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Gender-biased Diagnosing, the Consequences of Psychosomatic Misdiagnosis and 'Doing Credibility'

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“I ended up in the hospital, where he told me that the pills had been placebos, because he thought the symptoms were psychosomatic”:

Gender-biased Diagnosing, the Consequences of
Psychosomatic Misdiagnosis and ‘Doing Credibility’

Eda Clare Smith

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of the requirements for the degree of Bachelor of Arts

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Abstract

This research was aimed at exploring patient perspectives on the gender-politics of doctor-patient relationship, finding the number of men and women who had experienced psychosomatic diagnosis or misdiagnosis, and assessing the detrimental health consequences of psychosomatic misdiagnosis by investigating patient experiences. Thirty-nine respondents (13 men and 26 women) of ages ranging 18 to 71 completed open-ended questionnaires designed to gauge their relevant feelings and experiences. Hypothesis was that findings would be indicative of gender-biased diagnosing; that women would have significantly more reports of psychosomatic diagnosis and misdiagnosis, more negative experiences with doctors, and more experiences in which they physically suffered as a result of psychosomatic misdiagnosis. This research found strong evidence of gender-biased diagnosing. It also found that 1) many women reported experiencing sex discrimination in a doctor-patient relationship, and over half of women had discontinued seeing a doctor for this reason, 2) a small phenomenon of “doing credibility” was found in that patients, mostly female, reported downplaying severity of symptoms in dialog with their doctor in fear of complaining or appearing “irrational,” and 3) women were found to suffer traumatic and health-crippling experiences, sometimes ending up in the emergency room needing surgery or suffering for years with debilitating undiagnosed medical conditions, as a direct consequence of their symptoms being mislabeled as psychosomatic.

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Table 1

Clinicians, like ghetto schoolteachers, do not study themselves or publicize their own motives, personalities, and values as easily or frequently as they do those of their neurotic patients or 'culturally deprived' pupils.

-Phyllis Chesler, *Women and Madness* (2005:61)

Women are more than twice as likely to be told by their physician that their physical symptoms are psychosomatic. Although many explanations have been offered for why this is (physicians are acting upon gender stereotypes; women tend to report more symptoms than men do), this phenomenon of which has been called "gender-biased diagnosing" has repeatedly been found to permeate doctor-patient encounters (Munch 2004). There exists a good deal of research (Webster 1993; Maserejian 2009) on the fact that certain medical diseases are largely under-diagnosed in women and mental illness over-diagnosed (Council on Ethical and Judicial Affairs 1991), yet very little is understood about the everyday consequences of gender-biased diagnosing. Though there has been some research on the female patient experience of living with chronic, medically unexplained disease and the hardships of not being taken seriously by doctors, there has been virtually no research on the average patient's experiences of gender-biased diagnosing. This leaves us with little knowledge about whether patients receive psychosomatic diagnoses with which they disagree, in what ways they may have sustained costs to their well-being as a direct result of a psychosomatic misdiagnosis, and how patients feel about issues of gender in the doctor-patient relationship.

This research aims at finding how many patients, in an average group of everyday people, have been negatively affected by a false psychosomatic diagnosis. This study also seeks to find if men also report being given psychosomatic diagnosis, and to what extent psychosomatic diagnosis is actually gendered. Another point to this research is to probe how damaging the consequences of

psychosomatic misdiagnosis can be to a patient, or to find how serious this issue really is. Finally, this study also desires to explore the social politics of psychosomatization in doctor-patient encounters, more specifically, if male or female patients are aware of, anticipate, or behave in a certain way in order to avoid a psychosomatic diagnosis.

Through having men and women answer an open-ended questionnaire designed to assess their experience of psychosomatic diagnosing, I intend to study the experiences of both male and female respondents. Findings will be analyzed, described and discussed through the feminist theory of gender-biased diagnosing.

The Belief of the Female Emotional-Body Connection

The social construction of women as innately emotional or psychologically susceptible has permeated societal beliefs for centuries (Lorber and Moore 2002). Most influential in creating this gender stereotype was the early belief that women were psychologically connected to their reproductive organs. The ancient Greeks thought there to be a link between the womb and women's emotions (Bachmann 1990). Mid-nineteenth century upper class women equated being sickly and pale with being ladylike (Ehrenreich and English 1978). Twentieth century psychoanalysts created the notion of "hysteria," literally meaning "wandering uterus," referring to the female emotional-body connection, to describe psychologically disturbed women (Munch 2004). Freud described female hysteria as, "the mysterious leap from the mind to the body" (Nadelson and Notman 1990). Illnesses related to the female reproductive system have historically been the primary form of gender-biased diagnosing (Munch 2004). It was long taught that menstrual pain was the direct effect of a woman's rejection of the feminine role, and that infertility and 'morning sickness' were caused by a mother's emotional ambivalence about childbearing (Corea 1977; Nadelson and Notman 1990; Munch 2002).

Three distinct psychosocial disorders, in which a patient is thought to imagine, fabricate, and be fraught with unexplained disease, are and have always been extremely feminized. “Somatization disorder,” first described in the mid-nineteenth century, was diagnosed in patients who continued to complain of somatic (or bodily) symptoms, despite having repeated negative medical workups. This disorder was almost exclusively diagnosed in women. “Hypochondriasis,” in which a patient is over-occupied with health concerns and is thought to imagine symptoms, is so feminized that medical professionals have almost solely used female examples to represent hypochondriacs (Corea 1977). “Fictitious disorder,” in which women are believed to deliberately simulate illness in order to use the sick role as a means of escape from social pressures and dissatisfaction with life, has been called today’s new and accepted version of hysteria, only in the form of a medically recognized ‘disorder’ (Kanaan 2010).

Women’s issues in health care were first brought to light in America during the feminist health care movement of the 1970’s. This crusade pushed for a rethinking of the accepted “truths” about the biological and psychosocial nature of women and their bodies, and challenged the “pure” and “objective” scientific knowledge regarding women that male scientists and doctors had created within a male-dominated institution (Munch 2004). Along with the introduction of the popular concept of “medicalization,” or the process of making certain human conditions into medical problems, also came the feminist critique that western medicine served as a means of social control and male regulation of the female body (Lorber and Moore 2002).

It was during this revolution of women’s health care that feminists began to use medical sociology to analyze the power dynamics of doctor-patient relationship, medicine as a means of social control, and the false sociocultural beliefs concerning women that the medical institution had integrated into its own belief system (Richman et al. 2000). Whereas male physicians had long

studied the idiosyncrasies of women and their bodies, women now began to study the peculiarities of physicians and their interactions with women (Munch 2004).

The women's health movement inspired the first critique of modern medicine for continuing to wrongfully teach its students that normal female reproductive conditions were psychologically caused. In 1973, a female gynecologist and her physician husband pointed out that medical students were still learning that menstrual cramps and other reproductive conditions were emotionally caused, three decades after they had been scientifically proven to be of biological origin (Lennane and Lennane).

Though several other women's illnesses and conditions at this time were also disproportionately or erroneously thought to be caused by psychosocial or psychiatric causes (Richman et al. 2000), this was groundbreaking research. This feminist literature would be the inception of what eventually led to the feminist theory that women are commonly "psychologized" in this way by the social constructions of the historically androcentric institution of western medicine and their physicians (Corea 1977; Davis 1988; Richman et al. 2000; Lorber and Moore 2002).

Of utmost interest in the study of the psychologization of women and gender-bias diagnosing is the fact that western medicine's belief in "psychogenesis" (psychological and/or psychiatric origin of physical symptoms) was completely founded on sociocultural belief, and was not based on any medical research (Munch 2002). Psychosomatic diagnosis, nonetheless, became a common explanation for physical symptoms (Munch 2002).

As feminist scholars continued to research the psychologization of women within the institution of western medicine, they began to find that the exaggerated female emotional-body connection was still taught in everyday medical literature. Textbooks on the practice of medicine still taught medical students that women purposely overstress health complaints. As recently as 1971, a

gynecology textbook read, “many women, wittingly or unwittingly, exaggerate the severity of their complaints to gratify neurotic desires” (Corea 1977:75) A related study found that in that same year, 72% of physicians referred to women when describing the typical complaining patient, almost exclusively used “she” when describing psychogenic patients, and commonly referred to women to “hypochondriacs” in medical lectures (Corea 1977). It was clear that not only were physicians insensitive to sex role stereotyping--they were teaching it.

By the late 1970’s, a landmark study found that women’s health complaints were more likely than men’s to be dismissed as unimportant or as psychological (Armitage, Schneiderman and Bass 1979). This was the first published substantiation of gender-biased diagnosing (Munch 2004). Another study done the same year (Wallen, Waitzkin and Stoeckle 1979) also found that physicians more often told women their symptoms were psychosomatic. Feminist scholars, both men and women, were quick to agree that gender-biased diagnosing was a widespread problem, and played a “critical role in uncovering and problematizing gender bias in physicians’ diagnosing of female medical patients” (Munch 2004).

Gender-Biased Diagnosing

Doctors hold a great deal of social power in that they decide who is truly “sick” and what symptoms are regarded as minor, psychosomatic, or not worthy of medical tests and treatment (Ehrenreich and English 1978). Armitage, Schneiderman, and Bass (1979) carried out the first research study on gender-biased diagnosing and found significant evidence of its legitimacy as a phenomenon in the medical setting. Through the observation physician responses to five common health complaints in over one hundred doctor-patient encounters involving both male and female patients, they found that for each complaint, women were taken less seriously. The doctors provided men with more extensive testing and diagnosis. Women were more often given a psychosomatic diagnosis.

The researchers suggested that the physicians were most likely responding to sex stereotypes. In other words, the researchers concluded that the physicians may have been enacting upon the theory that men who are taught to hold in their feelings and not show weakness, rarely complain of symptoms unless it is something serious. On the other hand, women are given much more freedom to talk about how they feel, and may even feel more feminine when they report health issues.

A study by Wallen, Waitzkin and Stoeckle that same year found that physicians were not only much more likely to label female health complaints as psychosomatic, but that in addition, they were spoken to at a level of lesser intelligence than were men. The study found that physicians consistently offered women, as opposed to men, longer and more elementary explanations for their illness, speaking to them in a manner of lesser intelligence than that in which the woman had asked. This condescending speech was not found to occur between physicians and male patients. From this, the researchers concluded that the gendered doctor-patient encounter did not only affect diagnosis but was also political, in the way that doctors often purposefully withheld medical and technical information from their female patients.

In several medical settings and in the treatment of various ailments, women have repeatedly been found to be treated less seriously and to be given less diagnostic medical testing than men with the same health complaints, including heart palpitations (Steingart et al. 1991), neck pain (Hamberg et al. 2002) and various other symptoms (Hamberg et al. 2008). Numerous studies since the discovery of gender-biased diagnosing find further evidence (Bernstein and Kane 1981; Colameco, Becker and Simpson 1983; Friedlander and Phillips 1984; Kreiger, Rowley and Herman 1993; Malterud 1993; Oakley 1993). Studies now show that women are over twice as likely to be told by physicians that their physical health complaints are psychosomatic (Munch 2004).

Gender-Biased Diagnosing of Depression and Anxiety

The phenomenon of gender-biased diagnosing presents itself in several forms. Not only are women more likely than men to be told by their physicians that their physical symptoms are psychosomatic, but studies have found that women are more likely than men to be diagnosed with depressive and anxiety disorders because of physician gender bias (Friedlander and Phillips 1984; Floyd 1997; Laurence and Weinhouse 1997; Bertakis 2001; Aragoes, Pinol and Labad 2006). It has been estimated that 30-50% of women diagnosed with clinical depression are misdiagnosed (Council on Ethical and Judicial Affairs 1991). Women are more than twice as likely as men to be diagnosed with both anxiety and depressive disorders.

Sex-role stereotyping has also been blamed for the greater inclination of doctors to prescribe women anti-anxiety medication (Munch 2004). Physicians prescribe women benzodiazepines, or anti-anxiety medication, at a highly disproportionate rate than they do men (around 70% of benzodiazepine users are female) (Ashton 1991; Van der Waals 1995; Linden et al. 1999).

As already emphasized, whether a patient's somatic complaints are given medical attention or whether they are dismissed as psychosomatic is left to the physician's discretion. The probability of misdiagnosis is greatly increased by the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," or DSM, in which long lists of physical symptoms are listed as indicators of anxiety and depression (Fava and Molnar 1987). Women are also more likely to have a number of certain biological illnesses that closely resemble and can be misdiagnosed as anxiety (Zerbe 1999). The fact that anxiety and depression often are caused by, or are a comorbidity of biological disease (Zerbe 1999), the prevalence of bodily illness lacking biological markers (Richman et al. 2000), and the gendered perceptions of mental disorder (Hamberg et al. 2004; Chesler 2005) all complicate the accurate diagnosis of medical complaints in women.

The fact that women predominate in these mental illnesses (anxiety and depression) may in turn affect the diagnostic process when doctors take into account the patient's sex as a risk factor. In studying the process of diagnosis for Irritable Bowel Syndrome (IBS), a condition of chronic digestive problems for which there is no known cause, gender was found to play a significant role in the diagnosis of the illness (Hamberg et al. 2004). This is not surprising, as IBS is believed to be psychologically caused and/or exacerbated by stress.

However, because the sex of the doctor did not show any correlation with the presence of gender bias, and because doctors were much more likely to diagnose women, the researchers introduced the phenomenon of "knowledge-mediated gender bias." In this phenomenon, the researchers conclude, once gender differences in a certain condition have been established, it affects the diagnosis of patients by way of physicians using their sex as a determining factor. The DSM provides ethnic, age and gender characteristics of all listed mental illnesses. This could also encourage physicians to disproportionately diagnose women with medical anxiety or depression.

Gender and Doctor-Patient Interaction

Observational studies of doctor-patient encounters have sought to determine the impact of the sex of the physician on patient behavior. Research has found that both male and female patients speak more to female physicians, disclose more biomedical and psychosocial information, and appear more secure in their statements. With female doctors, patients are also more assertive, and take a more active role in finding a diagnosis (Hall and Roter 2002).

Another study found that patients prefer "caring" over "dominant" physician personalities, and that these physician personalities significantly affect patient behavior (Mast, Hall and Roter 2008). Patients engage less in medical dialog and display more submissive behavior in the presence of a "dominant" physician, while they express emotions more freely with a caring doctor. Both of

these studies on sex of doctor and doctor-patient interaction suggest that patients could more often anticipate psychosomatic diagnoses from male doctors.

The gender of the patient is also an important factor in the doctor-patient encounter. Women have been found to report physical symptoms at a higher rate than men (Kroenke and Spitzer 1998) and to seek medical care more often than men do (Todd 1989). Lorber and Moore indicate that women could report more symptoms than men because they might be more attuned to their bodies (2002). Sex-role socialization has also been blamed for women's higher symptom reporting, suggesting that it is more socially acceptable for women to indicate health problems and seek medical care (Todd 1989).

The above could even be used as a counterargument for the existence of gender-biased diagnosing, if it were argued that women report more symptoms because they worry too much. However, the Armitage, Schneiderman, and Bass study (1979) controlled for volume of complaints by categorizing complaints into types, and still found that women were given differential diagnosis.

Diseases Commonly Misdiagnosed in Women

There are several illnesses and diseases proven to be commonly misdiagnosed in women as anxiety, depression, or symptoms of psychosomatic cause. Women's susceptibility to under-diagnosis frequently leaves them untreated for a serious medical illness.

Interstitial cystitis (IC) is often pathologized in women who express the physical symptoms. A serious and painful bladder disease, ninety percent of sufferers of this particular illness happen to be women, and yet the illness is frequently misdiagnosed by physicians as a psychiatric problem, or as psychosomatic (Webster 1993). Since these women usually complain of several symptoms including chronic urinary urgency, irregular menstrual periods, painful urination, and pain during sexual intercourse, the doctors are more inclined to think it that they are overanxious about their health and that their symptoms are psychological (Webster 1993). The gender-biased misdiagnosis

of illness not only causes the wrongful diagnosis of mental illness but leaves several female patients undiagnosed as they continue to suffer the painful symptoms of the disease.

Coronary Heart Disease (CHD) is greatly under-diagnosed in women, despite the fact it is the leading cause of death of women in both the United States and worldwide. It is commonly misdiagnosed as stress or anxiety in women who show symptoms of the disease, such as erratic heartbeat (Maserejian 2009). It often manifests in ways that, when presented in women, are often interpreted by doctors to be an effect of an underlying anxiety disorder (Clark 1994). Studies have also found that physicians are generally less aggressive in treating this disease in women (Steingart et al. 1991), in spite of it being the most common cause of death for women. Women who are hospitalized for abnormal heart behavior receive fewer diagnostic procedures than men (Ayanian and Epstein 1991). Also, if a female patient who is experiencing signs of CHD admits to her doctor that she is going through a stressful time in her life, she is at an even higher risk of being misdiagnosed with anxiety problems (Chiaromonte and Friend 2006).

Medically Unexplained Illness and Credibility in Female Patients

Illnesses of no known biological origin, especially those from which women disproportionately suffer, are still claimed by the medical world to be “psychogenic,” though these claims are unfounded (Richman et al. 2000). A few studies have documented the struggles of women living with medical complaints of no known biological origin, or otherwise testable evidence of disease, who are continually told that their symptoms are caused psychologically (Richman et al. 2000; Werner et al. 2003; Nettleton et al. 2004; Werner et al. 2004; Newton et al. 2010). The phenomenon of medically unexplained illness (MUI) significantly affects women for unknown reasons, and could be blamed on sex-role theory or that many of these illnesses mostly affect women (Richman et al. 2000). Some MUIs are so feminized in society that male sufferers sometimes hide their suffering in fear of feeling emasculated (Richards et al. 2008; Unknown author 2010).

Chronic fatigue syndrome is a good example of a MUI erroneously believed to be solely a woman's disease.

Feminist theory would suggest that the male-dominant institution and belief system of medicine controls and decides what health problems are officially recognized as diseases, and who is defined as "sick" or "healthy" (Ehrenreich and English 1979; Zimmerman 1987). Some feminist scholars, in explaining the psychosomatic diagnosis of MUI's in women, have argued that western medicine generally operates from the reductionist viewpoint that to be truly "sick," one's cause of illness must be of proven biological origin (Ehrenreich and English 1978; Richman et al. 2000).

One explanation for the psychosomatization of medically unexplained illness, especially that which mostly affect women, is that the unknown origin of the disease makes it vulnerable to quick social inferences and leaves it open to interpretation, leading to the unfounded blaming of the disease on psychosomatic causes in scholarly literature (Richman et al. 2000). For instance, after the sudden and widespread emergence of Chronic Fatigue Syndrome, a controversial illness of unknown cause which primarily afflicts women (Richman, Flaherty and Rospenda 1994), over 800 medical publications readily offered explanations of biological, psychiatric, and psychosocial natures. One scholarly journal even proposed it to be a consequence of perfectionist and over-achievement personality styles (Fry and Martin 1996).

Conditions such as CFS, fibromyalgia, lupus and environmental illness are diseases that predominantly afflict women and are poorly understood. These illnesses, though they have very real symptoms and afflict millions, are still regarded with a degree of uncertainty in the medical world (Charmaz and Rosenfeld 2010). Women suffering from these debilitating illnesses are often belittled or ignored (Clarke 2002). As one sufferer of CFS put it, it is as if the principal investigator for the CDC, "couldn't find out what was causing the illness, and instead of admitting that, he called us

psychoneurotic” (Johnson 1996:260). CFS sufferers have lobbied for medical research funding with little success (Richman et al. 2000).

When it comes to the over-diagnosis of mental illness in the face of medically unexplained disease, a former surgeon who came down with the illness writes, “though many CFS patients are depressed, CFS is not depression. Antidepressants may treat that depression, but CFS persists. Likewise, therapists may support but not cure; some patients find their psychiatrist is the only one who believes they are physically ill” (English 1991:117).

Women suffering from chronic pain are also commonly not perceived as credible by their doctors (Werner and Malterud 2003). This causes the sufferers of these diseases to not only be plagued with symptoms but to constantly deal with what Stockl (2007) refers to as, “existential uncertainty,” or the questioning of one’s own competence as an adult, and to deal with feelings of shame, guilt, and fear (Werner, Isaksen and Malterud 2004).

Women suffering from medically unexplained chronic pain have been found to share a certain culture of “doing pain” (Werner, Isaksen and Malterud 2004). Though they differed in their styles, these women were hyper-aware of the doctor’s inclination to believe their symptoms to be psychosomatic, and used tactics such as downplaying the severity of symptoms, only reporting certain health concerns, acting as rational as possible, and pre-planning their appearance for the doctor’s visit in order to be perceived as a more credible patient.

Since the severe chronic pain they experience is unrecognized by doctors, it is extremely difficult for them to find a physician who can provide them with sufficient pain relief, and they find themselves leaving doctor’s office after doctor’s office feeling humiliated and ashamed (Richman et al. 2000). Sufferers of Chronic Fatigue Syndrome, in addition to being undertreated for pain, are often treated inappropriately with psychotropic medications that are ineffective (Richman et al.

2000). Blaming the syndrome on hormonal imbalance in the past has even led to unnecessary hysterectomies in female patients (Kaiser 1991).

The Consequences of Gender-Biased Diagnosing

Since the diagnosis of psychosomatic illness is one that is overwhelmingly socially constructed (Munch 2002) and which seems to have no diagnostic criteria other than personal discretion of the physician, it is important that the presence of real and biological illness is completely ruled out (Zerbe 1999). Health care practitioners who presume “psychogenic etiology” of a patient’s health complaints can negatively impact the patient’s health outcome by erroneously minimizing the severity of symptoms and overlooking the presence of serious illness in need of a medical diagnosis and treatment (Council on Ethical and Judicial Affairs 1991).

Phyllis Chesler, in her book, *Women and Madness*, on gender bias in the diagnosis of mental illness, recently (2005) added a personal concern for the under-studied negative effects of gender-biased diagnosing and sexism in western medicine:

When I first explored sexist bias among mental health professionals in 1972, I did not realize that when western medicine does not understand and/or cannot cure an illness, it often first denies that the illness is real by saying it is merely a psychiatric disorder. [...]

Increasingly, women with disabling medical illnesses are being psychiatrically diagnosed and sedated rather than tested or treated for a non-psychiatric illness. Just as asthma and arthritis were once viewed as psycho-somatic, today lupus, multiple sclerosis, Lyme’s disease, chemical and food allergies, Gulf War Syndrome, Chronic Fatigue Immune Dysfunction Syndrome, and certain neurological and endochronological diseases are still being dismissed as primarily psychiatric in nature.

Patients--usually women--are told, both by psychologists and psychiatrists, that they are probably imagining their pain, that their illness is all in their heads. Often it is not. While I so believe that psyche and soma are one, I know that viruses, parasites, bacteria, fungi, sexually transmitted diseases, and toxic chemicals are real and can cause neurological and cognitive dysfunction.

Depression is real too, and has a neurochemical basis; however, depression can also be a secondary symptom of chronic pain. Many psychiatric inpatients are still not believed when they complain of physical pain. Non-psychiatric medical care is often withheld until a patient collapses--or is discovered to have a terminal illness, long past treating. (3)

Though Chesler illustrates the detrimental consequences that can result from gender-biased diagnosing, there currently exists no evidence of, or research on such experiences.

Patient Experience of Gender Bias

Something yet to be explored are the perceptions and experiences of patients in the phenomenon of gender-biased diagnosing. Though there exists some research on the hardships of women seeking help for medically unexplained and commonly psychologized illness (Richman et al. 2000; Munch 2002; Werner and Malterud 2003; Werner, Isaksen and Malterud 2004), there is missing research on the general, everyday patient experience of gender-biased diagnosing.

Munch (2004) points out that existing research assumes that women are simply victimized, and indicates that “patient satisfaction surveys” could explore the impact of doctor-patient relationship on women, and their awareness and agency in gender-biased diagnosing. This type of research, she continues, could be used to “investigate if, and in what contexts, women actually ‘buy into’ and internalize being mislabeled.” Qualitative patient-based research, she indicates, could also provide answers as to whether women seek second opinions when they believe their symptoms have been mislabeled as psychosomatic, and their internal reactions to such experiences.

The aim of this research is to explore patient perspectives on the gendered aspects of doctor-patient relationship, and to describe patient experiences of psychosomatic misdiagnosis. This research also seeks to find if more women than men report having been given a false psychosomatic diagnosis. This study also seeks to understand the effects that gender-biased diagnosing can have on women, and to look for patient experiences in which a psychosomatic misdiagnosis has had a detrimental impact on their health outcome.

In addition, this research aims to see how aware women are of gender-biased diagnosing, and if they, more than men, report anticipating psychosomatic diagnosis. If they are aware of gender-biased diagnosing, does this cause them to feel that they need to under-report symptoms to be taken seriously? Lastly, this research seeks to find if women report being wrongfully or unnecessarily diagnosed with mental illness, namely anxiety or depression, or having been ineffectively medicated for physical symptoms.

I expect this research to result in findings that support the theory of gender-biased diagnosing. I imagine that more women than men will report having had not only psychosomatic diagnoses, but psychosomatic misdiagnoses. I hypothesize that women in particular will share instances of times they have suffered a great deal or had significant costs to their health as a direct result of psychosomatic misdiagnosis. I also hypothesize that women, much more than men, will speak of the hardships of being a patient, or of dealing with doctors who are inclined to dismiss or minimize their health concerns. I think that women may report sometimes behaving in a certain way in order to encourage a medical diagnosis as opposed a psychosomatic one. While I do think it is possible that some men will have experienced a psychosomatic misdiagnosis, I think that a gender pattern will be clear.

Methodology

A qualitative approach using an open-ended questionnaire was used to achieve substantive insight into the issue being studied. Through the use of an open-ended questionnaire, respondents could provide answers to personal and uncomfortable questions to the extent that they wished, and were given the opportunity to describe at length an experience they had. As seen in the lack of responsiveness from some respondents, interviews may have been lopsided, yielding hit-or-miss data. Questionnaires in place of interviews also allowed for a larger sample size, and the aim of this

research was to find how gender bias affects the average patient. Surveys that did not use open-ended questions would have yielded data not detailed enough for accurate interpretation.

The purpose of the research was to discover and assess patient experiences of sex discrimination and perspectives on the gendered aspects of the doctor-patient relationship. The questionnaire consisted of several questions, some of which were closed-ended (sex of respondent, age of respondent, use of general practitioner) and some of which were open-ended, aiming to assess their feelings and experiences.

Questions that were designed to illicit self-reported experiences of gender-bias included a range from direct statements such as, “have you ever felt treated in a certain way by your doctor because of your sex?” to more specific questions such as, “have you ever had a doctor tell you that “stress” is probably the cause of your health complaint, or downplay the seriousness of a health complaint? If you can remember any instances, please list/describe.” All questions that were used to assess whether they felt they had experienced sex discrimination were followed by encouragement of description or explanation of the experience.

The questionnaire also asked whether the respondent had ever been referred to a psychologist or psychiatrist by their physician for (a) physical health complaint(s). Another question asked if the respondent had ever been prescribed anti-anxiety or anti-depression medication from their general doctor, and asked what the reasoning for this was, if not specifically for sadness or anxiety. In addition, the questionnaire included an important question designed to assess whether the respondent has struggled with physical symptoms that have been misdiagnosed as psychosomatic by their doctor. This gives the respondent a chance to explain their story if they had ever had a hard time with symptoms that were misdiagnosed or with chronic illness that were difficult to diagnose, and if their experience was plagued by doctor’s opinions that it was all in their head.

These varying types of questions were together designed to elicit reports of any and all kinds of experience of gender bias in the medical setting, not just those that have already been discussed in scholarly literature on gender bias in doctor-patient relationship (gender politics in doctor-to-patient communication, gender-biased diagnosing), providing patients a medium by which they can describe any other ways they feel gender affects or has affected their medical encounters and treatment.

Benefits of surveying patients included that patients can describe meaningful first-hand experiences of any psychosomatic misdiagnosis, and can provide some quantitative data as to how many average patients are affected. Patients (as opposed to physicians) also have no incentive to withhold information regarding any negatively gendered experiences they feel have taken place in the medical setting. Patients who do not receive equal care or are maltreated on account of their race, gender, age, class or any other variable are the main focus of medical sociology itself.

The most important advantage of using patients as the unit of analysis in this research was that patient responses could provide new insights into any gendered patient performance in everyday medical encounters, and reveal just how aware of (and affected by) gender-biased diagnosing patients are. Patients could reveal to what degree they have agency, or if they ever refuse to accept a psychosomatic diagnosis, and in what ways, if any, women feel they have been negatively affected in their lives by gender-biased diagnosing. Because these questionnaires were given to both women and men, this research also served in itself as another small but useful study on the theory of gender-biased diagnosing, by looking at whether and to what degree the experiences of men and women differed.

The population to be studied was patients of primary care physicians and other doctors. The sampling frame consisted of male and female college-aged students and of male and female adults, using snowball sampling. All participation was voluntary and confidential. It took respondents an average of roughly five minutes to complete the questionnaire.

Limitations

One limitation of this particular study is that responses from the questionnaires cannot be generalized to the population they are intended to study due to the lack of representativeness; in other words, the results of this study are not to be attributed to the entire population that it seeks to study. Nonetheless, their experiences and perspectives can be indicative of patient behavior phenomenon that could be worthy of further research and therefore lead to a better understanding of the impact of gender-biased diagnosing. Another limitation was the over-representation of a young age group. The ages of respondents, although representing a wide range of age groups, included a large number of college-aged students. This could affect the findings because they have had less life experience and a much lower likelihood to have experienced diagnostic difficulties. This is something to keep in mind. One more limitation is that while sex of the respondent's current doctor was asked, this information could ultimately not be used to determine if there was a correlation between sex of the doctor and the occurrence of gender-biased diagnosing because of the retrospective nature of all experiences. However, sex of doctor was sometimes indicated in respondents' description of certain recalled experiences or in descriptions of doctors.

Respondent Demographics

There were 39 total respondents, consisting of 26 females and 13 males. Their ages ranged from 18 years to 71, and all age groups were well represented. The age group of 18-21, however, constituted over one third of respondents.

"Doing Credibility"

Women were more than twice as likely to report that they downplay the severity of their symptoms when talking to their doctor, directly out of fear of being perceived as irrational. This was operationalized by a respondent answering "yes" to the question of whether they downplay

their health problems in conversation with their doctor in fear of being perceived as irrational or complaining too much. If respondents were unsure, they were categorized as a “maybe” and counted as a “no.” The table below shows the categorized respondents by sex.

-----See Table 1-----

Among women who admitted to downplaying symptoms to their doctors, one woman wrote that she often gets the impression that her symptoms are “just not that important, and that too much information is worse than too little.” Another respondent wrote that, before she had more self-esteem, she “used to refrain from insisting on a diagnosis and resolution” and would accept the doctors’ advice that the problem would resolve itself.

The fact that women were more than twice as likely to admit to actively downplaying their health complaints in anticipation of doctors thinking they are over-anxious about their symptoms is indicative of a phenomenon. These findings suggest that some women are not only aware of gender-biased diagnosing, but anticipate it, and feel that they cannot provide a complete disclosure of their health symptoms. These women, consciously or unconsciously, seem to be aware of the fact that physicians are likely to label their symptoms as psychosomatic. The fact that these women purposefully under-report the severity of their symptoms is cause for large-scale research on how many women refrain from an open and trustworthy dialog with their doctor.

Trivializing of Symptoms

Over two-thirds (18 of 26) of female respondents recalled experiences of a doctor trivializing their symptoms. While these female respondents reported, and in some cases described, a time they had been told that their symptoms were not taken seriously or were said to be caused by stress, 0 male respondents recalled such experiences. Experiences of gender bias were operationalized as an answer of “yes” to the question of whether the respondent felt that their health complaints have ever been trivialized or deemed by the doctor to be caused by stress.

-----See Table 1-----

Doctors with “Bad Attitudes Toward Women”

Women commonly reported negative experiences with doctors, and men were found to report no such experiences. Over half of women respondents (14 of 26) reported having switched doctors because of the doctor’s uninterested or judgmental attitude towards them. This was operationalized by a conclusive answer to the question of whether the respondent has ever switched doctors for “personal reasons.” Only reasons that were related to the treatment of the patient were included. Other reasons such as health insurance or the doctor not being open to eastern/alternative medicine approaches were discounted.

Among these experiences described by women, one of the most common narratives were of doctors whom they felt had treated them with little attentiveness and/or invested concern. The most frequently brought up complaint was the feeling that a doctor did not listen, did not seem to care about or were “not interested” their health concerns, showed a lack concern about their symptoms, or showed a lack of attentiveness and rushed through the encounter without the patient feeling the doctor had devoted enough time necessary to thoroughly assess their symptoms. As one woman put it, her doctor showed no “bedside manner,” or display of genuine concern and interest in listening.

Another common characteristic among the reasons why women had switched doctors was that they felt the doctor was judgmental or demeaning towards them. Several women reported feeling talked down to by doctors, or that doctors were “insensitive” and “critical” towards them. As one woman put it, “male doctors [...] make me feel like a woman, not in a good way [...] just the way they treat me [...] they don’t make me feel like an intelligent person.”

This supports the findings of Wallen, Waitzkin and Stoeckle (1979) who found male physicians to engage in micro-politics of a gendered power dynamic. That study had found that male

physicians would not only more often tell women that their symptoms were psychosomatic but would also be condescending toward women in the way in which they responded to their requests for an explanation of their diagnosis. The complaints of the female respondents that they had left doctors for demeaning or belittling them greatly supports this concept of a sort of latent gender discrimination in doctor-patient conversation.

Not only do these findings suggest that this is still a common problem today, but that women will often leave doctors because of the extent of the discrimination. The problem is significant enough to for women to seek out health care from somebody who can respect them and take their health concerns seriously.

There were also complaints that doctors were more interested in flirting with them than in tending to their medical needs. One woman said reported she had switched her OB/GYN because of a comment her male gynecologist made to her that made her feel “quite” uncomfortable. Several other women reported negative experiences with male gynecologists. One woman complained of a male gynecologist she had who was “competent, but had a bad attitude toward women.” Another woman described her outright disbelief when she asked her OB/GYN for help with her hot flashes. He replied to her, “I know nothing about the female issues.”

Some women felt they had been purposely ignored or maltreated by their male doctors on account of their sex. One woman described a degrading experience with a doctor who she felt had likely discriminated against her because of her sex. She writes, “I have had a doctor place me in an embarrassing position in outpatient surgery, where I was exposed to passersby, to teach me a lesson, because I was too shy.”

Once again, over half of female respondents reported having discontinued seeing a doctor on account of these uninterested, condescending, or sexist attitudes. The fact that women

exclusively reported these negative experiences with doctors suggests that gender of the patient is a significant factor in determining how seriously a patient and her health problems are taken.

These findings not only reveal the some of the various ways in which women experience gender discrimination in doctor-patient relationships, but as we will see in cases of psychosomatic misdiagnosis, some experiences of gender discrimination can lead to serious health consequences for the patient.

Gender and Psychosomatic Diagnosis

Findings were extremely evident of the phenomenon of gender-biased diagnosing. Only women, exclusively, reported psychosomatic diagnosis, as not one male reported such an experience. Nearly half (12 of 26) of women reported having received a psychosomatic diagnosis. This was operationalized by a respondent's description of certain physical symptoms which were diagnosed by a doctor (or, in some cases, multiple doctors) to be caused by "stress" or to be "psychosomatic."

-----See Table 1-----

Some instances in which the respondent reported psychosomatic diagnosis were discounted. This was either in the case of common conditions such as stomachaches or headaches, or in cases where the respondent's experience fell under another category. For instance, one male respondent reported bringing up a symptom to his urologist who then took humor in his concern instead of taking his symptom seriously. This was not counted as a psychosomatic diagnosis because the doctor trivialized his concern instead of telling him it was psychologically based. This particular instance was also not counted as the respondent feeling that his health concerns have ever been trivialized by a doctor because he answered "no" to this question earlier in the questionnaire.

As mentioned above, responses of patients reporting being told that common ailments such as headaches, stomachaches, or recurring colds were caused by stress did not qualify as a psychosomatic diagnosis. That is, unless the respondent indicated that it later was found to be a

medical condition. This operationalization was used because those commonplace symptoms have been shown to often be brought upon by stress, such as the lowering of the immune system, or the experience of occasional headaches. Of notable mention is the fact that this type of operationalization was not used in any way to discount any instances of such experiences in men. Not one male respondent reported any instances of symptoms being blamed on stress or of psychosomatic diagnosis.

This research is exclusively focused on conditions labeled as psychosomatic that were either later found to be either caused by biological illness, unresponsive to treatment with psychiatric medication, or later diagnosed as a common condition of unknown origin believed to be caused by stress. In other words, psychosomatic diagnosis with which the patient either directly or eventually disagreed or were uncertain about, not those with that they agreed upon or that were relieved with psychiatric treatment, were the main focal point of this research.

Women found later to be diagnosed with a medical condition often reported multiple instances of having been given a psychosomatic diagnosis, particularly in the process of “doctor shopping,” or seeing several doctors for second opinions, who repeatedly misdiagnosed their symptoms as psychosomatic. These instances were counted as one psychosomatic diagnosis. One male respondent indicated that although he had never been given such a diagnosis himself, his wife had been misdiagnosed with a psychosomatic diagnosis. This was not counted in the number of respondents who experienced psychosomatic diagnosis, but was ultimately counted in the overall number of psychosomatic misdiagnoses.

Gender and Psychosomatic Misdiagnosis

In all, there were twelve (12) particular instances of psychosomatic diagnosis which were later diagnosed as biological illness (which I refer to as psychosomatic misdiagnosis). Three (3) additional instances of psychosomatic diagnosis ultimately ended up with a medically recognized

diagnosis, but one that was still medically unexplained and medically believed to be caused by stress, such as Chronic Fatigue Syndrome (CFS) or Irritable Bowel Syndrome (IBS). Only women reported having been given a psychosomatic misdiagnosis.

-----See Table 1-----

Erroneous psychosomatic diagnosis in women ranged from the misdiagnosis of less serious conditions to the doctor's failure to diagnose extremely serious, life threatening illnesses. Though one might assume that most conditions mislabeled as psychosomatic are more likely to be non-serious conditions, findings concluded just the opposite. Nearly all self-reported instances of false psychosomatic diagnosis were later found to be illnesses with serious health consequences, some of which had caused permanent health damage from years of not being properly diagnosed.

This could be explained by the fact that many respondents who had experienced false psychosomatic diagnosis ended up in the hospital, where they were finally taken seriously and accurately diagnosed. It could also be explained by the fact that some women refused to take the psychosomatic diagnosis and continued going to doctors until they received a diagnosis. However, many women simply did not find out that their "psychosomatic" health complaints were in fact the symptoms of real and serious disease until they had suffered for several years.

These self-reported experiences of psychosomatic misdiagnosis will be analyzed and discussed using the feminist theory of gender-biased diagnosing. It is possible that these experiences of misdiagnosis were influenced by confounding factors that may have complicated the correct medical diagnosis of such symptoms. However, the fact that these experiences were exclusively reported by women, and the strong indication of perceived sex discrimination in many of these experiences, strongly suggests that they are indicative of gender bias.

Experiences of Psychosomatic Misdiagnosis

When she came to her doctor for a persistent cough that was bothering her, one woman explains that her doctor, “tried to say that [her] cough was psychosomatic.” However, she writes, the doctor had overlooked a serious respiratory infection. “It ended up being whooping cough.”

Another woman writes, “I had an irritation in my nose and [my doctor] said it was just stress.” She later found out from another doctor that her symptoms were from a bacteria that was in need of treatment. She says, “almost a year later, [the original doctor] just kept giving me [over-the-counter products] and other non-helpful things.”

Three (3) women reported ending up in the hospital because their doctor had presumed their physical symptoms to be psychosomatic. One woman recalls a time in her life when she developed symptoms that did not readily offer themselves to a diagnosis. Her doctor gave her medication. Little did she know they were placebos, because he thought her symptoms were psychological. She recalls, “my internist prescribed pills for it. They didn’t work, and I ended up in the hospital, where he told me that the pills had been placebos, because he thought the symptoms were psychosomatic.”

Her doctor not only was quick to label her symptoms as psychosomatic, but apparently believed that she was so convinced that her symptoms were real that he could not tell her they were psychosomatic. His prescribing her placebos shows that he truly believed she was creating her symptoms psychologically. This is an undeniable form of malpractice, as this doctor purposely deceived and risked the health of his patient.

Another serious experience of psychosomatic misdiagnosis was that of a woman and her male gynecologist. His beliefs about women and their emotions led her to require emergency surgery after he had misdiagnosed her potentially fatal condition:

He was supposed to be the best in the [...] area, yet was very condescending, did not listen to me, refused to walk into the next room to look at the troubling results of the ultrasound test, ushered me out of his office during early pregnancy, and so missed my ectopic pregnancy by deciding I had created a “false” pregnancy because I so emotionally wanted a baby. I required emergency microsurgery, and my doc performed it, telling me that it must be an abscessed tooth where the abscess had travelled silently into my abdomen. He almost cost me my life.

This woman’s experience is a particularly perfect example of how gender stereotypes can contribute to false psychosomatic diagnosis and the negligence of serious conditions in need of medical attention. The fact that her doctor dismissed her health concerns solely based on his personal decision that she had created for herself an “emotional pregnancy” is quite significant. In addition, once she was in need of emergency surgery, the doctor continued to make excuses for his misdiagnosis.

This experience complements Munch’s idea that reproductive illness has historically been the most popular form of gender-biased diagnosing, stemming from the widespread and long-standing societal belief that the woman is emotionally connected to her womb.

Another woman describes how her mentioning of her symptoms of pain to her doctor over the course of years was ignored. She writes that when she ultimately ended up in the emergency room in need of surgery for what was found to be a serious infection, her doctor began to take her seriously:

I had gallbladder problems for several years and [my doctor] minimized my symptoms. When finally I had an infected gallbladder and was in the emergency room, he took me seriously and got me a surgeon. He told me that if I had had a gallbladder attack, I would have been in more pain so he made me wait until I was very sick.

It is not difficult to imagine that if male patient had brought up the same painful symptoms to his doctor over this long course of time, he may have eventually been ordered a battery of tests.

A female respondent who self-identified as a CFS sufferer wrote, “I have been trying to solve a chronic fatigue problem for over 5 years. It is not at the level where I cannot function but it is a change that affects me.” Having personally experienced the hardships of not being taken seriously that female CFS sufferers have been told to suffer (Werner, Isaksen and Malterud 2004), she had a strong opinion on the outright medical disregard of CFS. Her doctor, not entertaining the possibility of a MUI, diagnosed her with depression:

[It is important] to be aware of something. In our current health care system, there is something called a pre-existing condition. I was once with a female doctor and told her I have a lot of fatigue. She told me that there were only a few causes and one was depression. I told her I did not have the other diagnosis. She marked, “depression” in my record. I made them take it out. How dare they. Now I would have a “pre-existing” condition. [She was] very narrow-minded [and had no awareness] that there is something called chronic fatigue. And now that the AMA is saying there is a test for it, she will maybe allow for its existence. So arrogance comes in female and male form unfortunately.

Here we see the complications that come with the DSM’s diagnostic criteria for depression. As was discussed in the literature review, depression is often misdiagnosed in women. The estimation of 30-50% of women being misdiagnosed with depression is not that far-fetched considering how many doctors, such as this doctor, use solely or primarily the diagnostic criteria of physical symptoms. Had this woman not been so reluctant to accept her psychiatric diagnosis, she could be ineffectively taking anti-depressant medication while continuing to suffer her somatic symptoms.

Though this woman indicated that there have since been some advances in the medical treatment of Chronic Fatigue Syndrome, her experience is exemplary of western medicine’s reluctance to see medically unexplained illness such as CFS as legitimate, or even as a possible diagnosis. Though her concerns were centered on the health insurance burden of having a “pre-existing condition,” she was clearly most upset by her doctor’s narrow-minded and misguided

assessment of her symptoms. However, the fact that depression is considered a pre-existing condition by health insurance companies is another consequence of gender-biased over-diagnosis of mental illness in women.

This woman also gave her personal perspective on the phenomenon of gender-biased diagnosing, of which she seemed already aware:

I think that doctors in general are always looking for a diagnosis. That is how they are trained. And it is common knowledge that during residency, they joke around about [the “stress” diagnosis]-it is actually just part of the whole culture. Talk to some doctors doing residency who will be honest with you. They will tell you. They have a name for them. And they are almost always women. I have had [doctors tell me my symptoms are just caused by stress] all the time and that is why I go to a doctor today who practices eastern/western medicine.

These statements suggest something that could be the focus of future research surrounding gender-biased diagnosing. A topic of interest might be what doctors truly think about the psychosomatic diagnosis, and if they are aware that such a diagnosis is medically unfounded. It would be interesting to find if doctors simply give the psychosomatic diagnosis when they do not have another diagnosis to give, as a result of the pressure to provide a patient with a positive diagnosis. Finally, research could ask if psychosomatic diagnosis is a topic taken lightly, or even joked about, in the medical community, specifically among male doctors. These are worthy subjects of future study.

Two other women self-identified as sufferers of Irritable Bowel Syndrome (IBS). This medical phenomenon, like CFS, is also poorly understood, and is presumed to be caused by stress. Though this is in itself a kind of psychosomatic diagnosis, one sufferer described her troubles in receiving a medically recognized diagnosis. In her particular case, it took 18 years for her symptoms to be taken seriously:

I have had recurring digestive issues and stomach problems since I was 11. Multiple doctors told me it was just stress. It wasn't until I visited a GI

doctor at age 29 that I was told I have IBS. He was the first doctor to actually run blood work and testing to rule out other diagnosis.

She continues,

My ongoing stomach issues were dismissed by multiple doctors for many years. My ultimate diagnosis, IBS, is somewhat ambiguous. The doctor made the diagnosis based on an absence of evidence linking my symptoms to other conditions. IBS is kind of a catch-all diagnosis.

While she was glad to finally be given some sort of definitive diagnosis and acknowledgement of the severity of her symptoms, she also was unsatisfied with the lack of medical knowledge about her condition.

Another female self-identified sufferer of IBS was more critical its currently accepted psychosomatic cause. She explains, “IBS [is thought to be] caused by stress [and] is the easy-out answer given by doctors who don’t know what else to call it.” In calling conventional medicine’s blaming of the condition on stress an “easy-out” explanation, it is obvious that she does not have faith in the fact that her symptoms are simply caused psychologically.

Several female respondents reported having serious diseases that they suffered from for several years because a doctor told them that their symptoms were psychosomatic. One misdiagnosed woman, when told that her symptoms were psychosomatic, asked her doctor for a therapist referral. She explains, “I asked for the referral, when told it was all in my head.” Despite therapy, she continued to suffer serious health problems for 17 years until she found out that her symptoms were in fact very real:

I have had doctors tell me that my problem was in my head...but later, the problem was found to be a congenital defect, with serious side effects. The defect is genetic, in the kidneys and results in blood in my urine, sometimes extreme amounts causing low blood iron and related illness. I went for 17 years before a final and definitive diagnosis was made.

Another woman reports that her psychosomatic diagnosis caused her to live undiagnosed with Lyme disease for 9 years. She provides an explanation of how, in addition to suffering the

symptoms, permanent damage was made to her health because she was not properly diagnosed and treated sooner. When asked whether she had ever been referred to a therapist by her physician for physical symptoms, she wrote:

I have had several doctors, both male and female, tell me that my chronic pain was all in my head and I needed to see a psychiatrist when the reality was that the pain was caused by undiagnosed Lyme disease. I did not ask for the referral. In fact I was already seeing one, but that isn't the point. The doctor was convinced that the problems were all in my head.

To the question of whether she has ever had an illness that led to a misdiagnosis, she described her story in more detail:

I have chronic Lyme disease that went undiagnosed for 9 years. Multiple doctors suggested that it was an unknown virus that wasn't serious (Lyme disease left untreated has caused brain damage, arthritis, nerve damage, a compromised immune system... [it] has affected every system in my body) or that I was blowing my symptoms out of proportion and that most of it was psychosomatic. Thankfully, I did find a doctor who was willing to listen and was able to diagnose me even though the damage had already been done and I will never be without problems as a direct result of being misdiagnosed in 1999.

Her story of the pain she has suffered and the permanent damage that she now lives with at the cost of her psychosomatic misdiagnosis years ago is representative of the detrimental effects to health, both emotional and physical, that women often suffer as a direct result of gender-biased diagnosing.

Over-prescription of Psychiatric Medication

Findings revealed a few instances in which women reported that they had been unnecessarily or ineffectively prescribed anti-depressant, anti-anxiety, or other psychiatric medications. No men reported such instances. One woman explained that after being told that her severe migraines were caused by stress, she was given heavy-duty drugs that were ineffective. She explains:

I currently have atypical migraine with aura [of which] they cannot find the cause. I have been to 5 acupuncture treatments and have not had a

recurrence in over a week. The conventional doctors prescribed narcotics/anticonvulsants that were highly addictive.

Another woman recalled a certain medication causing her to have anxiety, and her doctor then prescribing her medication for the subsequent anxiety instead of helping her change the prescription. She writes, “when first put on birth control pills, I suffered extreme anxiety [and] rather than change the pill, I was given anti-anxiety med[ication]...[it was] not very helpful in the end.”

One woman reported being misdiagnosed with depression and put on anti-depressants for telling her doctor that she was fatigued. She later found out that she was not depressed, but rather just tired as a result of a shift change at work. These findings suggest that depression and anxiety are not only all-too-freely given diagnoses, but that female patients are at times unnecessarily diagnosed with and treated for such disorders as a direct result of psychosomatic misdiagnosis.

Conclusion

From this research, much can be learned about the detrimental effects to women’s health as a direct result of gender-biased diagnosing. The results of this research show that psychosomatic misdiagnosis does in fact have real and sometimes serious consequences on health outcomes of everyday patients. In this particular study, nearly half (46%) of women reported having been *inaccurately* given a psychosomatic diagnosis; in other words, nearly half of women reported having experienced a psychosomatic misdiagnosis. Though only one third of the 39 respondents were men, not one male respondent reported ever having received a psychosomatic diagnosis of any kind. Three women reported ending up in the hospital as a direct result of a psychosomatic misdiagnosis, and multiple women reported living for several years with debilitating health conditions as a result of a psychosomatic misdiagnosis.

These findings are certainly evident of the phenomenon of gender-biased diagnosing. These results from a random sample of everyday people suggest that everyday female patients may be commonly negatively affected by psychosomatic misdiagnosis. The findings show that gender-biased diagnosing is certainly a health threat to female patients. It can leave them living with medical conditions in need of treatment, cause them to suffer unnecessarily for long periods of time, ultimately damage their health outcomes, and in some cases can leave them in life-threatening situations.

This study also found that women are commonly discriminated against in their doctor-patient relationships. Over half of women respondents (69%) reported having left a doctor because he did not listen to them, minimized their symptoms, or simply treated them in a condescending manner. While some of these experiences may not have been a direct cause of the sex of the patient, the fact that no men reported such instances (and that over half of women did) is indicative of sex discrimination. Women also reported experiences with male doctors, including gynecologists, in which they felt the doctor was particularly insensitive to them as a direct consequence of their sex. This is sufficient cause for more research to be done on the gender politics of the doctor-patient encounter.

An additional finding of this research is that, though both women and men reported minimizing the severity of symptoms in fear of appearing irrational to their doctor, women were more than twice as likely to report such a fear (23% of men, 50% of women). This suggests that not only is there a phenomenon of gender-biased diagnosing, but there is also a phenomenon of women “doing credibility,” very similar to Werner and Malterud’s (2003) concept of “doing pain,” which referred to the phenomenon of women with chronic pain behaving in certain ways and censoring the severity of their symptoms in order to maintain their credibility. If women do not feel

comfortable having an open and honest dialogue regarding their health issues with their doctor, there is certainly something that needs to be changed.

In conclusion, the findings of this research further complement existing findings of gender-biased diagnosing, and prove the hypothesis that everyday women suffer negative health consequences as a direct result from psychosomatic misdiagnosis- a phenomenon that is unmistakably gendered. This study also supports previous findings that women are often discriminated against by doctors, whether it be in the form of not taking the patient's symptoms seriously, dismissing their concerns as unimportant or as psychosomatic, or simply treating female patients in a condescending manner. This research discovers that patients, mostly female, will hold back complete information about the severity of their symptoms in direct effort to avoid seeming irrational. This "doing credibility" phenomenon is indicative of a gender-politicized environment in medical encounters. Most importantly, this research finds that women can suffer traumatic and health-crippling experiences, sometimes ending up in the emergency room in need of surgery or suffering for years with debilitating medical conditions, as a direct result of their symptoms being mislabeled as psychosomatic.

The findings of this study are sufficient cause for large-scale research on the pervasiveness of gender-biased diagnosing, and women's experience of psychosomatic misdiagnosis, as it would be helpful to find more representative statistics regarding its effects. This study finds complementary evidence of the phenomenon of gender-biased diagnosing and goes further to show that it affects everyday patients, and has real and detrimental effects. Gender-biased diagnosing, by means of psychosomatic misdiagnosis, poses a genuine threat to women's health. Research on what kinds of programs could be implemented, such as educating physicians about sex stereotyping, or raising physician awareness of symptoms commonly misdiagnosed in women as psychosomatic, could be beneficial to protecting the health of female patients. Lastly, there is need for more research and

attention on the issue of gender-biased diagnosing, and a better understanding of the threat that it poses to women and their health.

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Table 1: Percentage of respondents by sex

	Male	Female
Downplay symptoms	23% (3/13)	50% (13/26)*
Symptoms trivialized	0% (0/13)	70% (18/26)*
Psychosomatic diagnosis	0% (0/13)	46% (12/26)
Psychosomatic misdiagnosis	0% (0/13)	46% (12/26)

n = 39

* One respondent responded 'maybe' and was not counted.