

Responding Faithfully to Women's Pain: Practicing the Stations of the Cross

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This essay explores the contemporary experiences of women who live with pain, given the complex responses they encounter within Western medical systems, including pervasive stigma, bias, clinician disbelief, and poor health outcomes. In response to these realities, as highlighted within recent literature and exemplified in a first-person account provided by the paper's author, this essay explores the Christian practice of the Stations of the Cross as a faithful response to women living with pain. The Stations provide a distinctive Christian practice that invites women living with pain, as well as their clinicians and loved ones, into faithful care marked by prayer, solidarity, and hospitable listening. Practicing the Stations provides one faithful response that Christian clinicians and those who live with pain might engage in the clinic and beyond.

Keywords: Christian practice, gender bias, pain, the Stations of the Cross, women's health

I. INTRODUCTION

The past two decades have brought a proliferation of attention to the topic of women's pain, present in sources ranging from peer-reviewed journal articles in medicine,¹ the social sciences, and public health,² to memoirs,³ long-form essays in popular media sources,⁴ and books published at the popular level.⁵ These diverse sources describe a variety of patterns among women⁶ who experience pain in contemporary Western contexts⁷: increasing rates of chronic pain among women,⁸ greater risk for health conditions marked by significant pain among women (including fibromyalgia, headache, osteoarthritis, and temporomandibular joint disorders),⁹ the prevalent under-treatment of women's pain by physicians,¹⁰ as well as patterns of misdiagnosis and delayed diagnosis.¹¹

In this essay, I take up the question of how Christians might faithfully respond to women who live with pain. I write as a Christian theologian, a woman who lives with chronic pain, and a clinician. As a Christian who occupies these various spaces, I illustrate how engagement with the ancient practice of the Stations of the Cross might empower a creative, faithful, and sustained response to women's experience of pain among women themselves, Christian clinicians, and Christian faith communities. I do so by first surveying further details regarding women's pain in contemporary Western medical contexts and offering an account of my own "way into" the complex realities of responding to women's pain. Next, I explore existing Christian responses to those who live with chronic pain in the contemporary research literature. I then introduce the practice of the Stations of the Cross as a historical and faithful Christian response to suffering. I conclude the essay by demonstrating how the Stations offer a fitting Christian practice for those seeking to faithfully respond to and care for women who live with pain in our contemporary context. Practicing the Stations of the Cross provides an ecumenical Christian practice of discipleship that can not only sustain women living with pain, but also empower ecclesial and clinical communities to respond to women's pain in a distinctively Christian manner.

II. KEY INSIGHTS FROM THE RESEARCH

Throughout the current literature, authors suggest a number of intersecting rationales that account for the striking realities of women's pain in contemporary Western contexts. These rationales include hormonal differences, as well as differences in genetics and "endogenous pain modulatory systems" in comparison to men (Hoffmann and Tarzian, 2001; Fillingim et al., 2009, 22; D'Arcy, 2011; Samulowitz et al., 2018). Alongside these biological factors, research documents pervasive medical bias, dismissal, and discrimination in response to women with chronic pain (Hoffman and Tarzian, 2001; Werner and Malterud, 2003; Fillingim, et al., 2009; *The Campaign to End Chronic Pain in Women*, 2010; Samulowitz et al., 2018). Women in pain are "met with skepticism and lack of comprehension . . . rejected, ignored, and belittled, blamed for their condition and assigned psychological explanation" (Werner and Malterud, 2003, 1409). Fillingim et al. (2009) as well as Hoffmann and Tarzian (2001) suggest that Western gender norms and patterns of socialization may disadvantage women with chronic pain—a tendency that is negatively enhanced by patterns of "andronormativity" in Western medicine (Samulowitz et al., 2018) as well as a widespread historical precedent categorizing women as "difficult patients" (Johannisson, 2001).

Stigma related to gender norms presents another major factor affecting women living with chronic pain (Werner and Malterud, 2003; Jackson, 2005; Goldberg, 2010; *The Campaign to End Chronic Pain in Women*, 2010; Pryma, 2017; Samulowitz et al., 2018). Although stigma is pervasive among patients with pain regardless of gender identity (Goldberg, 2017), Werner and Malterud theorize that stigma is experienced by women living with pain in two particular ways: first, stigma from having one's morality or character called into question in the clinical setting, and second, stigma and distress from being "psychologized by others, doctors in particular" (2003, 1416). Women face this stigma particularly when their pain does not have a corresponding medical diagnosis. Pryma (2017) describes the "barriers to credibility"¹² faced by women living with pain, suggesting that stigma prevents clinicians from reading women's reports of pain as legitimate. Additionally, Samulowitz et al. (2018) find that in comparison to men with chronic pain, women with chronic pain have their pain reports taken less seriously, receive less adequate pain treatment, and face increased occurrences of clinicians discounting their pain or rendering it as nonexistent.

Another central element contributing to current crises around women who live with pain resides in patterns of relationship and communication with clinicians. Research demonstrates that regardless of the sex and gender-identity of clinicians themselves, patient-clinician encounters often produce anxiety, perpetuate stigma, and evoke demoralization among women with chronic pain (Hoffmann and Tarzian, 2001; Werner and Malterud, 2003, 2005; Jackson, 2005; *Institute of Medicine*, 2011). In her theological work on women's health care in the United States, Aana Marie Vigen (2006, 42) also cites the cross-cultural and gendered complexities around communication of pain, especially noting the power of cultural and linguistic barriers for women with pain in medical encounters. Like Vigen (2006, 2) and Pryma (2017) also highlights the negative impact of layered disparities (including gender, race, class) that face women who require pain medication and ongoing medical management for pain conditions. For example, gendered assumptions can complicate the credibility of women with pain in their medical reporting to providers: common comments from clinicians include "you don't look sick!," "you are so young," "you look so attractive and put together," or "you always look very healthy!," leading to shame for patients, paired with disbelief of patient reports by clinicians (Hoffmann and Tarzian, 2001, 21; Werner and Malterud, 2003, 1413).¹³ These typical patterns of patient-physician communication regarding women living with chronic pain introduce a new burden for many women when trying to navigate the complex medical world of diagnosis and treatment—they must now also maintain a "subtle balance not to appear too strong or too weak, too healthy or too sick, or too smart or too disarranged" (Werner and Malterud, 2003, 1409).

A final key theme within scholarship on women with chronic pain in contemporary Western medical settings consists in a remarkable knowledge gap—a dearth of women-specific clinical research (Dusenbery, 2018). Beyond clinical research on assessment and treatment of women's pain, disparities also exist in studying epidemiology, clinical presentation, and risk assessment related to women's pain (Brewer, Svatikova, and Mulavagh, 2015, 363). For example, between 1996 and 2005, 79 percent of the animal studies published in *Pain* (the research journal associated with the International

Association for the Study of Pain) exclusively utilized male subjects, with only 4 percent of studies during this date range explicitly discussing data from both sexes (Mogil, 2009; D'Arcy, 2011). Even when specific clinical research is completed with regard to issues of women's pain, this research tends to lack a robust interdisciplinary synthesis, as well as an integrated clinical translation (*The Campaign to End Chronic Pain in Women*, 2010).

This lack of clinical research regarding women in general can directly impact bias and clinical care. Lagro-Janssen (2010, 30) describes this using the concept of gender-blindness—a “nonawareness of the fact that a great deal of knowledge is based on research performed in men” among clinicians who treat women's pain. Even when updated clinical research disproves commonly held medical assumptions (such as coronary artery disease being a “man's disease”), clinicians continue to hold onto these falsehoods, with potential negative impacts on their clinical judgment and reasoning in treating women with pain (Brewer, Svatikova, and Mulavagh, 2015). In light of these current research realities, Samulowitz et al. (2018, 11) highlight the pressing need to attend to gender bias in clinical care in order to offer more equitable care to all patients.

III. ATTEMPTS TO RESPOND

Within this existing literature on women's pain, a notable gap remains: how might women in pain, as well as their clinicians, best respond to lived realities of pain? What practices might lead to the lessening, management, solidarity within, and resolution of women's pain? And how might women who experience pain and those who care for them participate in practices where women are listened to in ways that dismantle stigma and medical bias?

The complexities of women's pain explored above call for responses beyond “technical interventions” alone (Goldberg, 2010, 435). Medical school curricula provide one area for revision, with specific attention devoted to education on gender bias in medicine and practices designed for meaningfully integrating a patient's subjective description of pain into medical documentation (Hoffmann and Tarzian, 2001; *The Campaign to End Chronic Pain in Women*, 2010). Heightened vigilance in identifying potential underlying causes of chronic pain among women also constitutes an area of needed intervention (Cain et al., 2002; Phillips, 2002; Rinto and Hillard, 2002; Hilgers, 2010; D'Arcy, 2014; Block, 2019; Thande et al., 2019). Additionally, medical schools and other physician training programs, such as residencies and fellowships, can benefit from providing trainees with practice opportunities (as well as explicit examples) of respectful patient-physician interactions and communications regarding pain (*The Campaign to End Chronic Pain in Women*, 2010). Werner and Malterud (2005, 45) encourage clinicians to consider their role in transforming “patients' experienced vulnerability into strength,” by taking on a “professional responsibility” explicitly to recognize and affirm patient reports of their pain experiences, as well as reveal, when applicable, their own clinical knowledge limitations and insufficiencies around particular patient presentations.¹⁴ McCaffery and Pasero (2001) stress the importance of accepting patient reports of pain as central to pain assessments, even if a clinician does not ultimately “believe” the patient report. “The gold standard for assessing the existence and intensity of pain is the patient's report, not the [clinician's] opinion. No other source of information has ever been shown to be more accurate or reliable than what the patient says” (McCaffery and Pasero, 2001, 73).¹⁵

Some literature on women's pain highlights practices that women who live with pain might take up in response to difficulties in medical contexts. For example, women with pain might request a change in their clinician, insist on further investigation of a particular referral or treatment, or request written information about their condition (Werner and Malterud, 2003, 1415). In addition, some groups of patients have created pain documentation tools. The Mankoski Pain Scale,¹⁶ developed by women with a diagnosis of endometriosis across a variety of countries and cultures, provides one strong example of how women occupying a particular “epistemological community” might influence pain assessment (Whelan, 2003). In response to gynecologists who “have tended to argue that women's emotional or psychological problems precede, or even cause their pain,” “women with endometriosis argue, instead, that if they have emotional or psychological problems it is only as a *result* of the pain, which has a physical origin” (Whelan, 2003, 474).¹⁷

In *Dusenbery's* (2018) book *Doing Harm: The Truth About How Bad Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick*, she describes a common practice among women living with pain: the sharing of “doctor stories.” A myriad of websites, blogs, and online discussion boards collate these “doctor stories” from women.¹⁸ In *Pryma's* (2017, 69) qualitative study of women with a diagnosis of fibromyalgia, all of the study’s participants could “describe at least one instance in which someone doubted the legitimacy of their pain or disability.” These stories stress the pressing need for identifying faithful practices that might sustain women in pain as they continue to face bias, delayed diagnosis, and under-treatment of chronic pain.

In order to articulate how the Christian practice of the Stations of the Cross constitutes a faithful response to women who live with pain, I first sketch my own “way into” realities of women’s pain. This first-person account offers an illustration of the interconnected experiences of Christian discipleship and pain, as well as the formative role of Christian practice in shaping faithful living.

IV. MY WAY INTO THE STORIES OF WOMEN’S PAIN

About eight years ago, I sat in an infectious disease clinic in a prestigious university hospital system. I found myself at this appointment following a year long struggle with a disruptive combination of maladies: significant fatigue, rashes, mouth sores, and my most prominent ongoing symptom of severe, debilitating joint and bone pain. Before an eventual diagnosis of multiple autoimmune diseases a year later at a clinic just two doors away in the same hospital system, I visited many specialists: a neurologist, an allergist, a dermatologist, an endocrinologist, a physical therapist, a pulmonologist, and an orthopedic surgeon. Most of these clinicians were unsure of an appropriate treatment course and referred me to other specialists who they thought might be better suited to provide an accurate diagnosis and course of intervention.

For the first of these specialist appointments, I found myself with an infectious disease clinician. Once I checked in and was escorted to the exam room, I tried to explain my pain as a 6 out of 10 to the fellow rotating at the clinic. “It feels like there’s the flu in my bones” I said to the fellow. “They ache. Deeply. All the time.”

The fellow typed behind her laptop. “Hmmm,” she reflected back to me. “I see you work at the hospital?”

“Yes,” I replied. “I’m a pediatric occupational therapist. I spend a lot of time in the Pediatric Intensive Care Unit [PICU]. And I also work with kids with disabilities in outpatient therapy. But did you hear what this pain feels like? It feels like the flu is actually inside of my bones and my joints. They ache. Deeply. All the time.”

“Well, we’ll get some answers for you,” she responded, heading out the door to consult with the supervising physician. Fifteen minutes later, the fellow came back into the exam room. She told me she could run a few additional blood tests, but that it was likely I simply needed to wash my hands more often. My pain was the result of repeated viral infections that I must have picked up at the hospital, due to my lack of appropriate hand hygiene practices. Notably, we had not discussed hand hygiene practices at any point during my clinic visit.

My “after-visit summary,” printed off on a slightly crinkled piece of paper, handed to me by a receptionist at the clinic’s back hallway desk, consisted of a single plan of care recommendation: “patient works in the PICU; she needs to practice more attentive hand hygiene. See PCP [primary care provider] if concerns persist.”

My concerns, along with my pain, did persist. I looked and longed for a faithful response to my experience of pain—a response I could not find in a clinical protocol or simply by summoning the fortitude to continue on to my next medical appointment. I looked and longed for responses that went beyond investigating relevant research and scholarship. Additionally, I looked and longed for responses that went beyond the anonymous exchange of ideas over the internet.¹⁹

In the persistence of pain, I began to look to other places, practices, and people who might more carefully listen to my story. I longed to encounter hospitable listeners, almost as much as I longed for pain relief and diagnostic answers to bring me a sense of understanding and solidarity. In this longing for hospitable listening, it dawned on me one day that maybe God was willing to be a hospitable listener to my stories of pain. And maybe others whom I knew as well—friends from my church,

co-workers, and other women in seminary with me who were also wading through experiences of chronic pain and illness—perhaps these people could accompany me and listen to me in my pain when medical providers would not.

Eight years after my own sense of disempowerment and disenfranchisement following a medical encounter regarding pain, and 8 years after my longings for faithful responses to my own pain and the pain of other women, I want to invite us to consider what distinctive Christian practices might help us respond faithfully. I suggest these practices not only for individuals in pain, but also for those who love them, for clinicians, and for faith communities—all who seek practices of hospitable listening as a distinctive Christian response.

V. EXISTING RESPONSES AMONG CHRISTIAN THEOLOGIANS AND ETHICISTS

In my longings for faithful Christian practices in the midst of my experiences of pain, I turned first to one of the communities I knew best—academic Christian theology and ethics.²⁰ However, as Deborah Beth Creamer (2013) argues in an essay on the intersections of chronic pain and theology, few scholars in Christian theology and ethics have suggested faithful practices in response to those living with chronic pain, despite research that demonstrates religious systems of meaning as supportive of life satisfaction among people with chronic pain (Dezutter et al., 2010). Creamer laments this absent response and encourages Christians to ask questions beyond “how do we treat pain?” (2013, 215). Creamer warns of the complexities around exploring questions of faithful practice for those who live with chronic pain, noting how these questions often “invite anxiety about any suggestion that suffering can be redemptive or pedagogical.” Instead, Creamer invites Christians into thoughtful engagement with pain by taking up practices that help us deconstruct our assumptions of the “wrong-ness of pain,” instead perceiving pain as:

a source of knowledge, as a way of knowing the world...and the depth of the human experience. Rather than trying to numb ourselves or erase our pain, to think about the ways that pain is embedded and entangled in the goodness of life, to welcome the ruptures, to dive deep into pain and find what can be learned within it. At times, we will still find it appropriate to protest pain, to resist it, or to treat it in various ways. I am not arguing for passivity or acquiescence, but rather for thoughtful engagement, allowing meaning to surface rather than be silenced, and for reflection to be invited rather than avoided. (2013, 219)

A number of historical and contemporary resources can help shape Christian prayer practices in response to women living with pain (Weil, 1951; Julian of Norwich, 1978; Catherine of Siena, 1980; Noffke, 1983; Morley and Ward, 1986; Morley, 2006; Geitz, Burke, and Smith, 2000).²¹ Notably, both historical sources of prayer, such as those offered by Julian of Norwich (1978), Catherine of Siena (1980), and Simone Weil, as well as present-day prayers offered in response to pain, focus on Jesus' crucifixion (Minore, 2014). In addition, prayers throughout the liturgical season of Lent, and in particular the days leading up to Easter, commonly referred to as Holy Week, share a strikingly common theme—Christ's cross, and in particular, his suffering and pain.

VI. TURNING TOWARD THE CROSS

Jesus' Passiontide underscores pain as a key reality and metaphor for the Christian life (Helsel, 2009). Innumerable Christian theologians and ethicists attend to Jesus' cross not only as the center of Christian prayer and devotional life, but also highlight Jesus' pain and suffering as central sources for Christian doctrine, discipleship, and practice (Gutiérrez, 1988; Douglas, 1994; Cone, 2013). Many contemporary theologians, particularly from feminist, liberationist, and womanist traditions, offer strong warnings against turning to the cross of Jesus to justify, rationalize, or sanction the pain that marks the experience of another, particularly those who live at the margins of privilege and power (Jones, 2000). While upholding this caution, many Christians simultaneously hold a deep conviction about the life-affirming practice of contemplating Jesus' Passion (Parker and Sonderegger, 2019). This life-affirming “God-who-suffers-along-with-us” offers presence and even transformation in the face

of fear and disappointment that so often accompany pain (Helsel, 2009). It is in solidarity with the “God-who-suffers-along-with-us” that I invite us to turn toward the church’s ancient practice of solidarity with the suffering of Jesus: The Stations of the Cross.

The Stations of the Cross: A Brief Background

The Stations are an ancient Christian devotional practice, thought to originate among the earliest Christian pilgrims who, in the aftermath of Jesus’ earthly ministry, crucifixion, resurrection, and ascension, walked the route from Pilate’s House to the site of Jesus’ crucifixion on Calvary (Jansen, 2017). In the fourth century, early Christians such as St. Jerome and Egeria documented their own journeys retracing Jesus’ way to the cross (Parker and Sonderegger, 2019). When travel to the Holy Land became dangerous during the Crusades, practicing the Stations expanded to local churches as a “spiritual pilgrimage” where Christians would pray the Stations with help from paintings, illustrations, sculptures, and other depictions of the events of Jesus’ Passiontide (Jansen, 2017).²²

In the thirteenth and fourteenth centuries, popularized by the Franciscans, pilgrims from around the world would travel to Jerusalem in order to stop and reflect at certain holy points along the route of Jesus’ Passion (also known as the Via Dolorosa or the Way of Sorrows) for prayer, in search of spiritual awakening and solidarity with Jesus (Jansen, 2017). This Christian practice of the Stations of the Cross continues up until the present day across a variety of ecumenical contexts, often framed as a penitential practice during Lent. Parker and Sonderegger argue:

Truly, the Stations of the Cross have no season. Suffering, sorrow, injustice, confusion, and death can touch any of us, at any time . . . the Stations can offer consolation and comfort when we are grieving; healing and restoration when we are parched; inspiration and guidance when we are searching or lost or simply beset by the turmoil and temptation, isolation and insecurity that unsettle all our lives. (2019, 1)

Across Christian traditions (including Orthodox, Roman Catholic, Anglican, and Protestant denominations), the traditional Stations consist of fourteen events, following the Last Supper through Jesus’ crucifixion and entombment (Jansen, 2017; Parker and Sonderegger, 2019). From the Anglican and Episcopal tradition, Parker and Sonderegger (2019) render the Stations as follows:

Jesus is condemned to death
 Jesus is made to carry the cross
 Jesus falls the first time
 Jesus meets his grieving mother
 The cross is laid on Simon of Cyrene
 A woman wipes Jesus’ face
 Jesus falls the second time
 Jesus meets the mourning women of Jerusalem
 Jesus falls the third time
 Jesus is stripped of his garments
 Jesus is nailed to the cross
 Jesus dies on the cross
 Jesus is placed in the arms of his mother
 The body of Jesus is laid in the tomb²³

The simple, stark descriptions of Jesus’ suffering in the final hours of his life invite Christians to both witness and name Jesus’ pain as central to his story as well as to theirs (Parker and Sonderegger, 2019, 21). This invitation to witness Jesus’ pain through the practice of the Stations is an invitation curiously marked by the presence of women—women who grieve, mourn, and offer care in both life and death. These women of the Stations witness what it means to live in spaces of great turmoil and pain—spaces that require bodily solidarity and pouring oneself out before God, in contrast to immediate healing, resolution, or hope. We now turn to how practicing the Stations as a contemporary response to women living with pain offers a distinctive Christian practice of faithful response and formation.

The Stations in Theological Context

The Stations provide one practice that invites Christians to not only witness the pain of Jesus' Passiontide but also to witness the pains that mark our own lives, met and embraced by a "God-who-suffers-along-with-us." Practicing the Stations ushers the stories of our pain and suffering into the presence of a hospitable God who listens to our mourning. The focus of the Stations is pain itself, but not a kind of pain that shuts us off from others. Rather, the pain we encounter in the Stations, though it is raw, grievous, and overwhelming, is a pain that we are called also to name in our own lives, in the lives of those we love, and in the lives of those to whom we offer care. The Stations do not orient us toward dismissal, disbelief, stigmatization, or denial of the pain and suffering we encounter in this life. It is a hospitable prayer that welcomes our pain, not to shame it or erase it or psychologize it, but to name it and proclaim that God dwells with us in this pain. In this way, practicing the Stations of the Cross provides an alternative response that challenges patterns of attending to women in pain within Western medical contexts. The Stations offer a practice of radical witness and listening.

Prayerful witness and listening help women bear their pain *together*: together with Jesus as "God-who-suffers-along-with-us," together with their neighbors, together with their caregivers and loved ones, and even together with their clinicians. The Stations form Christians in a central tension of following Jesus—that God meets us in our deepest agonies and pain. God does not require erasure of our woundedness for faithful Christian life. The Stations focus Christian practices of prayer and accompaniment on Jesus' Passion—a journey marked by profound pain and even a sense of abandonment by God.²⁴ In this way, the Stations help form Christians away from seeking quick resolutions of pain, and instead form faithful and prayerful encounters with the crucified Jesus who teaches us to be with one another in our pain, praying together, hospitably listening to one another, and witnessing truthfully to each other's pain in this earthly life.

The Stations of the Cross find their rootedness in theologies that center witness and solidarity. Practicing the Stations helps remind Christians that God witnesses their pain. Although one's experience of pain may be invisible to their neighbors and clinicians, their pain is never invisible to the "God-who-suffers-along-with-us." As Christians practice the Stations, binding themselves to the journey of Jesus' Passion, they encounter a God who encounters them in the midst of their pain—a God who is a witness to pain and who has endured a painful journey toward a violent death, filled with the shame of ridicule from others. Practicing the Stations calls Christians not into a singular act of religious devotion, but rather into a life of robust discipleship shaped by binding oneself to Jesus' Passion, confessing shortcomings before God, repenting of erasing others' pain, and journeying in newness of life in obedience to the "God-who-suffers-along-with-us."

Practicing the Stations of the Cross provides one avenue for Christians to witness to St. Bonaventure's thirteenth century proclamation—"crux est mundi medicina"—the cross is the medicine of the world. Jesus' Passion and crucifixion are paradoxical sources of healing for those who are caught in unbearable suffering and pain. This medicine of the cross, greater than all worldly interventions, proclaims that our lives do not ultimately move toward an end marked by the power of pain, sin, and death. Rather, as we sojourn with God in the midst of pain during this earthly life, the God-who-suffers-along-with-us bears pain with us and leads us to a good future. This future, the final resurrection where God will create the new heavens and a new earth, does not require us to ignore our current experiences of pain. God leads us to God's good future, even when we are unable to conceptualize or hope for a final end of joy. God leads us to God's good future as a faithful companion who is not repulsed by our wounds. Practicing the Stations of the Cross does not require Christians to embrace or even begin to sense joy, hope, or a brighter future. The Stations affirm that God-who-suffers-along-with-us accompanies us, even if our pain seems endless.

VII. PRACTICING THE STATIONS: ONE FAITHFUL RESPONSE TO WOMEN IN PAIN

In dialogue with *Praying the Stations of the Cross: Finding Hope in a Weary Land* by artist Margaret Adams Parker and Anglican theologian Katherine Sonderegger,²⁵ I now illustrate some possibilities for engagement with the Stations as a Christian practice for faithfully responding to women's pain.²⁶ Practicing the Stations may take on a variety of purposes for women living with pain: an act

of solidarity, Christian devotion, prayer, reflection, lament, or even rage. Now those who practice the Stations extend beyond women living with pain: this Christian practice offers an avenue of faithful response by Christian clinicians, caregivers, and loved ones who accompany women in pain. Among all these potential participants, practicing the Stations may take place privately in one's home or in a religious community, or perhaps in small groups of faithful Christians committed to hospitable listening and acts of solidarity. The Stations might be practiced during a home visit between a clergy person and a woman in pain. Additionally, an abridged version of a single Station might be engaged or recommended in clinical contexts.²⁷ The fourteen traditional Stations might be prayerfully practiced along with the stations of a particular woman's journey with pain: sites of diagnosis and misdiagnosis, sites like nurse triage or pharmacy lines, sites like a sleepless night as a result of the under-treatment of pain, sites like the back pew in a church where one can easily slip out the door to seek quiet or to take a dose of pain medication or to rest away from noise and light, sites like couches or recliners or beds or hospital benches where long, restless days are spent. Regardless of the location or people gathered for this Christian practice, the Stations bring us together around the site of wounds—of Jesus' Passion, and also as I suggest here, around sites of women's pain.

Parker and Sonderegger's (2019) reflections on the Stations include artistic renditions of the fourteen traditional scenes of Christ's Passiontide, accompanied by meditations on Scripture, prayers, and chant from the Taizé community.²⁸ Stations one through eleven contain the following prayerful chant from the Taizé community:

Stay with me,
Remain here with me,
Watch and pray,
Watch and pray.

For women in pain, this chant offers a prayer of longing and request to God and to neighbor. It is a plea for God to dwell with us in our pain, and not only to dwell, but to "watch"—to witness our reality and to intervene with prayer. Practicing the Stations invites us to join our own prayers with the intercessions of the Holy Spirit, and to join our witness with God naming our pain and need.

In the fifth station, where the cross is laid on Simon of Cyrene, Parker and Sonderegger offer a concluding prayer of comfort and solidarity: "we gather up these prayers in the name of the One who stands in our place and shoulders our burdens, Jesus Christ. Amen" (2019, 64). Practicing and praying the Stations invites women to co-labor in their burden of pain with the crucified Jesus—the one who co-labored in his painful Passiontide with Simon of Cyrene, who bore the partial load of carrying the cross. Practicing the Stations can create space for women in pain to share their burden of pain with God through practices of prayer and meditation—especially when other co-laborers are difficult to find.

In the sixth station, where a woman wipes Jesus' face, Sonderegger offers a meditation filled with a proclamation of hopeful solidarity:

For the gospel is this: he has gone this way before. We who follow walk in his path, and our end is not dereliction but great joy. And just like this nameless woman who wipes the face of Jesus, so we too will meet our Savior face-to-face and imprint his visage in our hearts: the Holy One of God, the afflicted deliverer, our gracious Lord and helper. (2019, 75)

Practicing this station invites women in pain to recognize their journeys marked with suffering and difficulty as a way already traveled by Jesus himself. This proclamation of solidarity does not seek to erase the pain of the journey, but to create space for naming the not-yet-encountered end—an end not marked by uncertainty or eternal damnation, but an end of "great joy." We who also walk earthly journeys marked by unspeakable experiences of pain hold the hope of a God who suffers with us, a God who has made a journey in this way before, and a God Whom we will meet face-to-face. And, this God Whom we will meet in great joy is not only our future hope, but also our very present help now.

Reflecting on the eleventh station, where Jesus is nailed to the cross, Parker and Sonderegger invite those who practice the Stations to witness and name the wounds inflicted on the body of God.

Those living with pain who prayerfully visit this Station are invited to “remember also his transfigured wounds, his gracious invitation to us to cast ourselves, our sorrows and our brokenness, into those very wounds for healing” (Parker and Sonderegger, 2019, 115). In this re-envisioned prayer for healing, healing emerges from those who turn to Jesus’ wounds for balm in their earthly journeys marked by pain and suffering. In practicing the Stations of the Cross, women who live with pain do not find direction to turn toward an unwounded God. Instead, those of us who live with pain encounter a Christian practice that names and identifies wounds as the very place of our healing. Practicing the Stations reinforces that God is the God Who heals us by accompanying us within our deepest woundedness, a healing not necessarily marked by removal of our wounds in the here and now.

A final poignant prayer for women with pain emerges in Parker and Sonderegger’s (2019, 128) response to station thirteen—where the crucified Jesus is placed in his mother’s arms. The prayers that correspond to this station exist “for those who feel their lives broken and shattered; for those who cannot see their life beyond this death; for those who cannot grieve or weep.” The diversity of prayers offered to Christians journeying in the way of the cross do not exclude those who see no source of hope, nor those who have lost the ability to name their suffering. The prayers that mark the thirteenth station are the prayers of those women who do not know what will happen next in their life marked by pain.

VIII. PRACTICING THE STATIONS IN THE CLINIC

In addition to the practices described above, Christian clinicians, especially those who treat women with chronic pain, ought to also consider how they might integrate the Stations of the Cross into their personal devotion and clinical work as one kind of faithful response.²⁹ Clinicians might engage in a brief prayer or meditation from the Stations as a kind of holy preparation for their clinical work: during a chart review, as they wash their hands, or while waiting for an elevator ride. Clinicians who practice the Stations as a personal devotion or within their religious community might find that it shapes anew their practices of hospitable listening and solidarity in lament alongside their patients experiencing chronic pain. The Stations provide avenues for clinicians to engage in prayer and preparation for holy listening to those under their care as part of a broader expression of neighbor love for their patients. Practiced over time, the Stations can form clinicians as companions who accompany women living with pain in solidarity, rather than companions whose primary orientation perpetuates stigma and bias, resisting practices of prayerful listening.

For clinicians in contexts where it is permissible to inquire with patients about participating in shared prayer, the Stations provide a rich possibility for shared practice. Jors et al. (2015, 10) encourage clinicians who work with patients experiencing chronic pain to inquire about prayer and, at the very least, to advocate for the provision of designated space for religious expression and reflection within clinical settings. Christian clinicians might take initiative in connecting their patients with chaplains and other spiritual care providers available through phone, virtual, or in-person modalities to explore the Stations. Additionally, Christians who practice in the clinic might consider co-laboring with pastoral care staff to provide a permanent or temporary representation of the Stations at their clinical site.

Clinicians might also consider practicing the Stations as a source of individual or group spiritual formation. In their introduction, Parker and Sonderegger argue that the Stations allow for “gracious spiritual exchange . . . entering into Christ’s sorrows may open our minds and hearts to the suffering of those around us. We remember Christ’s identification with the sick and the lost: *Just as you did it to one of the least of these who are members of my family, you did it to me*” (Matthew 25:40) (2019, 8). In this way, the Stations provide a spiritual discipline where Christian clinicians can enter into solidarity with Jesus by prayerfully accompanying their patients in pain.

In her theological reflection on the first Station where Jesus is condemned to death, Sonderegger reflects on Mark 12:30–31, writing:

Jesus teaches here that our love of self—our intense preoccupation with our own lives, our single-minded pursuit of our own ends, our effortless defense of our way of seeing things—is also to be accorded to our neighbor. He affirms that our willingness to imagine the joys and sufferings of our neighbors as though they were our own is indeed the proper worship of God. (2019, 35)

The emphasis here is not on the sin of “intense preoccupation” with self but rather on “proper worship,” consisting in a refreshed imagination that considers the pain of our neighbors as our own. It is this act of both spiritual and embodied solidarity (Barton, 2017) that practicing the Stations might begin to cultivate within the lives of Christian healthcare providers. Clinicians who follow Jesus might find in practicing the Stations a call to repentance and renewed discipleship, through a prayerful encounter with identifying the pain of their patients as a central part of the Christian life.

Throughout her theological explorations of the Stations, Sonderegger appeals to touch as another practice of embodied solidarity. In the context of clinical medicine, Sonderegger’s vision of touch offers another vital practice that helps Christian clinicians faithfully attend to those in pain:

How great is the desert, how deep the dryness, of those who are never touched! To walk into our nursing homes, our shelters, our hospital wards is to enter into places where human touch is now almost entirely absorbed into the technical, the hygienic, the bureaucratic handling—not touching—of patients or clients. The loneliness of those whose wounds are touched only antiseptically must be very deep indeed . . . [yet] the gracious presence and action of Jesus during the whole of his life was to touch: to bend himself down to the wounds and the wounded of this earth and to lift them up. What intimacy this Son of Man has with his own, most especially with his wounded own. (2019, 114)

Sonderegger’s meditation accompanying Station eleven highlights the intimate and transformative power afforded to healthcare providers who can serve women in pain in an embodied solidarity. This kind of solidarity offered by clinicians offers a strong contrast to these patients’ experiences of discrimination, bias, and disbelief in clinical settings, often compounded by the sterility and hygienic nature of many of these contexts. Clinicians who take up the ancient Christian practice of the Stations of the Cross might have a new, faithful way to respond to women in pain—a practice that honors and hospitably listens to their pain—joining in with that of Jesus himself.

IX. CONCLUSION

Women who live with pain experience a number of stark realities across contexts of contemporary Western medicine. Medical settings offer limited resources for robustly responding to women’s experiences of pain, as well as the compounding effects of stigma, bias, and clinician disbelief that many of these women encounter. Turning to the rich history of practicing the Stations of the Cross provides one faithful and distinctively Christian response for women in pain as well as their caregivers, loved ones, and clinicians. Through this prayerful practice of solidarity, witness, and hospitable listening, Christians find themselves accompanied by the God-who-suffers-along-with-us. This God-who-suffers-along-with-us promises presence and solidarity in women’s experiences of pain, pointing to a future of joy and resurrection, without requiring an erasure of pain in the present.

NOTES

- 1 See Croft, Lewis, and Hannaford (2003), Fillingim et al. (2009), D’Arcy (2011), Brewer, Svatikova, and Mulavagh (2015), Fayaz et al. (2016) and Samulowitz et al. (2018).
- 2 See Werner and Malterud (2003, 2005), Whelan (2003) and Pryma (2017).
- 3 See Huber (2017) and Norman (2018).
- 4 See Rettner (2012), Fassler (2015), Kiesel (2017), Billock (2018), Foster (2018), Pagán (2018), Barnes (2019) and Edwards (2019).
- 5 Dusenbery (2018) and the above references provide a brief and non-exhaustive list of notable contributions to literature addressing women’s pain in contemporary Western contexts within the past two decades.
- 6 Throughout this essay, I explore realities of women who live with pain and practices used to respond to that pain. In using the term *women*, I have in mind a range of people: those who are assigned a female sex at birth, cisgender women, and transgender women. I hope this essay provides helpful insight to readers in response to all those who live with pain—including those who are intersex, gender nonconforming, or male-identified. However, the research I focus on in this piece specifically considers biases and disadvantages encountered by women-identifying people in the context of contemporary Western medicine.
- 7 Research indicates that between one third and one half of populations in the contemporary Western hemisphere live with some form of chronic pain (Nahim, 2015; Fayaz et al., 2016).
- 8 See Croft, Blyth, and van der Windt (2010), D’Arcy (2011) and Fayaz et al. (2016).
- 9 See Fillingim et al. (2009).
- 10 See Hoffmann and Tarzian (2001), Institute of Medicine (2011) and Brewer, Svatikova, and Mulavagh (2015).
- 11 See Rothrock et al. (1995), The Campaign to End Chronic Pain in Women (2010), Arroyo-Quiroz et al. (2014), Brewer, Svatikova, and Mulavagh (2015) and Jovani et al. (2018).

- 12 Pryma (2017) stresses the layered and intersectional “barriers to credibility” faced by women with multiple minority identities, such as women of color and women with disabilities.
- 13 Interestingly, some women in these studies decided to attend medical appointments without makeup or their typical professional wardrobe, in order to avoid appearing “too healthy” (Werner and Malterud, 2003, 1414; 2005, 43).
- 14 This practice of humility and empowerment provides an alternative to disbelieving women's reports of pain, psychologizing women's pain, or blaming a woman for the experience of pain (Werner and Malterud, 2005, 45).
- 15 Carolyn M. Rouse's (2014) article “Cultural Scripts: The Elusive Role of Psychotropic Drugs in Treatment,” helpfully highlights the complexities of this gold standard in light of patterns of over-prescription of pain killers in the United States, as well as the profound impacts of epigenetic and social influences on pain.
- 16 This pain scale for endometriosis represents pain across three columns: one with a numerical value, one briefly describing related disruptions in function, and one with the efficacy of medication. A copy of the scale can be found here: <http://www.valis.com/andi/painscale.html>.
- 17 Psychogenic pain has been theorized and researched from a variety of medical, psychological, and philosophical perspectives, both in the United States and internationally. While a thorough treatment of these sources falls outside the scope of this essay, readers might consider consulting the following work for an introduction to existing conversations on psychosomatics and psychogenic pain: (Rubin, 2005; Levenson, 2007; Covington, 2008; Deter, Kruse, and Zipfel, 2018).
- 18 Examples include WomenHeart (<https://www.womenheart.org/blog/>); ButYouDon'tLookSick (<https://butyoudontlookick.com/>); and For Grace (<http://www.forgrace.org/>).
- 19 In seeking practices beyond this kind of virtual support and solidarity, I in no way wish to dismiss the power of connection with others via the Internet as a robust practice of living with pain as a woman. Dusenbery argues that the internet has provided new avenues “for patients today to share practical advice with each other and organize for more research and greater awareness. But, the Internet has provided something even more basic for many women patients, particularly for those with diseases that medicine doesn't understand: the assurance that they are not alone and that they are not crazy” (2018, 312).
- 20 Clinical outcome literature for people living with chronic pain suggests the presence of more positive outcomes (longer survival rates, decreased depression, and distraction from pain) for people who participate in Christian religious practices, including hope (Underwood, 2006), prayer (Wachholtz, Pearce, and Koenig, 2007; DeZutter et al., 2011; Jors et al., 2015), reading sacred texts (Wachholtz, Pearce, and Koenig, 2007), and participating in a religious community or in relationships marked by spiritual companionship (Wachholtz, Pearce, and Koenig, 2007).
- 21 This brief list includes exemplary Christian women who have offered prayers out of the experience of personal pain and/or in response to the pain of others.
- 22 The Church of San Stefano in Bologna, Italy hosted a set of remote stations as early as the fifth century (Parker and Sonderegger, 2019).
- 23 In 1991, Pope John Paul II offered an alternative list of fifteen Stations (rooted exclusively in the final events of Jesus' life as recorded in the New Testament, including the Resurrection). It is sometimes referred to as the Scriptural Stations of the Cross or the Scriptural Way of the Cross. The traditional Stations include five events that are not recorded in the New Testament canon. Roman Catholics are permitted to use either the traditional or Scriptural Stations in devotional and church life. The United States Conference of Catholic Bishops provides a liturgy including Pope John Paul II's alternative Stations here: <https://www.usccb.org/prayer-and-worship/prayers-and-devotions/stations-of-the-cross/scriptural-stations-of-the-cross>.
- 24 See Matthew 27:46 and Psalm 22.
- 25 While many prominent theologians in the past century have offered insightful commentary on practicing the Stations of the Cross (see, e.g., Newman [1860], Nouwen [1990], and Hauerwas [2004]), I choose here to prioritize the interpretation of two women (an artist and theologian), given the focus on contemporary women's experiences of pain in this essay. In this specific volume on the Stations, Sonderegger offers theological reflections on Parker's illustrations of the Stations.
- 26 As suggested in the preceding paragraphs, practicing the Stations provides a rich Christian response to many forms of suffering among people of diverse identities (gender and otherwise). In this paper, I focus on offering an exploration of the Stations through the hermeneutic of women's pain, drawing attention to the specific witness of women's pain within the narrative of Jesus' Passiontide.
- 27 I want to clarify that the Stations provide a supplement and not a replacement for foundational practices of clinical excellence. Christian clinicians who respond to women in pain ought to not only consider engaging the Stations, but first offer robust practices of active listening, thorough history taking, and clinically relevant question asking. In short, clinicians who take up the Stations ought to adopt them as part of a broader practice of clinical excellence, which includes potential modification of their practices of clinical decision making to resist the dangers of gender bias outlined earlier in this paper's literature review. I am grateful to one of the peer reviewers for this essay who suggested adding this clarification.
- 28 Taizé is a monastic, international community composed of brothers representing broadly ecumenical Christian traditions. The community is located in France and is well known for their ministries of music and to young people who come on pilgrimage. More information about the community can be found on their website: <https://www.taize.fr/en>.
- 29 Practicing the Stations of the Cross in the clinic provides one avenue for what Brett McCarty, describes as cultivating “an alternate medical imaginary” within contemporary Western medical institutions (2016, 636–637).

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