholarly research.

Aburmeileh's work is at the intersection of science, ethics and the humanities, a space she believes is critical to building a healthcare system that listens as attentively as it treats.