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Research Paper

From Dismissal to Distress: Mapping the Psychological Link Between Diagnostic Delay, Medical Invalidation, and Health Anxiety in Polyendocrine Metabolic Ovarian Syndrome (PMOS)

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ABSTRACT

Polyendocrine metabolic ovarian syndrome (PMOS), previously known as polycystic ovary syndrome (PCOS), is a complex endocrine and metabolic condition with reproductive, dermatological, metabolic, and psychological dimensions. In May 2026, an international consensus process published in The Lancet established PMOS as the new name, intended to better represent the condition's multisystem features and avoid the misleading implication that ovarian cysts define the syndrome (Teede et al., 2026). Alongside clinical management, the diagnostic journey can shape how individuals interpret symptoms, assess health threats, and engage with healthcare. Research on people previously diagnosed with PCOS documents delayed diagnosis, dissatisfaction with information, and challenging healthcare experiences (Gibson-Helm et al., 2017; Soucie et al., 2021). This conceptual review integrates these findings with health psychology and medical sociology to propose a pathway linking diagnostic uncertainty and perceived medical invalidation with disrupted illness representations, reduced trust, health-related worry, bodily monitoring, and varied health-seeking responses. The framework draws particularly on Leventhal's Common-Sense Model of Self-Regulation and the concepts of testimonial and hermeneutical injustice. It also considers weight stigma, digital health searching, reassurance seeking, and healthcare avoidance. These links are presented as plausible, testable relationships rather than an established causal sequence, because direct PMOS-specific evidence for the entire pathway remains limited. Implications include respectful symptom validation, transparent diagnostic communication, shared decision-making, and psychological support that does not minimise legitimate physical symptoms. Future research should test the proposed model longitudinally and evaluate interventions designed to improve both patient experience and continuity of care.

Keywords: *Polyendocrine Metabolic Ovarian Syndrome, PMOS, Polycystic Ovary Syndrome, PCOS, Diagnostic Delay, Medical Invalidation, Health Anxiety, Illness Perceptions, Medical Trust*

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From Dismissal to Distress: Mapping the Psychological Link Between Diagnostic Delay, Medical Invalidation, and Health Anxiety in Polyendocrine Metabolic Ovarian Syndrome (PMOS)

Polyendocrine metabolic ovarian syndrome (PMOS), previously called polycystic ovary syndrome (PCOS), is a common, heterogeneous condition involving interacting endocrine, metabolic, and ovarian features. The term PMOS emerged from a multistep international consensus process published in 2026. The change was intended to communicate the multisystem nature of the condition more accurately and to reduce the misleading emphasis on ovarian cysts (Teede et al., 2026). Because much of the existing clinical and psychological literature predates the name change, this paper uses PMOS in its own discussion while retaining PCOS when referring to the historical terminology used in study titles, guidelines, and published sources.

PMOS can involve ovulatory dysfunction, clinical or biochemical hyperandrogenism, and metabolic concerns, although its presentation varies across individuals and life stages. Psychological wellbeing is also relevant to care. Reviews have described elevated psychological burden, including anxiety and depressive symptoms, among people with the condition, while emphasising the need to consider biological, psychological, and social influences rather than attributing distress to a single cause (Cooney & Dokras, 2018; Simon et al., 2023). The condition should therefore be understood within a biopsychosocial framework that acknowledges both physical symptoms and the contexts in which people seek explanations and care.

Obtaining a timely and satisfactory diagnosis may be difficult. In a large survey of women with PCOS, Gibson-Helm and colleagues reported delays and dissatisfaction with information provided during the diagnostic process (Gibson-Helm et al., 2017). Qualitative work has further explored how women describe their diagnostic experiences and interactions with healthcare professionals (Soucie et al., 2021). Such studies do not mean that every person experiences delay or dismissal, nor do they establish that all delays arise from clinician bias. They do, however, show why diagnostic experiences merit attention as a component of health and wellbeing.

A person who experiences persistent symptoms without a clear explanation may have to manage both the symptoms themselves and uncertainty about their meaning. If concerns are minimised, attributed prematurely to weight or stress, or not followed by clear explanations, the person may feel unheard and may become less confident that healthcare services can help. Some may seek repeated opinions or search extensively online; others may postpone further consultations. These are possible responses, not inevitable outcomes, and may be shaped by access to care, prior experiences, social support, health literacy, and the severity of symptoms.

Health psychology offers useful concepts for examining this experience. Leventhal's Common-Sense Model of Self-Regulation explains how people develop cognitive and emotional representations of illness and use these representations to guide coping (Leventhal et al., 2003). The concept of epistemic injustice addresses situations in which a person's contribution as a knower is unfairly discounted or in which shared interpretive resources are inadequate (Carel & Kidd, 2014; Fricker, 2007). Bringing these perspectives together may help clarify how diagnostic uncertainty and perceived invalidation could influence health-related worry and healthcare engagement.

Problem Statement

Research has documented diagnostic delay, dissatisfaction, and psychological correlates in people with PCOS/PMOS. However, the specific conceptual pathway through which difficult diagnostic encounters might shape illness representations, health anxiety, bodily monitoring, and subsequent health-seeking behaviour requires clearer integration. This paper addresses that gap by proposing a theory-informed framework. It does not claim that diagnostic delay necessarily causes health anxiety or that the complete pathway has already been empirically demonstrated. Instead, it identifies plausible mechanisms and research questions that can be tested in future studies.

REVIEW APPROACH AND SCOPE

This paper is a narrative, theory-informed conceptual review rather than a systematic review or meta-analysis. It integrates selected literature on diagnostic experiences in PCOS/PMOS, psychological correlates of the condition, illness representations, epistemic injustice, health anxiety, cyberchondria, and psychological interventions. The conceptual discussion is informed by foundational work on epistemic injustice (Fricker, 2007; Carel & Kidd, 2014), the Common-Sense Model (Leventhal et al., 2003), literature on PCOS-related psychological wellbeing (Cooney & Dokras, 2018; Simon et al., 2023), and research on diagnostic experiences (Gibson-Helm et al., 2017; Soucie et al., 2021).

The purpose is to develop an explanatory framework, not to estimate prevalence or establish causal effects. The paper does not report a reproducible database search, formal inclusion and exclusion criteria, or a systematic risk-of-bias assessment. Accordingly, it should not be interpreted as an exhaustive account of all available evidence. A formal systematic or scoping review would require a documented search strategy, transparent screening, and structured appraisal of included studies. The terminology changes to PMOS occurred in 2026; searches and future updates should include both PMOS and PCOS to capture newer terminology and the large body of earlier literature.

DIAGNOSTIC DELAY AND PERCEIVED MEDICAL INVALIDATION

Socio-Cultural and Systemic Factors in Diagnostic Experiences

PMOS presents across several domains, including reproductive, dermatological, endocrine, and metabolic features. When symptoms are considered separately, the overall pattern may be harder to recognise. A person may initially seek help for irregular menstruation, acne, hirsutism, hair changes, weight changes, or difficulty conceiving, and may consult different clinicians over time. Fragmentation across primary care, gynaecology, endocrinology, and dermatology can make continuity and integration of information particularly important. This is a plausible systems-level contributor to diagnostic difficulty, although the relative contribution of each factor varies across settings.

Menstrual symptoms can also be normalised or treated as an expected part of adolescence or adulthood. In some circumstances, reassurance is appropriate; in others, persistent or concerning symptoms warrant further assessment. The key issue is not that every symptom should immediately be attributed to PMOS, but that symptoms should be taken seriously, assessed in context, and followed by a clear explanation of the clinical reasoning and next steps. Diagnostic evaluation must also consider alternative explanations rather than assuming that PMOS accounts for every symptom.

Access to specialists, cost, geographical location, time constraints, cultural expectations, and the availability of appropriate investigations may influence diagnostic pathways. Weight stigma and assumptions about lifestyle can further complicate encounters if weight is treated as a complete explanation for symptoms or if care appears conditional on weight loss. A balanced account should acknowledge that weight and metabolic health can be clinically relevant while rejecting blame-based communication and one-size-fits-all explanations.

Epistemic Injustice and the Language of Medical Gaslighting

Fricker (2007) describes testimonial injustice as an unfair credibility deficit applied to a speaker and hermeneutical injustice as a disadvantage arising when shared interpretive resources are inadequate to make sense of an experience. Carel and Kidd (2014) applied these ideas to healthcare, where professional authority and institutional routines can shape whose accounts are heard and how symptoms are interpreted.

In a diagnostic encounter, testimonial injustice may be relevant when a patient's report is discounted because of stereotypes or assumptions—for example, that symptoms are exaggerated, caused solely by anxiety, or reflect a lack of self-discipline. Hermeneutical injustice may be relevant when patients and clinicians lack a shared, accessible framework for interpreting a complex symptom pattern. These concepts should be used carefully: a delayed diagnosis alone does not prove injustice, and clinicians may reasonably need time, investigations, or differential diagnosis before reaching a conclusion.

The term medical gaslighting is widely used in patient narratives to describe experiences of being dismissed or made to doubt one's account of symptoms. It can communicate the seriousness of perceived invalidation, but it is not a precise diagnosis or a synonym for every unsatisfactory encounter. In academic writing, it is helpful to distinguish the patient-reported experience of dismissal from a demonstrated pattern of deliberate deception. This paper therefore uses medical invalidation as a broader, more neutral term and discusses medical gaslighting when describing the language used by patients or the wider debate.

Weight Stigma and Reductionist Explanations

Weight stigma can undermine trust and the quality of clinical communication. If a consultation centres exclusively on weight, a patient may feel that other concerns—such as menstrual irregularity, androgen-related symptoms, fatigue, or emotional distress—have not been considered. Weight and metabolic health can be important in PMOS, but they should be addressed without moral judgement and without implying that a person's symptoms reflect personal failure. Clinical assessment should follow relevant guidelines and individual presentation, and treatment should not be reduced to a single weight-related instruction.

A further concern is the interpretation of outcomes. If lifestyle advice does not produce the expected change, a patient may experience blame or may conclude that clinicians are unwilling to investigate further. Such experiences could contribute to shame, reduced self-efficacy, or avoidance of future care. These are plausible psychological responses that require direct investigation; they should not be assumed for every person or every clinical setting.

HEALTH ANXIETY AND ILLNESS REPRESENTATIONS

The Common-Sense Model of Self-Regulation

The Common-Sense Model proposes that people construct cognitive and emotional representations of health threats and use these representations to guide coping (Leventhal et al., 2003). Common cognitive dimensions include identity (the symptoms and label associated with an illness), cause, timeline, consequences, and controllability or cure. These representations are influenced by symptoms, prior experiences, social messages, and information from healthcare professionals.

A timely and understandable explanation can help a person organise symptoms and understand the purpose and limits of treatment. By contrast, prolonged uncertainty or inconsistent explanations may leave the person unsure which sensations are relevant, what might happen next, or what actions are useful. If the person's account is repeatedly discounted, this uncertainty may be accompanied by reduced trust and increased attention to symptoms. The proposed link is theoretical: existing evidence on diagnostic dissatisfaction supports the importance of the experience, but does not by itself establish that invalidation causes a specific pattern of illness representation or health anxiety.

Three mechanisms are particularly relevant. First, identity and cause may remain uncertain when symptoms lack a coherent explanation. Second, perceived consequences may feel more threatening when a person cannot anticipate the course of symptoms. Third, perceived controllability may decline when the person receives no clear plan or feels excluded from decisions. These processes could contribute to distress and may help explain why transparent communication and shared decision-making are important.

Health Anxiety, Bodily Monitoring, and Somatic Interpretation

Health anxiety refers to persistent concern about the possibility of illness and the interpretation of bodily information as threatening. Monitoring one's body is not inherently maladaptive: people with a chronic condition may reasonably track symptoms, cycles, medication effects, or clinical indicators. Concern arises when monitoring becomes repetitive, difficult to disengage from, or closely linked to catastrophic interpretations and impairment.

After an unsatisfactory diagnostic experience, some individuals may become especially attentive to bodily changes because they do not feel that reliable clinical monitoring or explanations are available. Others may pay less attention to symptoms or avoid monitoring because it is distressing. The direction of response may depend on prior anxiety, symptom severity, past healthcare experiences, social support, and access to services. It is therefore more accurate to describe bodily hypervigilance as a possible response than as a direct or universal consequence of diagnostic invalidation.

The concept of somatosensory amplification describes a tendency to experience bodily sensations as intense or alarming (Starcevic & Berle, 2013, in the broader literature on health anxiety and excessive health-related internet use). Applying this concept to PMOS requires caution: symptoms may reflect genuine endocrine, metabolic, dermatological, or reproductive processes, and psychological interpretation must not be used to dismiss them. The clinical task is to assess physical symptoms appropriately while supporting proportionate interpretations of uncertainty.

A stress-related physiological feedback loop is sometimes proposed in discussions of chronic illness. However, claims that anxiety-related cortisol changes directly worsen PMOS pathophysiology should not be treated as established in the absence of direct evidence for the specific pathway. Future studies could examine stress-related processes, but the present conceptual framework does not assume that such a biological mechanism has been demonstrated.

Potential Behavioural Responses: Online Searching, Reassurance Seeking, and Avoidance

Online Health Searching and Cyberchondria

When people feel that their concerns have not been answered, they may turn to search engines, online communities, and social media for information or validation. These sources can provide connection, practical advice, and access to experiences that may be difficult to discuss elsewhere. They can also expose users to contradictory information, anecdotal claims, frightening possibilities, or unsupported treatments. The effect depends on the quality of the information, the person's goals, and the way searching is used.

Cyberchondria is commonly used to describe excessive online health searching associated with distress or increased health anxiety (Starcevic & Berle, 2013). It should not be used to label all online health information-seeking as pathological. In the proposed framework, repeated searching may become unhelpful when it is driven by urgent reassurance needs, produces only short-lived relief, and leads to further checking. This possible cycle deserves empirical study in PMOS populations rather than being assumed from general health-anxiety literature.

Healthcare Avoidance and Repeated Consultation

Perceived invalidation may be followed by different, sometimes opposing, patterns of healthcare use. Some individuals may avoid future consultations because they anticipate stigma, disbelief, cost, or emotional exhaustion. Others may seek additional opinions because they still need an explanation or because previous consultations did not resolve their concerns. Seeking another opinion can be a reasonable and adaptive response; it becomes potentially problematic only when repeated reassurance seeking is distress-driven, uncoordinated, or associated with unnecessary burden.

The term doctor-shopping can sound judgemental and may obscure legitimate attempts to obtain appropriate care. Where possible, this paper uses repeated consultation or specialist switching, while recognising that coordinated second opinions can be clinically appropriate. These patterns may also coexist: a person might avoid one service while seeking another, or delay routine care while urgently seeking answers about a particular symptom.

The proposed pathway therefore does not treat health anxiety as a patient-only problem. It highlights the interaction between uncertainty, access to trustworthy information, previous clinical encounters, and the availability of respectful follow-up. Health systems can reduce unnecessary uncertainty by explaining diagnostic criteria, communicating what has and has not been ruled out, documenting follow-up plans, and helping patients navigate referrals.

AN INTEGRATIVE CONCEPTUAL FRAMEWORK

Proposed Pathway from Diagnostic Experience to Health-Related Distress

The framework developed here links three levels: (1) systemic and clinical conditions, including delays, fragmented care, communication problems, and perceived invalidation; (2) cognitive and relational processes, including uncertainty in illness representations and reduced trust; and (3) possible emotional and behavioural responses, including health-related worry, increased monitoring, online reassurance seeking, repeated consultations, or avoidance. The framework integrates the Common-Sense Model with epistemic injustice to generate testable propositions.

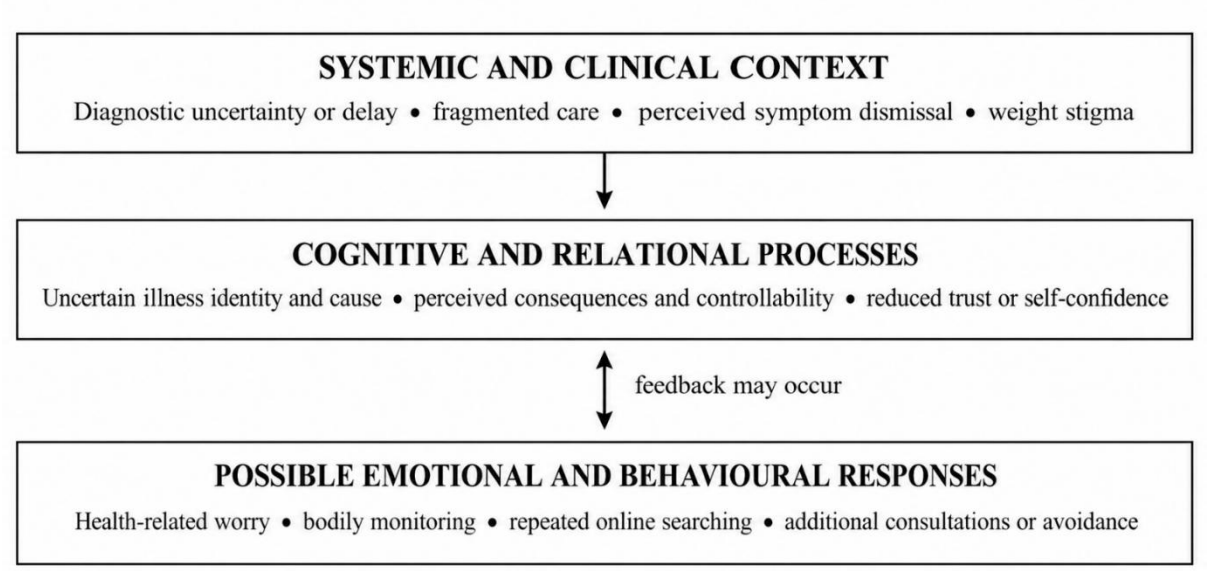


Figure 1. Proposed conceptual pathway linking diagnostic experiences with possible psychological and behavioural responses. The model is a theory-informed synthesis and has not been empirically validated as a complete causal sequence.

The arrows represent a proposed direction for investigation, not proof of causality. Feedback may occur: for example, heightened worry may increase searching or consultations, while a further unsatisfactory encounter may renew uncertainty. Conversely, clear explanations, coordinated care, social support, and a respectful therapeutic relationship may interrupt or modify the pathway. The model also allows for variation: not every person experiencing delay or invalidation will develop health anxiety, and some people may respond with resilience, effective advocacy, or support-seeking.

Testable Propositions for Future Research

1. Greater perceived diagnostic uncertainty and invalidation may be associated with lower confidence in illness representations and lower trust in healthcare providers.
2. Uncertainty and reduced trust may be associated with health-related worry and symptom monitoring, after accounting for prior anxiety, symptom severity, and access to care.
3. The relationship between difficult diagnostic experiences and later healthcare engagement may be mediated or moderated by illness perceptions, social support, health literacy, stigma, and continuity of care.

4. Transparent communication, shared decision-making, and respectful follow-up may be associated with better patient-reported trust and more coordinated healthcare engagement.

These propositions are deliberately framed as hypotheses. Longitudinal studies and mixed-methods research are needed to establish temporal ordering, identify alternative explanations, and determine which processes are most relevant in different clinical and cultural contexts.

PSYCHOLOGICAL AND CLINICAL IMPLICATIONS

Psychological Support and Cognitive Behavioural Approaches

Cognitive behavioural approaches may be relevant when health-related worry, catastrophic interpretations, repeated checking, or reassurance seeking are causing distress. The aim should not be to persuade patients that physical symptoms are imaginary. Instead, psychological support can help distinguish the presence of a symptom from the most threatening interpretation of that symptom, identify useful sources of information, and develop coping strategies while appropriate medical assessment continues.

Any intervention should be collaborative and sensitive to the possibility that the person has previously felt dismissed. Before addressing catastrophic interpretations or reassurance seeking, clinicians should acknowledge the person's reported experience, clarify what medical evaluation is appropriate, and avoid implying that psychological treatment substitutes for physical assessment. Where exposure-based strategies are considered, they should be clinically indicated and adapted to the individual; they should not discourage appropriate help-seeking for new, severe, or changing symptoms.

Acceptance and Commitment Therapy and Psychological Flexibility

Acceptance and Commitment Therapy (ACT) focus on psychological flexibility, acceptance, cognitive diffusion, values, and committed action (Hayes et al., 2006). These processes may be useful for some people living with persistent symptoms or uncertainty. For example, diffusion may help a person notice a frightening thought without treating it as a certainty, while values-based action may help preserve meaningful activities alongside condition management.

However, the present review does not establish ACT as a specifically validated treatment for PMOS-related diagnostic trauma. The rationale is a potential application of a broader therapeutic model. Future studies should assess acceptability, effectiveness, and possible harms of tailored interventions, particularly whether patients feel heard and whether psychological care is integrated with appropriate medical follow-up.

Provider-Level Practice: Restoring Trust and Shared Decision-Making

Psychological support cannot by itself resolve structural barriers or poor communication. Providers and services can help reduce avoidable uncertainty by explaining the assessment process, acknowledging uncertainty honestly, documenting symptoms, discussing differential diagnoses, and clarifying when and how follow-up will occur. Patient accounts should be treated as meaningful clinical information while being integrated with examination, investigations, and relevant guidelines.

The following practices may support more respectful encounters:

- Explicitly acknowledge symptoms and the impact they have on daily life without assuming a cause before assessment.
- Explain diagnostic criteria, the rationale for tests, alternative explanations, and what remains uncertain in accessible language.
- Discuss weight and metabolic health without blame; do not make respectful care conditional on weight change.
- Use shared decision-making, inviting patients to identify priorities, ask questions, and discuss the benefits and limitations of management options.
- Offer a clear follow-up plan, including what changes should prompt re-evaluation and how referrals or results will be communicated.
- Where possible, coordinate care across relevant disciplines and provide reliable educational resources rather than leaving patients to navigate conflicting information alone.

Table 1 Core practices that may support trust in PMOS-related clinical encounters

Core Practice	Target	Potential contribution
Symptom validation	Perceived dismissal	Communicates that the patient's account is heard and merits assessment.
Transparent diagnostic framing	Uncertainty and information gaps	Clarifies reasoning, next steps, and limits of current knowledge.
Non-stigmatising discussion of weight	Blame and shame	Keeps attention on individual health needs rather than moral judgement.
Shared decision-making	Reduced agency	Supports informed choices and collaborative management.
Coordinated follow-up	Fragmentation and uncertainty	Makes results, referrals, and review plans easier to understand.

Note. These practices are proposed as communication and care principles; their specific effects on PMOS-related health anxiety should be evaluated empirically.

CONCLUSION AND FUTURE DIRECTIONS

Synthesis

This conceptual review has considered how the diagnostic journey for PMOS may shape psychological experience beyond the physical manifestations of the condition. Studies conducted under the former PCOS terminology document diagnostic delay, dissatisfaction with information, and varied patient experiences in healthcare (Gibson-Helm et al., 2017; Soucie et al., 2021). Health psychology and medical sociology provide complementary ways to interpret why prolonged uncertainty or perceived invalidation may matter: the Common-Sense Model highlights the role of illness representations in coping, while epistemic injustice draws attention to whether patients are recognised as credible contributors to knowledge about their own bodies.

The proposed framework links systemic and clinical conditions with possible cognitive, emotional, and behavioural responses. It suggests that uncertainty and perceived dismissal may contribute to reduced trust, health-related worry, bodily monitoring, online reassurance seeking, repeated consultations, or healthcare avoidance. These responses are neither inevitable nor mutually exclusive. Their occurrence and impact are likely to depend on personal, social, cultural, and service-level factors.

A central implication is that patient-centred care requires both appropriate clinical assessment and respectful communication. Psychological interventions may help people manage worry and uncertainty, but they should not be used to minimise legitimate symptoms or replace medical evaluation. Provider-level practices—including transparent explanations, non-stigmatising communication, shared decisions, and coordinated follow-up—may help reduce avoidable uncertainty. The framework remains conceptual and should be tested rather than treated as an established causal model.

Limitations and Future Research

This paper has several limitations. It is a narrative conceptual review and does not provide a systematic search or formal quality appraisal. Some links in the proposed pathway are extrapolated from general health psychology and health-anxiety literature rather than demonstrated specifically in PMOS. The literature on diagnostic experiences also includes studies published under the former PCOS terminology and may not represent all countries, healthcare systems, age groups, or cultural contexts. The framework should therefore be interpreted as a basis for research rather than a definitive account of patient experience.

1. Longitudinal research should examine whether diagnostic delay and perceived invalidation precede changes in illness representations, trust, health anxiety, and healthcare engagement, while accounting for prior psychological distress and symptom burden.
2. Qualitative studies should explore how people with PMOS describe diagnostic encounters across different cultural and healthcare settings, including how the transition from PCOS to PMOS terminology affects understanding and communication.
3. Researchers should evaluate existing measures of health anxiety, medical trust, stigma, and patient experience before developing new disease-specific instruments. Any proposed scale should undergo careful content validation, psychometric testing, and patient involvement.
4. Intervention studies should test whether clinician communication training, coordinated care, and integrated psychological support improve patient-reported experience, continuity of care, and relevant psychological outcomes.
5. Psychophysiological studies may examine stress-related correlates where justified, but should avoid assuming that diagnostic distress directly worsens endocrine or metabolic dysfunction without suitable longitudinal and mechanistic evidence.

The 2026 transition to the PMOS name offers an opportunity to improve public and clinical understanding of the condition. Future research should use both PMOS and PCOS terminology when searching and indexing evidence during the transition, while using the updated term consistently in contemporary discussion.

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Conflict of Interest

The author declared no conflict of interests.

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