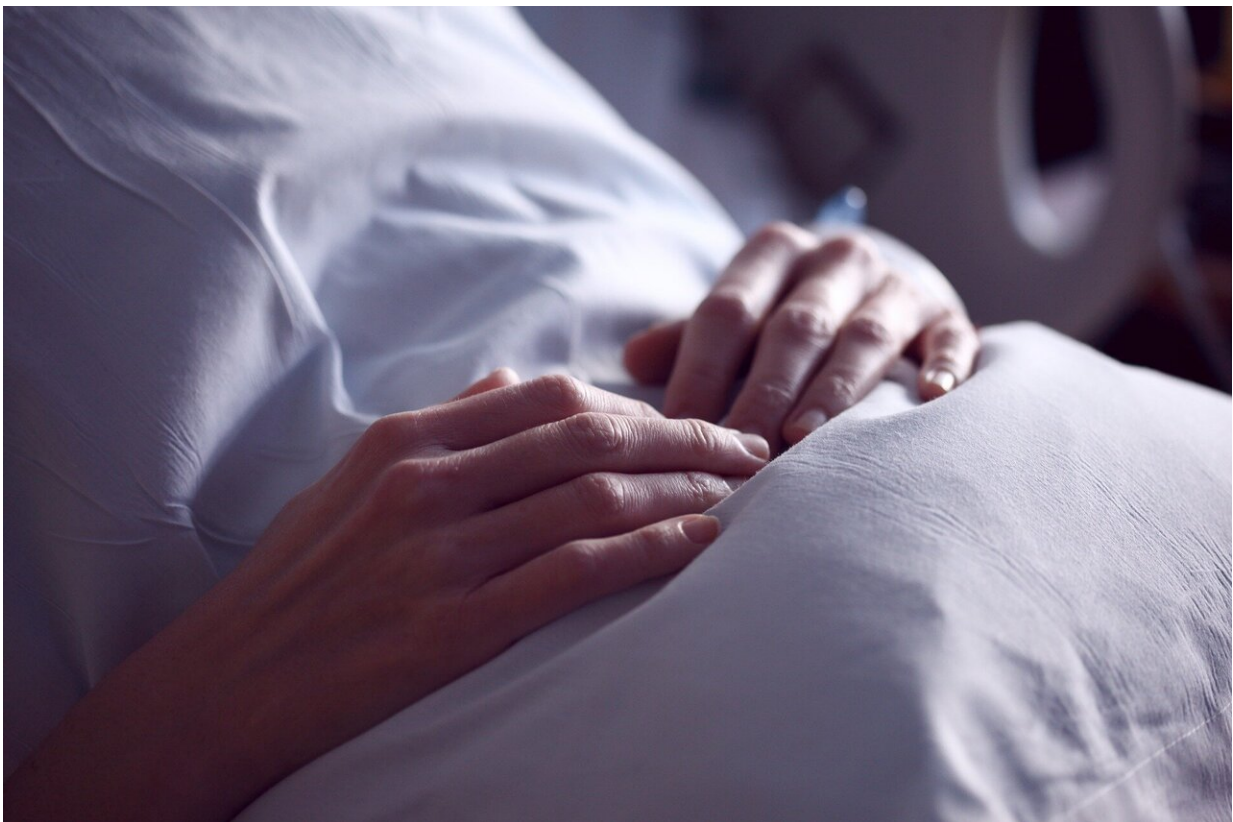


Women seeking credibility in health care feel 'on trial,' struggle with constraints of double binds

September 27 2023, by Sharita Forrest



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Having a chronic illness is a great deal of work, communication researchers have long known. But having an illness that is stigmatized,

not well understood or not perceived as a priority by clinicians is uniquely burdensome for many women, who find themselves struggling to establish both the legitimacy of their medical problems and their credibility with clinicians, family members and friends, a recent study suggests.

Sasha, a 25-year-old woman interviewed for the project, told the researchers she has a binder 3 inches thick containing all her [medical records](#) that she lugs to every doctor's appointment to provide documentation of her symptoms, tests and treatments.

Sasha, identified by a pseudonym, is not unique, the researchers say. Often labeled "crazy" by those around them or perceived as difficult patients when they challenge physicians' opinions, women whose undiagnosed health concerns have been dismissed in the past feel as if they are "on trial" and adopt strategies similar to those of defendants preparing their case for court, according to communication professor Charee Thompson and her co-authors, graduate students Sara Babu and Shana Makos, all of the University of Illinois Urbana-Champaign.

They published their findings in the journal *Communication Research*.

"These patients' preparations for doctors' appointments involve extensive research about their symptoms, possible treatments and their doctors' expertise and backgrounds," Thompson said. "They carefully build their case by collecting evidence such as keeping logs of their symptoms or recording their heart rate with their Fitbit and taking it to the appointment. And they marshal witnesses, coordinating the timings of their appointments with family members so they can attend to corroborate their experiences."

Sasha was one of 36 pseudonymous women across the U.S. managing [chronic illnesses](#) who were interviewed for the project, which explored

the credibility work women undertook when their medical problems were treated dismissively by skeptical providers, [family members](#) and friends.

Credibility work was defined in the study as the activities patients used to validate their [medical problems](#), gain [social support](#) and establish their need for treatment.

Ranging in age from 21-70, most of the women were white, eight were multiracial, six were Black and three were Filipina, Hispanic or of Middle Eastern descent. They were the same population as that in the researchers' prior [study](#) about medical disenfranchisement—also called medical gaslighting, defined by the researchers as the denial of a person's symptoms or knowledge of their body. That study was published in the journal Health Communication.

Patients' difficulties obtaining treatment are compounded when they have an intersecting, socially devalued identity—such as their race, gender or mental health history—that providers may associate with damaging preconceptions about their credibility and basic knowledge of their body, Thompson said.

Many of those interviewed described feeling frustrated and angry at being shamed, silenced and dehumanized during past medical interactions and said that clinicians reflexively attributed their physical symptoms to psychological problems without medical evidence to support a mental illness diagnosis.

Maria, a 26-year-old white Pacific Islander, told the researchers she asks her husband to accompany her to office visits because physicians are more apt to listen to a male than to her.

When presenting their case to health professionals, these patients

recounted how they carefully described their symptoms in an objective, controlled manner and in other ways they believed would convey validity; fastidiously managed their appearance, including how they dressed; and monitored providers' reactions for evaluative clues while talking to them.

When their pain or concerns were challenged, discounted or minimized by providers, these women told the researchers they often felt too vulnerable to object or withstand critical reactions. Instead, they pivoted to less "face-threatening" strategies such as asking questions to indirectly dispute providers' diagnoses or opinions, obtain clarifications and request referrals.

This was one of several "double binds" or no-win communication situations these patients found themselves in during these encounters, along with awareness they needed to appear physically ill enough or in sufficient distress to warrant medical intervention—while taking care to avoid being perceived as overly dramatic or attention-seeking.

"But if patients seem too rational and controlled, expressing minimal emotion or distress, then providers may conclude there is nothing really wrong with them," Thompson said.

Participants struggled to strike a balance of being informed patients who were appropriately assertive and self-advocates—confronting mistreatment, poor service and diagnoses they disagreed with—without threatening providers' sense of expertise, alienating their staff if they complained about something or being labeled a "complainer" or "nasty."

Intertwined with these dilemmas are moral judgments about which societal members are worthy of being evaluated and treated—and those who are "not doctorable or are burdensome, wasteful and malingering," the researchers wrote.

"And to me, that's one of the most important findings of this study: to recognize all sorts of the double binds that people face, and for providers to not perpetuate these situations and to validate folks who feel like there's no winning," Thompson said. "Because there are situations where there is no winning since they're set up that way—to reinforce power imbalances in these doctor-patient relationships. They shouldn't be."

While the study explored the medical context of credibility work, it is important to realize that these forms of doubt and disempowerment occur in "our everyday lives and our personal relationships in ways that are equally pernicious," she said. "And we all have a responsibility –whether we are a provider, family member or a friend—to check our biases and our assumptions and understand how they might perpetuate or prolong someone's suffering. The default should be belief and support."

More information: Charee M. Thompson et al, A Grounded Theory of Credibility Work and Illness: Explication and Application to the Case of Women on Trial in Health Care, *Communication Research* (2023).

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