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Pain, Power, and Policing: Emotional Injustice in Healthcare

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ABSTRACT

Chronic pain patients frequently encounter not only physical suffering but also emotional dismissal and misrecognition in clinical settings. This paper argues that such experiences reflect a pervasive form of structural harm: *emotional injustice*. Chronic pain sufferers, especially women and members of marginalized groups, are often subject to *emotion policing*—the unjust regulation of emotional expression that distorts, suppresses, or discredits their feelings of frustration, sadness, and anger. Stereotypes like "women are emotional" or "boys don't cry" shape how patients' pain is interpreted and whether their emotional expressions are seen as credible, appropriate, or pathological. As a result, patients' emotions are routinely misread, their reports of pain discounted, and their treatment delayed or denied. Through the lens of *emotion stereotyping*, *display suppression*, and *emotion hegemonizing*, I show how dominant emotional norms constrain how chronic pain patients can express distress and advocate for themselves. These practices compromise emotional autonomy—their ability to experience and express fitting emotions in ways that reflect their circumstances, values, and lived reality—and reinforce systemic inequities in healthcare. While these harms intersect with forms of *epistemic injustice*, I argue that emotional injustice captures a distinct and deeper wrong: the denial of patients' ability to make sense of and communicate their emotional suffering on their own terms. Recognizing emotional injustice in the treatment of chronic pain is crucial for promoting more equitable, respectful, and compassionate care—care that honors the emotional realities of patients' lives.

1 | Introduction

Healthcare is not just about diagnosing and treating illness; it is also about navigating patients' lived experiences, including their emotions. This is particularly evident in the treatment of chronic pain sufferers, whose reports of distress are often met with skepticism, dismissal, or even outright disbelief. Consider the case of a woman experiencing severe, unexplained pain who is repeatedly told by doctors that she is "too anxious" or "overreacting," while a male patient with a similar condition receives immediate, serious consideration. Such differential treatment reflects not just biases in medical diagnosis but a deeper, systemic issue: the policing of emotions in healthcare.

Emotions play a fundamental role in clinical encounters, shaping how patients communicate suffering and how providers interpret and respond to it. Like other aspects of behavior, emotions are governed by social norms, which dictate when, how, and by whom emotions should be experienced and expressed. While such norms are essential to social life, they can also function as mechanisms of control—particularly when they systematically disadvantage certain groups in medical settings. I argue that emotion policing in healthcare constitutes a form of emotional injustice that undermines patient autonomy and exacerbates inequities in pain treatment. Specifically, I use the concept of emotion policing—a form of unjust emotion regulation that enforces conformity to dominant emotional norms, leading to the suppression, distortion, or dismissal of patients'

emotions [1]. Emotion policing is a structural problem within institutionalized power hierarchies in medicine, affecting diagnostic practices, treatment decisions, and patients' access to equitable care.

This analysis situates emotional injustice within the broader bioethical discourse on healthcare inequity, epistemic injustice, and medical paternalism. It expands these discussions by showing that emotional norms function as an overlooked mechanism of medical control, shaping how patients express distress, advocate for care, and are perceived by clinicians. While scholars have highlighted how testimonial injustice results in patients' credibility being systematically undermined [2], I argue that the problem goes beyond mere credibility deficits. Emotional injustice operates by controlling how patients are permitted to feel and express distress, thereby compromising their emotional autonomy—their ability to experience and express fitting emotions in ways that reflect one's circumstances, values, and lived reality. As a result, patients may suffer affective harms, such as being denied recognition of their emotions and experiences, as well as concrete medical harms, including misdiagnosis, inadequate pain management, and substandard treatment.

To demonstrate some of the ways in which emotional injustice is perpetuated in healthcare for the chronic pain sufferers, I proceed as follows. Section 2 introduces key features of chronic pain. Section 3 examines the dual nature of emotions as psychological and social phenomena, emphasizing their role in the experience and communication of chronic pain. Section 4 defines the concept of emotional injustice and identifies three kinds of emotion policing—emotion stereotyping, display suppression, and hegemonizing—each of which reinforces disparities in the treatment of chronic pain. Section 5 addresses potential objections, including distinctions between pain and emotion, overlaps with epistemic injustice, and critiques of framing men as both beneficiaries and victims of hegemonic norms, clarifying the scope and significance of emotional injustice. I conclude by reflecting on how recognizing and addressing emotional injustice can foster more equitable and compassionate healthcare practices.

2 | Chronic Pain: Some Key Features

Chronic pain is defined as pain lasting longer than 3 months, often persisting beyond the typical healing process. It affects over 20% of adults globally, making it a significant public health issue [3]. Chronic pain encompasses a range of conditions, including musculoskeletal disorders such as arthritis and fibromyalgia, neuropathic pain such as migraines and diabetic neuropathy, and idiopathic conditions like chronic fatigue syndrome and irritable bowel syndrome. It also includes pain related to specific conditions, such as endometriosis and cancer. These conditions significantly impair physical, emotional, and social well-being, affecting daily activities, relationships, and productivity.

Chronic pain is not only a physical experience but also an emotional and psychological one, deeply intertwined with feelings of frustration, isolation, and even helplessness. Pain can be understood as having two interconnected aspects: one is the immediate sensory experience that signals something wrong in the body, and the other is a negative evaluation of that experience characterized by pain's negative hedonic character, which typically motivates protective or avoidance behaviors [4–7]. In this way, while pain is not generally classified as an emotion, both share the crucial feature of having both an evaluative and a motivational component—as explained in more detail in the next section [8]. In the case of chronic pain, the sensory experience may persist without ongoing bodily harm, and the evaluative and motivational components can become maladaptive, exacerbating emotional distress and disrupting normal functioning.

Chronic pain has strong, well-documented links to mental health, particularly depression, anxiety [9], anger [10], and suicidal ideation and suicide [11]. Psychological distress is a highly significant predictor of pain levels and patterns[1], and the relationship between pain and mental health is bidirectional: emotional distress exacerbates pain, while pain worsens psychological distress [13]. Chronic pain's negative hedonic character, and its connection with anxiety and depression, creates and perpetuates a cycle of physical and emotional suffering.[2]

While chronic pain and its emotional toll highlight the interaction between physical and psychological experiences, understanding this dynamic also requires examining the social functions of emotions. Emotions not only shape individual responses to pain but also play a vital role in how pain is communicated, perceived, and addressed within social and healthcare contexts.

3 | The (Social) Functions of Emotions

Emotions are central to our social lives, shaping how we connect, communicate, and coexist with others across private and public spheres. Through emotional responses, we engage with the cultural, social, and political dimensions of collective existence. Our social lives are inherently emotional.

To see this, let us consider what emotions are and the various functions they serve. I take emotions to be felt evaluations that track matters of import for an organism in relation to its environment [16]. Emotions *identify* the objects at which they are directed as having certain value properties, *inform* the organism about how it is faring in relation to it, *motivate* the organism to respond appropriately, *communicate* to others the subject's emotional state, and *produce* emotional and behavioral responses in others.

In the case of chronic pain, emotions such as frustration, sadness, or anger identify the pain as a persistent and significant problem that disrupts well-being. These emotions inform the sufferer about the ongoing toll the pain takes on their physical and emotional health, signaling the need for coping strategies or external intervention. For instance, frustration may arise when pain limits daily activities, highlighting the value of lost abilities or independence. Emotions associated with chronic pain also prepare the sufferer to respond appropriately: anger may motivate advocacy for better treatment or insistence on being

taken seriously by healthcare providers. Conversely, sadness may encourage reflection or signal the need for support from others. These emotions communicate the individual's state to others, often through verbal expressions, body language, or facial expressions: visible frustration or tears can inform others—whether loved ones or healthcare professionals—about the level of suffering. Finally, these emotions can produce emotional and behavioral responses in others. A patient's emotional distress might motivate an empathetic healthcare provider to reevaluate the treatment approach. Similarly, a loved one might feel concern and offer comfort or assistance.

This framework illustrates that emotions associated with chronic pain not only serve to evaluate and respond to the experience but also play a critical communicative role in social and healthcare contexts, influencing how others perceive and engage with the sufferer's condition.

The social functions of emotions are regulated by *feeling rules*—social norms governing emotional experiences and expressions. Social norms regulate not only emotions, but also beliefs and behaviors, shaping everything from expectations around intimate relationships, such as monogamy, to everyday etiquette like holding doors or maintaining personal space in public. Feeling rules specify not just what emotion is fitting, but how it should be experienced, acted on, and displayed: spilling coffee calls for embarrassment and a simple apology, not guilt or over-the-top remorse.[3] While these norms are vital for coordinating social life, they can also impose unfair disadvantage, resulting in unjust treatment of emotional agents.

4 | Emotional Injustice and Emotion Policing

Social norms regulating emotions can cause harm, injustice, and oppression. While harm refers to injury or disadvantage inflicted on individuals or groups, injustice involves unfair treatment that violates principles of equality, and oppression reflects systemic patterns of domination entrenched in institutions and culture. Emotional injustice, as defined by Pismenny et al. (2024), occurs when emotions themselves are treated unjustly, or used to treat people unjustly [1, p. 154].[4]

Here I focus on the first kind, describing what occurs when individuals or groups are denied the experience, expression, or recognition of their emotions, resulting in an arbitrary disadvantage that undermines their emotional autonomy, and impairs their ability to advocate for themselves. I zoom in on *emotion policing*—a form of emotional injustice, which occurs when "the nature of emotions is distorted, or their expression is suppressed" [1, pp. 161–162]. It is typically systemic because it is applied to individuals based on their group membership, aiming to enforce emotion norms that uphold unjust social structures and perpetuate oppression and harm.

Emotional injustice operates across various aspects of emotional functioning, from elicitation to uptake. To illustrate emotion policing in healthcare contexts, I examine three interconnected forms—emotion stereotyping, display suppression, and hegemonizing—with a primary focus on gender and racial biases in the treatment of chronic pain. Because healthcare systems reflect broader social biases, inequalities in the recognition and validation of emotions are pervasive, often compounding along lines of gender, race, class, and age.

4.1 | Emotion Stereotyping

Stereotypes are generally held beliefs (implicit or explicit) or generalizations about a social group having a set of particular traits [20, p. 612]. These beliefs are both descriptive and evaluative. For instance, gendered stereotypes are beliefs that men are ambitious, rational, and competitive, while women are nurturing, empathetic, and collaborative. Not only do these generalizations aim to capture men's and women's characteristics, but they also dictate the kinds of traits men and women *should* possess. Stereotypes and social norms work in tandem: "Whilst stereotypes inform our assumptions about someone based on their gender, social norms govern the expected and accepted behaviour of women and men, often *perpetuating* gendered stereotypes" [21, p. 2].[5] This way norms and stereotypes reinforce the standards not only of behavior but also of feeling for men and women.

Stereotypes need not be negative (e.g., "Black people are good at sports," "women are nurturing") but because they are generalizations, they tend to have a negative effect on those to whom they are applied [21]. They become particularly problematic when, in conjunction with norms, stereotypes reinforce the marginalization of the groups they target, augmenting their position of disadvantage. Emotion stereotyping works in just this way since emotion stereotypes specify which people can have which emotions and in what kind of circumstances. When these stereotypes are applied to members of a particular social group, their actual emotions may be distorted or altered.

Consider the stereotype "women are emotional" [22].[6] It suggests that womens' emotional responses are irrational and therefore not to be taken seriously, which becomes especially troubling when those emotions reflect experiences of wrongful treatment, such as anger at injustice or frustration with systemic barriers. This dynamic is particularly harmful in medical contexts, where stereotypes not only delegitimize women's frustration but also invalidate their interpretation of the experiences that give rise to it.

Because women are often perceived as prone to overreaction, their expressions of pain—such as crying, frustration, or verbal complaints—are frequently dismissed by medical professionals as exaggerated or irrational. Anke Samulowitz and colleagues found that "...[W]omen with pain can be perceived as hysterical, emotional, complaining, not wanting to get better, malingerers, and fabricating the pain, as if it is all in her head. Other studies showed that women with chronic pain are more often assigned psychological rather than somatic causes for their pain" [24, p. 5]. As a result, women are less likely to receive appropriate pain management and more often prescribed antidepressants, reinforcing a bias that frames their pain as emotional rather than physical. Yet chronic pain commonly arises from biological processes such as inflammation, nerve dysfunction, or musculoskeletal problems—factors easily obscured by a psychological focus.

The dismissal of women's pain creates a cycle where women are less likely to be believed, leading to increased emotional distress, which is then further delegitimized. It reinforces the stereotype of emotionality, which distorts the nature of women's distress and pain, treating their emotional expressions as irrational, inaccurate, or fictitious. This causal misattribution undermines the *communicative* function of emotions, meant to convey important needs or problems, by failing to elicit appropriate recognition and action from healthcare professionals. This breakdown in uptake creates an arbitrary disadvantage for women, simply because they are women, depriving them of equitable care and reinforcing systemic inequalities, thus contributing to oppression as well as harming them by failing to alleviate their suffering. It can also result in emotion gaslighting when women no longer trust their own emotions and pain because an authority figure—a healthcare professional—is refusing to believe them. That further undermines the *epistemic* function of emotion, as well as distorting the very nature of the emotion and pain. In contrast, men's reports of pain and distress are more often treated as credible and legitimate, reflecting a gendered disparity in the acknowledgment and value given to emotional expressions. Emotion stereotyping thus acts as a form of emotion policing that sustains gender oppression.

4.2 | Emotion Display Suppression

Another kind of emotion policing is emotion display suppression. These are cases in which stereotypes of race and gender interact to cause the suppression of emotional expressions of distress, particularly in the healthcare experiences of many Women of Color (WOC).

Emotion display rules, governed by social conventions, dictate what emotions are appropriate to express and in what contexts. Emotion display suppression, as a form of emotion policing, typically targets marginalized groups. It constrains their emotional autonomy by restricting their ability to express legitimate emotions, to advocate for their needs, or to respond effectively to their circumstances [25].

To see this consider again the stereotype, "women are emotional." African American women reporting chronic pain are often characterized as "drama queens" even by white female nurses [26, p. 128]. Black women are subjected to this stereotype and experience emotion delegitimizing described in the previous section. There is, however, another stereotype uniquely applicable to African American Women—the Strong Black Woman (SBW) stereotype. It constructs Black women as inherently resilient, self-sacrificing, and emotionally stoic. Rooted in historical narratives of Black women's survival under systemic oppression, the SBW stereotype idealizes their ability to endure hardships without showing vulnerability or seeking help. Because this stereotype is also an ideal in Black culture, it is internalized by Black women themselves as well as others around them, setting up an expectation that Black women will be strong and self-reliant in the face of adversity.

When it comes to chronic pain, Lakeshia Cousin and colleagues found that African American women often felt compelled to suppress their emotional expressions, including distress and vulnerability, to align with cultural expectations of strength. Black women reported feeling obligated to maintain a positive outlook and hide their pain, even when it was severe. This suppression was so ingrained in their daily lives that many rarely admitted to experiencing pain, as one participant noted, pain "wouldn't be anything new for us [Black people]" [26, p. 134]. This expectation reinforces the silencing of emotional distress. By normalizing the suppression of legitimate emotional expressions, this behavior not only diminishes the visibility of their suffering but also enables the minimization of their pain by others, including healthcare providers.

A similar pattern emerges among Hispanic American women. Stoicism (*aguantar*) is a key pain management strategy, emphasizing endurance without complaint [27]. Gendered expectations pressure Hispanic women to prioritize caregiving roles over their own health, often leading them to neglect their own pain [28]. As with African American women, emotion suppression among Hispanic American women is reinforced both culturally and socially, exacerbating under-treatment and invisibility in healthcare settings. Hispanic American women also report feeling that healthcare professionals "do not understand their pain and do not believe them when they say they are in pain" [27, p. 521]. This combination of cultural stoicism and medical disbelief compounds emotional and physical suffering, further institutionalizing emotional injustice.

Similarly, studies have found that Indigenous women often suppress pain through stoicism and endurance, resulting in underreporting and under-treatment [29, 30]. Moreover, Indigenous women often experience discrimination and stereotyping, such as being labeled "drug-seeking," and a broader lack of culturally competent care. In fact, Indigenous women are the racial group most often perceived as exaggerating distress [29, p. 519], highlighting another layer of emotion display policing that systematically disadvantages them in clinical encounters.

In each case, cultural expectations compel WOC to self-police their emotional expressions to avoid being perceived as weak, overreactive, or incapable. This self-regulation constitutes a form of emotional injustice: the norm of stoicism creates an arbitrary disadvantage by preventing WOC from expressing emotions that are legitimate and appropriate to their circumstances. By framing emotional vulnerability as weakness, this expectation institutionalizes the suppression of distress, resulting in emotional masking, delayed diagnoses, and inadequate treatment.

What is more, the stereotype that "women are emotional" and cultural norms valorizing stoic endurance place WOC in a double bind: they are expected to suppress their emotions to conform to ideals of strength, yet when they do express pain or frustration, they are dismissed or stigmatized as overly emotional. These intersecting pressures make it nearly impossible for WOC's emotions to be taken seriously or understood on their own terms, thus perpetuating oppression of WOC.

4.3 | Emotion Hegemonizing

Differential treatment of women's and men's distress highlights another form of emotion policing: emotion hegemonizing. It

occurs when the emotional norms of a dominant group are imposed as universal standards, marginalizing or invalidating alternative emotional expressions [1, p. 163]. Unlike emotion stereotyping (which assigns group-specific emotional traits) or suppression (which restricts display), hegemonizing is also sometimes *homogenizing* when it seeks *emotional uniformity*, privileging the dominant group's emotional expressions as legitimate while invalidating others.

In healthcare, this often takes the form of *andronormativity*—the assumption that male-coded emotional traits (e.g., stoicism, emotional restraint) are the default or ideal [24, p. 3]. This normative framework treats men's emotional expressions as the universal standard of affective legitimacy and credibility.[7]

Andronormativity reflects the standard of hegemonic masculinity, which posits traits such as strength, autonomy, and emotional suppression as superior to other masculinities and femininities. Within this framework, chronic pain is viewed as a threat to masculinity, leading men to deny or minimize their pain and avoid seeking medical help [24, pp. 9–10]. Acknowledging vulnerability conflicts with traditional masculine ideals, creating societal pressure for men to downplay their suffering and conform to norms of endurance and control. Failing to adhere to these expectations often results in being perceived as less masculine, further reinforcing the stigma around seeking care. The emotional stereotype "boys don't cry" encapsulates this expectation, perpetuating the notion that men should suppress vulnerability and avoid addressing their pain. In this way, emotion hegemonizing regulates men's expression of pain to align with this masculine standard.

Women are judged against these male-centric norms, and their emotional expressions, such as distress and discomfort, are often dismissed as irrational or overreactive. Although both men and women are evaluated according to these male-centric norms, they are not expected to conform to them in the same way. Instead, women are caught in a double bind because masculinity and femininity are defined as opposites [31, p. 63]. As a result, women's emotional expressions will be interpreted as psychological and inappropriate whenever they express them strongly, or as not very serious, when they express them mildly in a "manly" manner. Either way, women's pain reports will not be adequately addressed.

While emotion hegemonizing typically involves the imposition of emotional norms by a dominant group onto a subordinate group, its principles also apply within hierarchies of dominance, such as the internal regulation of masculinity under the hegemonic standard. In this case, the dominant group imposes norms on its own members to uphold its dominance and sustain its ideals. Thus, even within the dominant group, emotion hegemonizing functions to maintain the social order by silencing expressions of emotions like distress or pain that conflict with its ideals.

Emotion hegemonizing not only reinforces gendered stereotypes but also sustains an arbitrary disadvantage for those who fall outside the dominant emotional norms. Women's emotional expressions are distorted since they do not align with male-centric expectations, depriving them of equitable access to empathy, validation, and medical treatment. This systemic silencing of emotions exemplifies emotional injustice, as it denies women the opportunity to communicate their needs effectively and exacerbates existing inequalities. For men, hegemonic masculinity imposes restrictive emotional norms that pressure them to suppress vulnerability and pain, marginalizing those who deviate from these ideals and creating barriers to seeking support or care. Thus, men too experience emotional injustice and harm under the rigid gender emotion norms.

Emotion stereotyping, display suppression, and hegemonizing each illustrate how emotion norms are weaponized in healthcare to delegitimize, silence, or distort patients' affective experiences. Together, these mechanisms of emotion policing sustain systemic inequities, undermine emotional autonomy, and contribute to the broader pattern of emotional injustice faced by chronic pain sufferers.

5 | Objections and Replies

The previous section outlined how emotion policing operates through stereotyping, suppression, and hegemonizing. But some may wonder: do we really need the concept of *emotional injustice* to make sense of these harms? After all, scholars have already pointed out the dangers of misreading or dismissing patients' pain. What does this new concept add? In what follows, I consider three objections that press this question and use them to clarify what *emotional injustice* helps us see that other frameworks might miss.

The first objection is that my examination of chronic pain through the lens of emotional injustice is misleading because pain and emotions are distinct kinds of mental state. While pain and emotions, as we have seen, both have algedonic and motivational dimensions, they are nonetheless different. For instance, it may be argued that pain inherently motivates actions related to bodily disturbances, whereas emotions have a broader motivational scope, and are more connected to evaluative representations of situations or objects other than bodily damage. As a result, I should have been talking about *affective*[8] rather than emotional injustice since pain is an affective phenomenon, and not an emotion.

In response, note first that what matters here is not whether pain *is* an emotion, but how pain, emotion, and suffering are interconnected. To understand the experience of chronic pain suffering, we must recognize that emotions are an essential part of the picture. So, the distinction between pain and emotion does not undermine my approach.

Second, emotion norms and stereotypes—such as "women are emotional" or "boys don't cry"—play a crucial role in shaping how people's pain is perceived, expressed, and responded to. These norms often delegitimize suffering, particularly for marginalized groups, by distorting or constraining the emotional resources needed to make sense of and communicate that suffering.

This is why *emotional* injustice, rather than a broader affective category, is the appropriate framework: it captures the ways

unjust emotion norms create arbitrary disadvantages, particularly by undermining emotional autonomy—the capacity to express, interpret, and respond to one's suffering in meaningful and productive ways.

Another objection might be that my core arguments are better captured by the concept of *epistemic injustice*. For instance, emotion stereotypes like "women are emotional" can undermine the credibility of women's pain reports, exemplifying Miranda Fricker's notion of *testimonial silencing* [32, p. 1]. Similarly, norms like "boys don't cry" or the suppression of emotion in clinical settings encourage self-censorship, reflecting Kristie Dotson's concept of *testimonial smothering*, where individuals limit their own testimony to what their audience is deemed capable of receiving [33, p. 244].

While epistemic injustice highlights the problematic treatment of someone *as a knower*, often resulting in credibility deficits, failures of uptake, or forms of smothering, I argue that emotional injustice, as seen in cases of chronic pain, captures a broader set of wrongs that extend beyond this epistemic framework. Emotional injustice undermines *emotional autonomy*: the capacity to experience and express one's fitting emotions freely and on one's own terms, without coercion, distortion, or imposed conformity.

Emotions do more than convey information; they help us evaluate our circumstances, motivate action, and communicate with others. Frustration at chronic pain identifies the persistence and significance of a problem; anger can drive a person to demand better treatment or recognition; sadness can express a need for comfort or connection. When these emotional experiences are policed—framed as overreactions, irrational, or pathological—their core functions are undermined. This impairs individuals' ability to make sense of their experiences, advocate for themselves, and reach out for support.

In the context of chronic pain, such emotional policing is especially harmful. Patients whose frustration is dismissed, whose sadness is medicalized as depression, or whose anger is read as instability are denied the opportunity to recognize and act on the significance of their pain. These forms of suppression not only erode emotional autonomy but also reinforce broader patterns of systemic inequity.

Thus, while epistemic injustice highlights important dimensions of silencing and credibility, emotional injustice provides a fuller account of how emotional lives are shaped, constrained, and sometimes deformed by unjust social norms. It captures harms not only to our status as knowers but to our capacity to live emotionally meaningful and agentic lives.

By undermining the evaluative, motivational, and communicative functions of emotions, emotion policing denies individuals the ability to navigate their circumstances effectively, advocate for their needs, and connect with others. In doing so, it not only erodes emotional autonomy but also exacerbates emotional injustice, reinforcing systemic inequities and perpetuating harms.

The last objection I consider is about the connection between injustice and oppression as it relates to emotion hegemonizing and men. Men are not an oppressed class in our society; rather, they belong to a class that generally benefits from the patriarchal order. When norms of stoicism and emotional restraint are enforced for men, they do not undermine men's position but instead serve to reinforce their dominance in the social hierarchy. Stoicism aligns with ideals of control, rationality, and authority, which are highly valued in patriarchal systems, thereby perpetuating the association of power and privilege with masculinity.

This raises a challenge to my argument: if these norms serve to consolidate men's social advantage, can their enforcement truly be considered an injustice? One might argue that the harm caused by emotion hegemonizing in this context does not rise to the level of injustice but instead functions as a mechanism of maintaining privilege.

In response, first, the injustice lies in the arbitrary disadvantage imposed on individuals—men included—who do not conform to these norms. Such individuals may face stigma, marginalization, or exclusion from the social and emotional benefits of vulnerability, connection, and self-expression. Second, hegemonic masculinity prevents men from adequately experiencing and expressing their vulnerability *because* they are men. In that regard, then, they are emotionally disadvantaged as a class. Thus, men are oppressed by this norm via their group membership even though they benefit most from the current social order.

As we have seen, hegemonic masculinity defines itself in opposition to femininity, a dynamic particularly evident in the emotion stereotypes I have discussed: "women are emotional" and "boys do not cry." These stereotypes frame emotionality as a feminine trait, contrasted with rationality—associated with keeping emotions in check—which is coded as masculine. Hegemonic masculinity, and hegemonic gender standards more broadly, disadvantage men, women, and people of other genders, illustrating that the current gender system is harmful and oppressive to everyone, albeit in different ways.

6 | Conclusion

In this paper, I have demonstrated how emotion policing in healthcare, particularly in relation to chronic pain, constitutes a significant form of emotional injustice. By exploring mechanisms such as emotion stereotyping, display suppression, and hegemonizing, I have shown how entrenched social norms and biases distort, dismiss, and suppress the emotional experiences of chronic pain sufferers, particularly those from marginalized groups. These practices not only undermine emotional autonomy but also perpetuate systemic inequities, exacerbating harm and oppression.

Recognizing and addressing emotional injustice is crucial for fostering a more equitable healthcare system. This requires challenging the harmful norms that govern emotional expression, ensuring that diverse emotional experiences are validated, and rethinking how healthcare providers engage with patients' emotional and physical needs. Beyond healthcare, this analysis can inform broader efforts to combat

structural inequalities and promote justice in other domains. By centering emotional autonomy and dismantling oppressive norms, we can take meaningful steps toward building a society that values and supports all individuals' emotional and physical well-being.

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Conflicts of Interest

The author declares no conflicts of interest.

Endnotes

[1]The patterns include the persistence, intensity, and progression of pain over time. Psychological distress can predict chronicity, where acute pain evolves into long-term chronic pain, as well as fluctuations in pain severity and the likelihood of experiencing recurrent episodes. These trends emphasize the reciprocal relationship between emotional distress and the trajectory of pain conditions. For further discussion, see [12].

[2]For discussion of suffering see Eric J. Cassell [14] and Michael Brady [15]. While Cassell defines suffering as distress arising from threats to a person's integrity, Brady understands it as unpleasant feelings one desires to escape. Both emphasize that suffering depends not only on pain itself but also on how it is emotionally interpreted and experienced.

[3]On feeling rules see [17]. On display rules see [18].

[4]See also [19].

[5]Emphasis added.

[6]Lisa Feldman Barrett and colleagues [23] found that while women describe themselves as more emotional than men, men and women experience emotions in similar ways.

[7]It foregrounds all kinds of aspects of male experience, not just emotional ones, including male-based physiological norms, diagnostic criteria, drug testing, and behavioral expectations.

[8]Unfortunately, in the current literature on affective injustice, "affective" is typically used to mean "emotional."

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