heard. truth

NARRATIVE REVIEW

Not Just Growing Pains

A narrative review of medical dismissal of young people: why adolescents' symptoms are minimised or disbelieved, what it costs them, and how health care can listen better.

Anonymous Aletheia Research Team

"It's just period pain." "You're stressed." "Lots of teenagers feel like that." For many young people, these words are the first response they receive when they describe a symptom to a health professional. Sometimes this reassurance is correct. But a growing body of research shows that, for some young people, it is the beginning of a long road of repeat appointments, missed diagnoses and the slow learning that their own account of their body will not be believed. This report asks a central question: why are young people's symptoms so often minimised or disbelieved in health care, and what can be done about it?

This report synthesises 34 academic and grey literature sources, including systematic reviews, cohort studies, qualitative research and Victoria's Inquiry into Women's Pain. It focuses on young people aged roughly 10 to 24, with particular attention to girls and young women, gender-diverse young people and young people from culturally and linguistically diverse (CALD) backgrounds. The findings are organised into three themes: how and why young people are dismissed; the cost of dismissal in delay, harm and lost trust; and what helps young people be heard.

AT A GLANCE

- 34 academic and grey-literature sources
- For young people, families, clinicians, educators and policymakers

THEMES

- Not believed: how and why young people are dismissed
- The cost of dismissal: delay, harm and lost trust
- Being heard: what helps

CONTENTS

BACKGROUND
Why Medical Dismissal Matters Now

THEME 1
Not Believed – How and Why Young People Are Dismissed

THEME 2
The Cost of Dismissal – Delay, Harm and Lost Trust

THEME 3
Being Heard – What Helps

SUMMARY
Key Findings of Report

BACKGROUND

Why Medical Dismissal Matters Now

Medical dismissal is not a new problem, but it has become far more visible. Young people, patient advocates and governments are naming it, measuring it and, increasingly, trying to fix it. Four features of the current evidence make this an urgent issue for young people in Australia.

Many common youth symptoms are easy to dismiss

Some of the most common symptoms in adolescence are also the easiest to wave away as "normal". Period pain is a clear example. A systematic review and meta-analysis of 38 studies involving 21,573 young women under 25 found that around 71% experienced dysmenorrhoea (painful periods). About one in five reported missing school or university because of it, and around two in five said it affected their concentration or performance in class (Armour et al., 2019). Because period pain is so common, it is often treated as something to put up with, even when it may be a sign of an underlying condition such as endometriosis (Sims et al., 2021).

RESEARCH

Around 71% of young women experience painful periods, and about 20% miss school or university because of them.

Armour et al., 2019

TERM

Dysmenorrhoea

The medical term for painful periods. "Primary" dysmenorrhoea has no underlying disease; "secondary" dysmenorrhoea is caused by a condition such as endometriosis.

Dismissal is widely reported in Victoria

Victoria's Inquiry into Women's Pain heard from more than 13,000 people, including 12,792 survey responses, 328 written submissions and 41 focus groups. Being ignored, dismissed or having pain minimised by health professionals was the single most common challenge reported, described by 71% of respondents. Respondents recalled being told there was "nothing wrong" with them, or that their pain was psychological or "attention-seeking". Over half reported a delayed diagnosis, and 43% reported a misdiagnosis (Department of Health, 2025). The Inquiry was a self-selected consultation rather than a representative survey, but its scale makes it the most significant Australian record of how dismissal is experienced.

RESEARCH

71% of Inquiry respondents reported being ignored, dismissed or having their pain minimised by health professionals.

Department of Health, 2025

Adolescence is a critical window

Adolescence is now widely understood to stretch from about 10 to 24 years, a period in which young people move from having parents make health decisions for them to managing their own care (Sawyer et al., 2018). Experiences in this window shape whether young people learn that health care is a place where they will be listened to. Many chronic conditions, including endometriosis, ADHD, autism and some cancers, first appear or are first noticed during these years (Armour et al., 2020; Herbert et al., 2018; Hull et al., 2020; Young et al., 2020). When symptoms are dismissed at this stage, the effects can follow a young person into adulthood.

TERM

Adolescence (10–24 years)

A broader definition of adolescence that reflects how biological, social and legal transitions to adulthood now extend into the early twenties.

Some young people face compounded barriers

Dismissal does not affect all young people equally. Research describes how women, transgender, intersex, queer and racialised people are more likely to experience what is often called "medical gaslighting" (Sebring, 2021). In the Inquiry, only 57% of respondents who completed the survey in a language other than English had sought help for their pain, compared with 95% of the overall sample, and many did not know which services could help (Department of Health, 2025). Among trans young people in Australia, 42% had contacted a service provider who did not understand or respect their gender identity (Strauss et al., 2017). For young people at these intersections, being disbelieved is often one barrier among several.

RESEARCH

Only 57% of non-English survey respondents had sought help for pain, compared with 95% overall.

Department of Health, 2025

DIAGRAM

The Dismissal Cycle

The research reviewed in this report points to a repeating pattern. Dismissal is rarely a single event; it is a cycle in which each unhelpful encounter makes the next one more likely to go wrong. The Dismissal Cycle describes how a young person's symptom can move from being raised, to being discounted, to being hidden, while the underlying problem continues to grow. Breaking the cycle at any stage, by a clinician asking one more question, a young person bringing written notes, or a service offering an interpreter, can change the outcome.

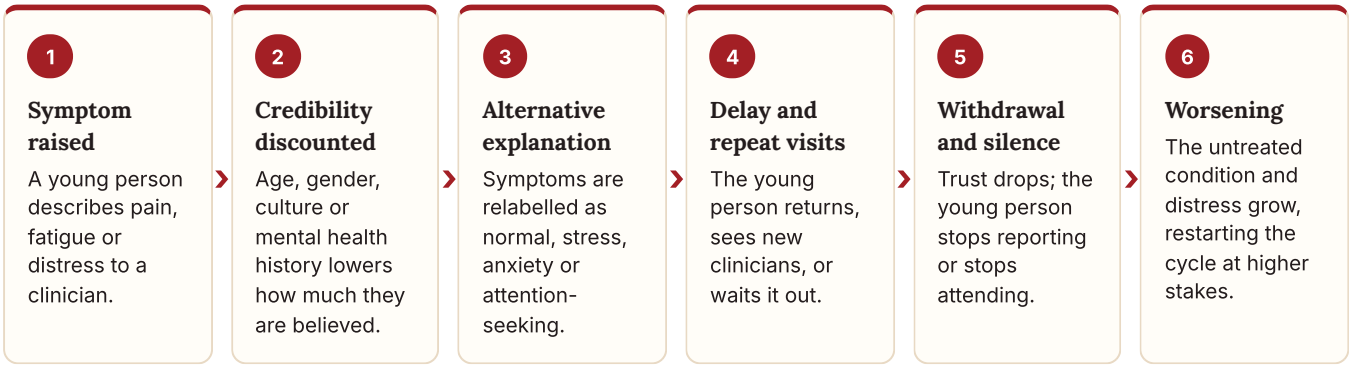


Figure – conceptual model developed from the literature reviewed in this report.

THEME 1

Not Believed – How and Why Young People Are Dismissed

Young people's accounts of their own bodies are filtered through assumptions about age, gender, culture and mental health before they are ever tested against evidence. This theme examines the concepts that help explain dismissal and the everyday features of health care that allow it to happen.

Finding 1.1 – Dismissal is a form of epistemic injustice, not just poor bedside manner

EPISTEMIC INJUSTICE

Philosopher Miranda Fricker (2007) described "testimonial injustice" as what happens when a speaker is given less credibility than they deserve because of prejudice about who they are. Carel and Kidd (2014) applied this idea to health care, arguing that patients are especially vulnerable because medicine privileges clinical and technical knowledge over the patient's own lived experience of illness. Under this framework, dismissal is not simply a doctor being rushed or unkind. It is a systematic discounting of the patient as a source of knowledge about their own body.

Carel and Györffy (2014) argue that children and young people are particularly exposed to this kind of injustice. Because they are young, their testimony is often treated as less reliable, and adults routinely speak on their behalf. A related form, "hermeneutical injustice", occurs when people lack shared words or concepts to make their experience understood. Blease et al. (2017) showed how both forms combine for patients with chronic fatigue syndrome, who frequently report being disbelieved, suspected of exaggerating, or told their illness is psychological. For a teenager who does not yet have the vocabulary to describe an unusual pain, both forms of injustice can operate at once.

TERM

Testimonial injustice

When someone's account is believed less than it should be because of prejudice about their identity, such as their age, gender or ethnicity.

RESEARCH

Children's testimony is often discounted in health care because of their age, a form of epistemic injustice.

Carel & Györffy, 2014

TERM

Hermeneutical injustice

When a person lacks shared language or concepts to make their experience understood, so it is overlooked or misread.

Finding 1.2 – Girls' pain is judged as less severe from childhood

GENDER BIAS

Gender bias in judging pain begins early. In a preregistered experiment, adults watched the same video of a child in a clinical scenario. When the child was described as a boy, participants rated the pain as greater than when the same child was described as a girl. The difference disappeared when the researchers accounted for participants' gender stereotypes, such as the belief that boys are more stoic and girls more emotional (Earp et al., 2019). These findings involved adult members of the public rather than clinicians, but they show how easily a stereotype can change how pain is perceived.

RESEARCH

Adults rated the same child's pain as lower when told the child was a girl rather than a boy.

Earp et al., 2019

RESEARCH

Women's pain was more often attributed to psychological causes, and their reports were often mistrusted.

Samulowitz et al., 2018

Among adults, a theory-guided review of 77 studies found that women with chronic pain were often described as hysterical, emotional, complaining, or as fabricating pain, and were more likely than men to have their pain attributed to psychological causes. Women also tended to receive less effective pain relief and more referrals to mental health services (Samulowitz et al., 2018). Young women grow up inside these same norms. When a teenage girl reports severe pain, she may meet a clinician primed to read her distress as emotion rather than evidence.

Finding 1.3 – Prior mental health diagnoses can overshadow new physical symptoms

DIAGNOSTIC OVERSHADOWING

"Diagnostic overshadowing" occurs when new symptoms are wrongly attributed to an existing mental health condition. A concept analysis of 25 publications found that overshadowing is a recognised contributor to poorer physical health outcomes and higher mortality among people with mental illness (Hallyburton, 2022). In a qualitative study of 39 emergency department doctors and nurses in London, clinicians described cases in which a patient's mental illness contributed to a missed or delayed physical diagnosis, including two deaths and five cases of irreversible harm. Crowded departments, time pressure and stigmatising attitudes held by a minority of staff all played a role (Shefer et al., 2014).

This matters for young people because anxiety and depression are common in adolescence, and 29% of young Australians surveyed named mental health as one of the most important issues facing the country (Mission Australia, 2025). A young person who has disclosed anxiety may later find that every new symptom, from chest pain to fatigue, is explained by it. The reverse also occurs: girls with ADHD are more likely than boys to first receive a diagnosis of an internalising condition such as anxiety or depression, which can delay recognition of the underlying neurodevelopmental difference (Young et al., 2020).

TERM

Diagnostic overshadowing

When a clinician attributes new physical symptoms to a person's existing mental health condition, so the real cause is missed.

RESEARCH

ED clinicians described missed diagnoses linked to mental illness, including two deaths and eleven near misses.

Shefer et al., 2014

Finding 1.4 – "Medically unexplained" can quietly become "not real"

LABELLING

When tests come back normal, patients are often told their symptoms are "medically unexplained". Nettleton (2006), in a study titled 'I just want permission to be ill', explored how people living with such symptoms seek legitimacy: recognition that they are genuinely unwell. Without a diagnosis, their illness can be left neither confirmed nor ruled out. Werner and Malterud (2003) described the effort women with chronic pain put into being seen as credible patients by their doctors. A related review noted that women may be doubted for looking "too healthy" (Samulowitz et al., 2018).

TERM

Medically unexplained symptoms (MUS)

Symptoms that do not have a clear cause after standard tests. It describes the limits of current testing, not proof that symptoms are imagined.

RESEARCH

"It is hard work behaving as a credible patient"

Werner & Malterud, 2003

For young people, the label can carry extra weight. A teenager whose tests are normal may be told, explicitly or implicitly, that their pain is stress, school avoidance or a bid for attention. Parents in the Victorian Inquiry described being reprimanded for supposedly making their children "paranoid" about their health (Department of Health, 2025). "Unexplained" is meant to mean "not yet explained", but in practice it can be heard as "not believed".

Finding 1.5 – Short consultations and adult-led conversations crowd young people out

CONSULTATION STRUCTURE

The way consultations are structured leaves little space for patients to speak. In an analysis of 112 recorded clinical encounters, clinicians asked about the patient's concerns in only 36% of visits. When they did ask, they interrupted after a median of 11 seconds in two-thirds of cases (Singh Ospina et al., 2019). Patients who were allowed to finish took a median of only six seconds to state their concern. The study involved adults, but the pressures are similar in youth consultations, where time is short and a parent is often present.

In paediatric settings, decision making is shaped by power relations between clinicians, parents and the child. A systematic review of 79 studies found that power imbalance was the most commonly reported barrier to shared decision making from children's perspective, while insufficient time was the most common barrier for clinicians (Boland et al., 2019). When parents speak for their child, they may be helpful advocates, but they can also unintentionally replace the young person's account with their own, particularly on sensitive topics. Adolescents are more willing to disclose information and seek care when clinicians assure them of confidentiality (Ford et al., 1997), which is difficult when they are never seen alone.

RESEARCH

Clinicians elicited the patient's agenda in only 36% of visits and interrupted after a median 11 seconds.

Singh Ospina et al., 2019

RESEARCH

Children identified power imbalance as the main barrier to shared decision making in paediatric care.

Boland et al., 2019

Finding 1.6 – Bias and language barriers compound dismissal for CALD and gender-diverse youth

INTERSECTIONAL BIAS

A systematic review of 42 studies found that health professionals hold implicit biases at levels similar to the general population, and that these biases were associated with lower quality of care in every study that tested this relationship (FitzGerald & Hurst, 2017). In a United States study, half of a sample of white medical students and residents endorsed false beliefs about biological differences between Black and white people, and those who held these beliefs rated Black patients' pain as lower and made less accurate treatment recommendations (Hoffman et al., 2016). While this research comes from a different context, it shows how cultural assumptions can directly shape how pain is assessed.

RESEARCH

Health professionals show implicit bias at similar levels to the general public, linked to poorer care.

FitzGerald & Hurst, 2017

TERM

Medical gaslighting

A popular term for when a patient's symptoms are dismissed or explained away in ways that make them doubt their own experience.

In Australia, CALD communities face barriers including limited interpreter availability, low familiarity with the health system, cost and a lack of cultural awareness among providers (Khatri & Assefa, 2022). For young people from migrant families, a parent may need to interpret, or the young person may interpret for their parent, making it harder to raise sensitive symptoms. Trans and gender-diverse young people describe services that lack knowledge of gender diversity, and in the Inquiry one respondent described hiding their non-binary identity from providers to avoid mistreatment (Department of Health, 2025; Strauss et al., 2017). Sebring (2021) argues that this is not a matter of a few individual clinicians, but of ideas embedded in Western medicine about whose bodies count as the "standard".

Form of dismissal	What it can sound like	Concept in the research
Normalising	"All girls get bad periods."	Normalisation of menstrual pain
Psychologising	"It's probably just anxiety."	Diagnostic overshadowing
Discrediting	"Are you sure it's that bad?"	Testimonial injustice
Moralising	"You just want to skip school."	Gendered norms of credibility
Speaking over	Questions directed only to a parent	Adult-led consultations
Closing down	"Your tests are normal, so you're fine."	"Medically unexplained" labelling

PROPOSED SOLUTIONS

In the consultation

- **Ask, then wait**
  Clinicians invite the young person's full concern and avoid interrupting for the first minute.
- **Time alone**
  Offer every adolescent part of the consultation without a parent, with clear confidentiality rules.
- **Name uncertainty honestly**
  Say "we haven't found the cause yet" rather than "there's nothing wrong".

In clinician education

- **Bias awareness training**
  Include gender, age, cultural and diagnostic overshadowing bias in medical and nursing curricula.
- **Pain is real teaching**
  Train clinicians that normal tests do not rule out real pain.

In services

- **Professional interpreters by default**
  Avoid relying on family members, especially young people, to interpret.

- **Gender-affirming practice**
  Use correct names and pronouns and record them across the service.

THEME 2

The Cost of Dismissal – Delay, Harm and Lost Trust

When dismissal becomes a pattern, the costs build up over years. This theme examines the evidence on diagnostic delay in conditions that often begin in youth, and on what being disbelieved does to young people's mental health and their relationship with health care.

Finding 2.1 – Endometriosis shows how normalising period pain delays diagnosis

DIAGNOSTIC DELAY

Endometriosis is a chronic condition in which tissue similar to the lining of the uterus grows outside it, causing pain that often begins in adolescence. In an Australian survey of 409 people with endometriosis or chronic pelvic pain, symptoms of endometriosis most often began in the late teens, and the average delay from first symptoms to diagnosis was around eight years. Encouragingly, the delay between first seeing a doctor and diagnosis has fallen sharply over time, from almost ten years for those who presented before 2005 to around 1.5 years for those who presented from 2013 onwards (Armour et al., 2020).

International reviews estimate average delays of 7 to 11 years between symptom onset and diagnosis, and identify stigma and the normalisation of menstrual pain, by families as well as clinicians, as key drivers (Sims et al., 2021). Brosens et al. (2013) describe adolescent endometriosis as a "hidden, progressive and severe disease", warning that by the time it is diagnosed, lesions may have already caused damage that affects fertility. One Inquiry respondent described how it "took over six years and eight GPs to get a referral" (Department of Health, 2025).

RESEARCH

Endometriosis symptoms usually began in the late teens, with an average delay of about eight years.

Armour et al., 2020

TERM

Endometriosis

A chronic condition where tissue similar to the uterine lining grows elsewhere in the body, often causing severe pelvic and period pain.

RESEARCH

"took over six years and eight GPs to get a referral"

Department of Health, 2025

Finding 2.2 – Young women with cancer see their GP more often before referral

SEX DIFFERENCES

Cancer in young people is rare, which can make it hard to recognise. The BRIGHTLIGHT study followed 830 adolescents and young adults aged 12 to 24 with cancer in England. More than a third (35%) of those who saw a general practitioner had three or more consultations before being referred. Young women had higher odds than young men of needing three or more consultations, and their overall time from symptom onset to diagnosis was on average 24 days longer, even after adjusting for cancer type and other factors (Herbert et al., 2018).

RESEARCH

Young women with cancer were more likely than young men to need three or more GP visits before referral.

Herbert et al., 2018

These findings echo a much larger pattern. A study of almost 6.9 million patients in Denmark found that, across hundreds of diseases, women were on average diagnosed at older ages than men (Westergaard et al., 2019). The causes are complex and not all are about dismissal, but the consistency of the pattern suggests that sex and gender shape how quickly symptoms are taken seriously, starting in adolescence.

RESEARCH

Across hundreds of diseases in 6.9 million Danish patients, women tended to be diagnosed later than men.

Westergaard et al., 2019

Finding 2.3 – Girls with ADHD and autism are missed or misread

NEURODEVELOPMENTAL

Diagnostic criteria for both ADHD and autism were largely developed from studies of boys. An expert consensus statement concluded that "a large number of girls with ADHD are likely to remain unidentified and untreated", partly because girls' less disruptive presentations are overlooked, and partly because their difficulties are more often first diagnosed as anxiety, depression or personality disorders (Young et al., 2020). For autism, a narrative review found that girls and women tend to be diagnosed later than boys and men, and that "females require more additional difficulties than males to receive an autism diagnosis" (Hull et al., 2020).

RESEARCH

"Females require more additional difficulties than males to receive an autism diagnosis"

Hull et al., 2020

TERM

Camouflaging (masking)

Strategies, often exhausting, that some autistic people use to hide autistic traits so they appear to fit in socially.

Hull et al. (2020) also describe "camouflaging", the conscious or unconscious masking of autistic traits in social settings, which can hide a young person's needs during assessments. Camouflaging is associated with anxiety, depression and suicidal thoughts. In these cases, dismissal often looks like a well-meaning statement: "she seems fine" or "she's just shy". The result is that girls may reach adulthood without the support or understanding a diagnosis can bring.

Finding 2.4 – Being disbelieved harms mental health

MENTAL HEALTH

Living with untreated symptoms is distressing in itself, but being disbelieved adds a further layer of harm. In the Victorian Inquiry, 89% of respondents said their pain affected their mental health, rising to 90% among LGBTIQA+ respondents (Department of Health, 2025). Women with chronic pain who are repeatedly psychologised can come to doubt their own perceptions, which is why the language of "gaslighting" has resonated so strongly (Sebring, 2021).

RESEARCH

89% of Inquiry respondents said pain affected their mental health, rising to 90% for LGBTIQA+ respondents.

Department of Health, 2025

RESEARCH

60% of trans young people felt isolated from medical and mental health services.

Strauss et al., 2017

Young people from groups that already face discrimination carry a heavier load. In Trans Pathways, a national study of 859 trans and gender-diverse young people, around three in four had experienced anxiety or depression, and 60% felt isolated from medical and mental health services (Strauss et al., 2017). When the health system that should help them is also a source of invalidation, young people lose a

key protective support. For girls whose ADHD or autism is missed, years of being told they are simply anxious or not trying hard enough can shape how they see themselves (Hull et al., 2020; Young et al., 2020).

Finding 2.5 – Dismissal erodes trust and pushes young people away from care

DISENGAGEMENT

One of the most lasting costs of dismissal is the loss of trust. Blease et al. (2017) argue that epistemic injustice reduces diagnostic accuracy and erodes trust, leading patients to withdraw from care or move between doctors. In the Victorian Inquiry, 52% of respondents had seen six or more services for their pain, and 23% had seen more than ten (Department of Health, 2025). Every new service means re-telling the story, with the risk of being disbelieved again.

For adolescents, early experiences shape future behaviour. Young people say that being respected, listened to and assured of confidentiality are central to whether they will return to a service (Ambresin et al., 2013; Ford et al., 1997). A young person who is laughed off at 15 may hesitate to seek help at 19, when the stakes may be higher. The Dismissal Cycle (see Diagram) shows how withdrawal and silence then allow the underlying condition to worsen, making the next presentation more complex and the next dismissal more harmful.

RESEARCH

52% of Inquiry respondents had seen six or more services for their pain; 23% had seen more than ten.

Department of Health, 2025

COMPOSITE CASE

Composite case: Amira, 16

This is a composite illustration drawn from patterns in the research, not a real person. Amira, 16, is from an Arabic-speaking family and has had severe period pain since she was 13. Her mother interprets at appointments. Two GPs tell her that painful periods are normal and suggest pain relief. A third notes that she has seen a school counsellor for stress and suggests the pain may be anxiety. Amira begins missing school each month and stops mentioning the pain, worried she will be seen as dramatic. At 19, she sees a new GP alone, with a written symptom diary. The GP asks open questions, refers her for specialist review, and she is diagnosed with endometriosis. Each point in Amira's story maps onto a stage of the Dismissal Cycle, and each was an opportunity for it to be broken.

PROPOSED SOLUTIONS

Faster recognition

- **Red-flag awareness**
  Teach GPs that period pain causing missed school warrants further assessment.
- **Count the visits**
  Treat a third visit for the same symptom as a trigger to review or refer.
- **Gender-informed criteria**
  Use ADHD and autism assessment tools that reflect how girls present.

Protecting wellbeing

- **Validate first**
  Acknowledge that the symptoms are real, even before a cause is found.
- **Joined-up care**
  Treat mental and physical health together rather than one explaining the other away.

Rebuilding trust

- **Continuity of care**
  Support young people to see the same clinician over time where possible.
- **Feedback channels**
  Make it easy for young people to give feedback or raise complaints safely.

THEME 3

Being Heard – What Helps

Medical dismissal is not inevitable. This theme draws together evidence on tools that help young people speak up, approaches that help clinicians listen, and system-level reforms such as those recommended by Victoria's Inquiry into Women's Pain.

Finding 3.1 – Self-advocacy tools help young people say what matters

SELF-ADVOCACY

Simple tools can shift the balance of a consultation. A review of question prompt lists, structured lists of questions that patients can use in appointments, found that providing a relevant list endorsed by the clinician just before the visit can help patients ask more questions and lead doctors to share more information (Sansoni et al., 2015). Symptom diaries, written summaries of what has already been tried, and agreed questions such as "What else could this be?" give young people a concrete way to make their account harder to dismiss.

RESEARCH

Question prompt lists handed out before visits can help patients ask more questions and receive more information.

Sansoni et al., 2015

Self-advocacy also depends on health literacy: knowing what is normal, what is not, and what to ask. Endometriosis education delivered in schools has been developed in New Zealand as a model to improve early recognition of symptoms (Bush et al., 2017), and the Victorian Inquiry recommended expanding school-based education on pain and women's health (Department of Health, 2025). Importantly, self-advocacy tools should support young people, not shift responsibility onto them. The duty to listen remains with the health system.

TERM

Question prompt list

A short written list of questions a patient can bring to an appointment to help them raise concerns and understand their options.

Finding 3.2 – Clinician training can target bias and overshadowing directly

CLINICIAN TRAINING

Because bias often operates without conscious awareness, training that makes it visible is a first step (FitzGerald & Hurst, 2017). The Earp et al. (2019) study suggests that gendered beliefs about stoicism and emotion are a key mechanism behind underestimating girls' pain, giving training a clear target. For diagnostic overshadowing, Hallyburton (2022) argues that understanding the concept itself may help prevent it, and identifies possible interventions for nurses and other health providers. Shefer et al. (2014) similarly recommended training for emergency staff and clear shared responsibility between mental health and medical teams.

Blease et al. (2017) suggest that clinicians should engage with patients' own understanding of their illness rather than simply correcting it, and that medical education should address conditions with uncertain causes. The Victorian Inquiry recommended consistent pain education across the health workforce and embedding women's health in medical training (Department of Health, 2025). Training on its own will not remove bias, but it gives clinicians the language to notice when an explanation such as "just anxiety" is closing down a question too early.

RESEARCH

The Inquiry recommended consistent pain training across the sector and women's health in medical education.

Department of Health, 2025

Finding 3.3 – Shared decision making puts young people at the centre

SHARED DECISION MAKING

Shared decision making is a process in which clinicians and patients make decisions together, combining clinical evidence with the patient's values and preferences. Stiggelbout et al. (2012) note that many clinicians believe they already practise it, but research reveals a gap between perception and reality. In paediatric care, facilitators include good-quality information, trust and respect, and access to decision tools and resources (Boland et al., 2019).

For adolescents, shared decision making means gradually moving from parent-led to young-person-led decisions, in step with the young person's developing capacity (Sawyer et al., 2018). Parents remain important, but the young person's voice should be heard directly. Because children reported power imbalances as the main barrier (Boland

TERM

Shared decision making

A way of making health decisions where the clinician and patient decide together, using medical evidence and the patient's own values.

RESEARCH

Clinicians often believe they practise shared decision making, but research shows a perception–reality gap.

Stiggelbout et al., 2012

et al., 2019), practical steps matter: speaking to the young person first, checking their understanding, and asking what matters most to them before discussing options.

Finding 3.4 – Youth-friendly, culturally safe services make listening easier

YOUTH-FRIENDLY CARE

A systematic review of young people's own views identified eight domains for assessing youth-friendly health care, providing a framework for evaluating how well services engage young people (Ambresin et al., 2013). Confidentiality is especially important: adolescents are more willing to disclose information and seek care when clinicians assure them of privacy (Ford et al., 1997).

For CALD young people, professional interpreters are essential. A systematic review found that care with professional interpreters was better than care with untrained interpreters, such as family members, and brought care for patients with limited English close to that of patients without language barriers (Karliner et al., 2007). Australian research highlights the need for more interpreter services, multilingual health information and culturally aware providers (Khatri & Assefa, 2022). For trans and gender-diverse young people, services that understand and respect gender identity are a basic precondition for being believed about anything else (Strauss et al., 2017).

RESEARCH

Professional interpreters improved care compared with untrained or family interpreters.

Karliner et al., 2007

Finding 3.5 – Victoria's Inquiry offers a roadmap for system change

POLICY REFORM

Bridging the Gender Pain Gap, the report of Victoria's Inquiry into Women's Pain, makes 27 recommendations across seven areas: research, policy, training, cultural change, models of care, workforce and affordability (Department of Health, 2025). Key recommendations include a Women's Pain Action Plan, public awareness campaigns, a pain resource library, expanded school education programs, person-centred models of care through women's health clinics, improved non-surgical pathways for endometriosis, and advocacy on cost barriers.

The Inquiry itself acknowledges that it collected limited age-specific data on girls and limited trans-specific data (Department of Health, 2025). This is an important gap. If reforms are to reach young people, girls, gender-diverse young people and CALD young people need to be explicitly included in implementation, monitoring and evaluation. Youth-led organisations are well placed to help design resources, test messages and hold services accountable for whether young people feel heard.

RESEARCH

The Inquiry made 27 recommendations across research, policy, training, culture, care models, workforce and affordability.

Department of Health, 2025

Level	Example action	Supporting evidence
Young person	Bring a symptom diary and question list	Sansoni et al., 2015
Consultation	Ask for the full agenda; time alone	Singh Ospina et al., 2019; Ford et al., 1997
Clinician	Bias and overshadowing training	FitzGerald & Hurst, 2017; Hallyburton, 2022
Service	Professional interpreters; youth-friendly design	Karliner et al., 2007; Ambresin et al., 2013
System	Women's Pain Action Plan; school education	Department of Health, 2025

PROPOSED SOLUTIONS

For young people and families

- **Write it down**
  Keep a symptom diary covering pain, timing, missed school and what has been tried.
- **Bring three questions**
  For example: What else could this be? What happens next? When should I come back?
- **Ask for a second opinion**
  Seeking another view is a normal and reasonable step.

For clinicians and services

- **Youth-friendly standards**
  Audit services against young people's own indicators of good care.
- **Shared decision tools**
  Use decision aids written for adolescents and check understanding directly.
- **Interpreters and inclusion**
  Book professional interpreters and record names and pronouns.

For policymakers

- **Include young people explicitly**
  Collect age, gender identity and language data when implementing pain reforms.
- **Fund school health literacy**
  Expand menstrual and pain education in schools, co-designed with young people.
- **Youth co-design**
  Involve youth-led organisations in designing awareness campaigns and resources.

SUMMARY

Key Findings of Report

1 **Dismissal is common and well documented**

Victoria's Inquiry into Women's Pain found that being ignored, dismissed or having pain minimised was the most common challenge, reported by 71% of respondents. Respondents described being told their pain was psychological or attention-seeking.

2 **Young people are given less credibility**

Research on epistemic injustice shows that young people's accounts of their bodies are often discounted because of their age, and that adults frequently speak on their behalf. Short, interrupted consultations leave little space for their voices.

3 **Bias shapes whose pain is believed**

Gender stereotypes lead adults to underestimate girls' pain, and implicit bias in health professionals is linked to poorer care. CALD and gender-diverse young people face additional barriers, including language and lack of respect for identity.

4 **Dismissal delays diagnosis**

Endometriosis often begins in the teens, with an average delay of around eight years in Australia. Young women with cancer need more GP visits before referral, and girls with ADHD and autism are diagnosed later or misdiagnosed.

5 **The harms go beyond the body**

Being disbelieved affects mental health, erodes trust and leads young people to move between services or withdraw from care altogether. This can create a cycle in which conditions worsen and future dismissal becomes more likely.

6 **Listening can be built into health care**

Question prompt lists, symptom diaries, time alone with clinicians, shared decision making, professional interpreters and youth-friendly services all help. The Inquiry's 27 recommendations offer a roadmap, but young people must be explicitly included.

WHERE TO GET HELP

Kids Helpline
free, confidential counselling for young people aged 5 to 25, 24/7
1800 55 1800 / kidshelpline.com.au

headspace
mental health support for young people, including online chat with clinicians
headspace.org.au

healthdirect / NURSE-ON-CALL
speak to a registered nurse about any health concern, 24/7
1800 022 222

Emergency
if someone's life is in danger, call Triple Zero
000

Lifeline
24/7 crisis support by phone or text
13 11 14 / text 0477 13 11 14

QLife
anonymous peer support for LGBTIQ+ people, 3pm–9pm every day
1800 184 527 / qlife.org.au

Health Complaints Commissioner (Victoria)
free, impartial service for complaints about health care
1300 582 113 / hcc.vic.gov.au

In an emergency, call 000. This report is health education, not medical advice.

METHOD

Research Method

This report is a narrative literature review of peer-reviewed research and grey literature, including government inquiry reports and reports from non-government organisations. Sources were identified through searches of PubMed, Google Scholar and government and organisational websites, using terms related to medical dismissal, epistemic and testimonial injustice, diagnostic overshadowing, medically unexplained symptoms, diagnostic delay, gender bias in pain, and youth-friendly and culturally safe health care. The review focused on young people aged approximately 10 to 24, and included English-language Australian and international evidence. Systematic reviews, large cohort studies and government reports were prioritised. Studies of adults were included where they illuminated mechanisms relevant to young people, and these limitations are noted in the text.

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