Spring 2016

JESUS’ COMMAND TO “GO AND SEE” IN MARK 6:30–44 AND ITS SIGNIFICANCE FOR CREATING GENDER-RESPONSIVE, TRAUMA-INFORMED CARE FOR WOMEN IN THE CRIMINAL JUSTICE SYSTEM: GATHERING THE GIFTS AND MEETING THE HUNGERS OF ALL GOD’S PEOPLE

Pamela Chaney

*John Carroll University, pchaney17@jcu.edu*

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JESUS’ COMMAND TO “GO AND SEE” IN MARK 6:30–44 AND ITS SIGNIFICANCE FOR CREATING GENDER-RESPONSIVE, TRAUMA-INFORMED CARE FOR WOMEN IN THE CRIMINAL JUSTICE SYSTEM: GATHERING THE GIFTS AND MEETING THE HUNGERS OF ALL GOD’S PEOPLE

An Essay Submitted to
The Office of Graduate Studies
College of Arts and Sciences
John Carroll University
in Partial Fulfillment of the Requirements
for the Degree of
Master of Arts

By
Pamela Chaney
2016
The essay of Pamela Chaney is hereby accepted:

Advisor – Prof. Sheila E. McGinn, PhD

Date

I certify that this is the original document

Author – Pamela Chaney

Date
In Gratitude to ...

My anam cara, Kellie Binczyk — you embody compassionate presence. I cherish your friendship.

Sr. Dion Horrigan, SND — your delightful spirit teaches me how to love and serve Jesus with joy.

Dr. Sheila McGinn — you inspire me because you use your social capital and education to empower others, including me.

Finally,

My children, John and Rebecca — you inspire me to “go and see,” and remind me that it’s never too far, and it’s all good.
To say that God is compassionate, feeling and concretely concerned, is to say that God cares for human well being for all, which includes those ground down [crushed] as victims of historical injustice.¹

Love heals. It heals those who give it. And it heals those who receive it.²

**INTRODUCTION**

The Gospel of Mark contains one of the most beloved stories of Jesus and his ministry in chapter 6:30–44. This is the Miracle of the Loaves and Fish, and even children know the story: Jesus takes five loaves and two fish and, after blessing these gifts, he feeds more than five-thousand men³ until everyone is filled, providing so abundantly that his disciples collect twelve baskets of left-overs! It does sound


²Karl Menninger, [http://www.hazeldenbettyford.org/recovery/thought-for-the-day](http://www.hazeldenbettyford.org/recovery/thought-for-the-day); accessed February 14, 2016.

³Mary Ann Beavis, *Mark*, Paideia Commentaries on the New Testament, Mikeal C. Parsons and Charles H. Talbert, eds. (Grand Rapids, MI: Baker Academic, 2011), 106. “The detail that five thousand men (*andres*) were fed does not necessarily mean that only males were present, but echoes reckonings of the congregation of Israel in the wilderness” (e.g., Exod. 12:37; Num. 11:21). While we are not told exactly what—or whom—the disciples found, one can be fairly certain that the description of “5000 men” is a stylistic choice by the writer.

The lack of women as actors in the narrative of 6:34–44 is puzzling, as women are agents of discipleship throughout Mark’s Gospel. However, not citing women in the text does not mean they were not there, since the “men” likely represent household groups. The presence of women and children is supported if one considers how a roaming group of five thousand men would be perceived by Roman oppressors during the time Mark writes: such a unit would surely be crushed by Rome as a quasi-military uprising.
miraculous indeed but, upon close examination we find another, more human, miracle; one in which, by taking a step in faith, Jesus’ disciples discover unknown gifts of the crowd itself. This is the hidden miracle, as Jesus commands his disciples to “Go and see” those who have arrived in “the lonely place” before them (v. 38). Go and see what? What was so important about placing his disciples in the company of these poor seekers that Jesus commanded those who would literally become the foundation of his Church, “You yourselves give them something to eat” (v. 37) and “Go and see” (v. 38)?

In this scene of the “Feeding of the 5000,” Mark provides a layered account of Jesus’ actions that is practical and instructive yet highly evocative due to Mark’s tender depictions of Jesus himself—the hungry and tired teacher—whose compassion and receptivity to all people compels him to send his disciples to “go and see.” The Markan Jesus’ attitude and behavior thereby provide a seminar in willingness and humility to Jesus’ disciples, the crowd, and to those in the present time who desire to emulate his style of leadership and way of being with others. The Markan author describes a particular compassionate and embodied theology in which compassion inspires action in community with others. The community that receives all people who seek God is the context in which such miracles occur.

Mark 6:30 finds the disciples gathered around Jesus to report on their successful mission trips. Mark writes, “because so many people were coming and going … they did not even have a chance to eat” (31), thereby placing hunger in the bellies of Jesus and his disciples as they enter the “lonely place” of the pericope. The implication in Jesus’

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invitation (and perhaps the disciples’ expectation) is that they will dine alone together, then engage in much-needed rest alone with Jesus. However, the “lonely place” turns out not to be so lonely after all. A large crowd is waiting for Jesus there, even arriving before him and his disciples.

“GO AND SEE”: GATHERING THE GIFTS OF ALL THE PEOPLE

30 The apostles gathered around Jesus and reported to him all they had done and taught. 31 Then, because so many people were coming and going that they did not even have a chance to eat, he said to them, “Come with me by yourselves to a quiet place and get some rest.” 32 So they went away by themselves in a boat to a solitary place. 33 But many who saw them leaving recognized them and ran on foot from all the towns and got there ahead of them. 34 When Jesus landed and saw a large crowd, he had compassion on them, because they were like sheep without a shepherd. So he began teaching them many things.

35 By this time it was late in the day, so his disciples came to him. “This is a remote place,” they said, “and it’s already very late. 36 Send the people away so that they can go to the surrounding countryside and villages and buy themselves something to eat.” 37 But he answered, “You give them something to eat.” They said to him, “That would take eight months of a man’s wages! Are we to go and spend that much on bread and give it to them to eat?” 38 “How many loaves do you have?” he asked. “Go and see.” When they found out, they said, “Five—and two fish.”

39 Then Jesus directed them to have all the people sit down in groups on the green grass. 40 So they sat down in groups of hundreds and fifties. 41 Taking the five loaves and the two fish and looking up to heaven, he gave thanks and broke the loaves. Then he gave them to his disciples to distribute to
the people. He also divided the two fish among them all. They all ate and were satisfied, and the disciples picked up twelve basketfuls of broken pieces of bread and fish. The number of the men who had eaten was five thousand (Mark 6:30–44; NIV).

Mark 6:30–44 presents a “Jesus and the Disciples” vignette that reinforces the embodied Markan theology found throughout the Gospel; namely, that Jesus’ compassion leads to compassionate action in his own time and place, performed among and with his future Church and those who seek him, and all are necessary for this action to be effective. Grounded in prayer and meditation, Mark’s Jesus requires disciples to recognize people in lonely places as crucial to his ministry.

We hear not a word from Mark’s displaced refugees, yet they seem to be the ones who provide the gifts—their loaves; their fish—for Jesus’ miraculous banquet. It is after the command to “go and see” that the disciples present to Jesus the meager provisions he uses to create abundance from scarcity. This human and hungry Jesus embodies God’s kingdom enacted in relationship, community, and the sharing of adversity, as the author demonstrates in this feeding narrative.6

5 Adela Yarbro Collins, Mark: A Commentary, H. W. Attridge, ed., Hermeneia (Minneapolis: Fortress, 2007), 12. Josephus writes that, near the beginning of Jewish-Roman war in 66 CE, massacres and imprisonment of Jews was happening throughout Syria, in which case the crowd is Syrian refugees. Internal evidence points to Mark and her/his audience probably living outside Rome, having come from Judea, including Galilee, or Syria, where persecution of Jews was rampant.

6 While subsequent gospel authors include this feeding miracle, Mark alone cleverly creates a doublet emphasizing the ecumenical nature of Jesus’ ministry by placing the first in Jewish territory, the second (Mark 8:1) in Gentile territory. Mark insists the audience understand
While modern readers may emphasize the eschatological implications of the pericope, Mark’s audience would hear it as people who have felt the ache of physical hunger. Mark tells us that not only the crowd but also *Jesus and his disciples are hungry* in this encounter. The Markan Jesus provides the climactic template of God who suffers with God’s people; who demands that all who seek the Holy One be encountered and received. Mark’s Jesus reflects a God who is hungry; in the words of Dietrich Bonhoeffer, “a suffering God.” This God *requires* the contributions of poor, displaced, and marginalized people—those who are uncounted and do not count—in order to create miracles. Thus, these poor refugees become co-creators of this prolific meal, which will assuage the hunger of God. Their whole and holy welcome, then and now, is good news, indeed.

**GO AND SEE**

In Cleveland, Ohio, in 2016, there are medically ill, suffering people wandering in deserted places and their cries are heard by the Shepherd who longs to gather his sheep to that Jesus’ ministry is one of compassion to *all* people.

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7 In the time of Jesus and Mark, food is a sign of social status with “political overtones” due to its scarcity, especially animal protein. Mark’s Jesus is the recognized host of this literal and eschatological banquet.


9 See Isa 58:6–7: “Is not this the kind of fasting I have chosen: to loosen the chains of injustice and untie the cords of the yoke…? Is it not to share your food with the hungry and to provide the poor wanderer with shelter—when you see the naked, to clothe him, and not to turn away from your own flesh and blood?” (NIV)
himself (Mark 6:34). They are sick in body and soul, forced to move within the deserted places of our communities because their disease is treated as a crime rather than a medical emergency. These wanderers in the lonely places are the poor with the disease of addiction. While many “citizen refugees” in jails, prisons, shelters, and the streets have been wounded by the cavernous yawns of a culture that finds them expendable, the Markan Jesus epitomizes a stance of inclusion that commands they be encountered.

Whom might we meet if we respond to the Call of the Caller with faith enough to walk into the lonely places in geographies that are foreign to us, in order to “go and see?”

In a desolate area of Cleveland, a residential treatment facility receives prisoners from Cuyahoga County Jail, referred there because they are too poor to go elsewhere. I first heard of the Community Assessment and Treatment Services (CATS) through my work as a spiritual director in Rosary Hall, a treatment center for chemical dependency at St. Vincent Charity Medical Center (SVCMC) in Cleveland, Ohio. In Rosary Hall, I

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10 Of these, 1.9 million are addicted to prescription opiates and over half a million more (586,000) are addicted to heroin. See “Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health Administration” (Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2015). Available at http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

11 St. Vincent’s, founded in October 1865, is Cleveland’s oldest private hospital. The Sisters of Charity established the hospital in the city’s center to provide medical care for the poor. Rosary Hall, the nation’s second oldest center for the treatment of alcoholism (and now all substance-use disorders) was founded by Sister Mary Ignatia Gavin, SC in 1952. Sister Ignatia, called “the angel of Alcoholics Anonymous,” first founded a treatment unit for alcoholics at St. Thomas hospital in Akron, Ohio. After her transfer to Cleveland, she founded Rosary Hall in order to provide medical detoxification and treatment to alcoholics. Prior to Sr. Ignatia and her
have listened and prayed with countless patients whose medical charts document a cycle of disease and despair hidden from those with better access to medical care, especially the preventative care made possible by access to services such as primary care doctors and dentists. I frequently meet patients who began using opiates, for example, due to chronic, excruciating back or dental pain. They quickly became addicted, then moved to the cheaper, far more available drug with a similar chemical composition: heroin. Of course, this terrible panacea for chronic pain quickly turns deadly, as the opiate epidemic in Cleveland and elsewhere attests. The most recent statistics from the Center for Disease Control and Prevention (CDC) and other U.S. agencies, reveal there were 47,055 drug overdoses in 2014; 18,893 of these were from prescription pain relievers, and 10,574 were from heroin. Sadly, death by drug overdose is now the leading cause of accidental death in the United States. There is a preferential option for the poor in these numbers, but not the one the Church intends.

fierce belief that alcoholics were “God’s children,” those with chemical dependency died in the streets of Cleveland, as they were simply considered to be “morally derelict.”

12 While some patients do begin using heroin “recreationally” and then become addicted, it is shocking to learn how many patients first became addicted to opioids through prescription drugs provided by doctors for chronic pain. When patients become part of the masses of poor people who obtain their medication from the street, they leave the medical system, and enter the criminal justice system. These patients become criminals and casualties in “the war on drugs.” In my experience, the poor without health insurance most commonly fell into this sub-category of patients.

Community Assessment and Treatment Services, or CATS, is one of too few residential centers for addiction treatment in Ohio. CATS states their mission is “to provide high quality, cost effective, holistic, evidence-based interventions addressing the chemical dependency, mental health and social justice needs of a diverse clientele.”

They operate two locations in the state of Ohio, with the facility closest to Rosary Hall located at 8411 Broadway. I went there in 2015 in order to volunteer with women in the criminal justice system who were now also in the CATS community.

There is a dearth of gender-responsive, effective programming for women who are reliant on the criminal justice system to be linked to care. This is especially problematic, because according to the CDC, “Women are more likely to have chronic pain, be prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men. Women may become dependent on prescription pain  


14 Community Assessment and Treatment Services, Inc. mission statement; see the “CATS’ Mission” section of their website at http://communityassessment.org/about-us/.

15 Editorial review of CATS from Rehabs.com, a comprehensive site that offers reviews from participants, family members, and other interested community members who have experienced the treatment setting provided by an organization:

Community Assessment & Treatment Services, Inc. (CATS) in Cleveland, Ohio is a substance abuse treatment center offering comprehensive residential and outpatient care for adults. ... [T]he nonprofit facility has, according to its website, served over 35,000 individuals to date. The organization’s mission is to address the needs of under-served populations, especially those in the criminal justice system. ... [K]ey staff include a clinical director who is also a licensed social worker and a psychiatrist. ... The CATS women’s and men’s residential treatment centers are housed in utilitarian, no-frills buildings in Cleveland. ... According to the CATS website, services are available to clients who have been referred by agencies or the court. Payment options include Medicaid and self-pay (original emphasis; http://www.rehabs.com/listings/community-assessment-treatment-services-inc-796330938/#editorial-review; accessed 3 April 2016).
relievers more quickly than men.” Consider Elizabeth, a 24-year-old woman I met at CATS. In her application to a group I facilitated, Elizabeth wrote, “The most important reason I want to be in the grief and loss support group is I’m real sad about the loss of my teeth. I never been to a dentist, so they (emergency dental care) had to pull all my teeth.” Elizabeth became addicted to the opioids given her when her teeth were removed. She turned to heroin after she was hooked because it is far cheaper and easier to obtain.

Women like Elizabeth are left without access to the type of medical care available to those with more money—or, at least in Cleveland, to men in the criminal justice system.

According to William Denihan, head of the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Cleveland is woefully underserved in facilities where women can live and receive treatment services. Such centers are called “residential treatment facilities.” While there are too few facilities for women or men who need care, there are even fewer resources for women. Further, the facilities that do treat women actually are designed for men. I knew I needed to do what I could to empower the women at CATS who were attempting to create lives of hope, health, and


17 Pseudonyms are used throughout this essay for all of the women in treatment centers in NE Ohio who provided consent for their words or artwork to be used, staff and volunteers, with the exception of myself, Sister Dion Horrigan, SND, and Magda Bowditch, MSW, Director of Women’s Services at CATS.

18 The Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County. Comments at the meeting of re-entry committee on Friday, March 19, 2016 at the ADAMHS board headquarters.
work. I say, "create," rather than "re-build," because the women I met never had a life they wanted to live; they were creating such a life for the first time.

As I considered the women at CATS, I remembered the words of my Episcopal priest, reminding us of the need to change both systems and circumstances. He said, "We have to pull people out of the river … but we also have to hike upstream and find out why people are falling into the river!" Going to CATS felt like helping to insure that women were not falling into the river of the criminal justice system without a hand offered to help them find dry ground.

In the residential treatment program, CATS houses approximately 153 male and female clients in total. As of March 24, 2016, there were 53 women referred from the county jail and receiving treatment for substance use disorders. Called “treatment in lieu of incarceration,” diversion programs are championed by many in social justice work and even in the criminal justice system itself. Such programs have helped ameliorate the tremendous overcrowding in county jails and made chemical dependency treatment available to those who are too poor to access private services.

In diversion programs, people who are convicted of nonviolent drug crimes—that is, using drugs, carrying drug paraphernalia (such as needles, spoons, tourniquets), and/or

19 Reverend Alan Gates, former rector of St. Paul’s Episcopal Church in Cleveland Heights, OH. Gates is now Episcopal Bishop of Massachusetts.

20 According to the Director of Women’s Services, Magda Bowditch, MSW, there were 53 women at CATS in residential treatment as of March 24, 2016.

public intoxication—are offered chemical dependency treatment rather than serving their sentence in jail. While treatment in lieu of incarceration is, in theory, a better system than incarcerating those with the disease of addiction, it is problematic as well. The program tends to target the poor who have substance use and mental health issues. In other words, these programs are another way of using legal coercion, including the threat of jail or imprisonment, to treat medical diseases. According to the municipal judges with whom I spoke, participants in the diversion program often have concurrent mental illnesses that typically remain untreated; in other words, many non-violent participants in diversion programs are both mentally ill and addicted. According to clients and staff, this was the case at CATS during the months I volunteered.

I sat in on a group run by two male clinicians. It was all men and one woman. One of the facilitators said something to the woman in front of the male participants that made me feel deeply uncomfortable. I thought, “If I were a woman in this group, I would never come back.”

Like Mark’s author counting only the men present (Mark 6:44), most often only men have been studied and counted in the field of addiction treatment. Dr. Stephanie Covington, co-director of the Center for Gender & Justice and board-certified addiction medicine specialist writes, “many studies have examined alcoholism in fathers and son, clearly indicating a genetic link in men. Few studies, however, have focused on the genetic link in women.” Not only have studies of women been lacking, when women

22 Director of nursing at a treatment center in Cleveland (March 19, 2016, at the ADAMHS Board meeting of re-entry providers in Cleveland, Ohio).

23 Stephanie Covington, “Helping women recover: Creating Gender-Responsive
are counted they are judged by the standards of men and the patriarchal culture at large. The casual vitriolic language our culture openly uses to describe poor, addicted women—slut, lush, and bad mother—and the places where they live—ghettos, crack houses, dumps—evidences that the bodies of poor, addicted women and the very geographies where they and their children live—their homes, communities, and schools—are seen as worthless by the greater community.\textsuperscript{24} This devaluation is convenient for a patriarchal capitalist society; it alleviates our corporate responsibility to protect the poor, sick, and vulnerable, by recasting them and the places where they live as without commercial value and, therefore, without human worth.

However, when it comes to profiting from the bodies of women, especially poor addicted women, the tables are turned. Women are blamed for the sexual violence committed against them. It is poor and addicted women who frequently are found in the “entertainment” clubs designed for men to watch them strip, perform lap-dances, or engage in prostitution. Many of the women with whom I work have shared with me that they must first use illicit substances in order “to do what I do to make money.” As a single mom of three children told me in a grief and loss support group, “If I’m not high, I can’t do it.”

It is impossible to talk about substance use disorders—addiction—within communities of impoverished women, without addressing physical and sexual violence and exploitation perpetrated on them. According to the Bureau of Justice Statistics,

\begin{flushright}
\textsuperscript{24} Covington, “Helping Women Recover,” 52–72.
\end{flushright}
Over half the women in state prisons have histories of physical or sexual abuse, and other studies report that more than 80% of women in prison have experienced significant and prolonged exposure to physical abuse.

And

[I]mprisonment is more punishing to the female psyche than to that of the male. Indeed, society would be hard pressed to relegate female offenders to circumstances more detrimental to their well-being than the condemnation into isolation within prisons constructed for the very purpose of separating and secluding them.\(^{25}\)

**Gender-Responsive and Trauma-Informed Care**

In order to move closer to a model of care which includes women as co-creators, I went to meet with a group of ten women at CATS for six weeks, once per week, in order to learn what type of care or mentoring they most desired. The women expressed a strong preference for a group that would be emotionally healing, such as a grief and loss support group. They shared that they often felt lonely and depressed due to the losses they were grieving, with no appropriate resources or groups in which to process their feelings.\(^{26}\)

After learning what the women felt they most needed, I agreed to begin a grief and loss


\(^{26}\) I learned there formerly had been a Grief and Loss support group at CATS however, due to funding cuts, the facilitating organization (Cornerstone of Hope) had stopped coming to CATS more than 18 months prior. I have not found evidence of commensurate men’s programming that was cut during the same time period.
group as soon as I could obtain approval from the Director of Women’s programming. I was required to interview with the Volunteer Coordinator at CATS, who explained I would undergo a full background check and drug screen. The entire process took approximately three weeks. Following an all-clear from the Volunteer Coordinator, I was allowed to begin planning the grief and loss support group.

The template for the structure of the group was built on a model of cultural humility, rather than “cultural competence.” Cultural humility is grounded in the person of the service-provider (for example, spiritual directors, counselors, social workers, or probation officers) and their willingness to practice personal humility. The practice of humility influences all interactions, and the resulting community of care is built on reciprocity: there are not “care receivers” and “care providers” in programs built on cultural humility. Everyone learns from each other.

“Cultural competence in clinical practice is best defined not by a discrete endpoint but as a commitment and active engagement in a lifelong process that individuals enter on an ongoing basis with patients, communities, colleagues, and with themselves.

This training outcome, perhaps better described as cultural humility versus cultural competence … is a process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners and reflective practitioners. It is a process that requires humility in (order to) bring into check the power imbalances that exist in the dynamics of … communication by using patient-focused interviewing and care. … It is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities on behalf of individual
patients and communities in the context of community-based clinical and advocacy training models.”

Unlike “cultural competence,” a discrete skill measured in employee performance reviews (at Rosary Hall and elsewhere), cultural humility is grounded not in specific knowledge of cultures but in the person of the clinician. Cultural humility recognizes the clinical setting and delivery of care as being a co-creation with the patient/client. Cultural humility is led by the patient/client(s), as the model emphasizes that clients have strengths and skills that the clinician may not possess. Therefore, seeing, honoring, and empowering the strengths and skills of clients become paramount as the clinician provides “accompaniment” to greater health and self-efficacy rather than authoritarian “leadership.” Cultural humility always respects clients as the final authority concerning their own personhood; their own selves. Christians will recognize this stance in Jesus when he asks those who seek him, “What do you want me to do for you?” This stands in contrast to what all too often is seen in Christians (and others) when they encounter people in need, which can be described as “perpetrating love” rather than cultivating relationships of reciprocity in which care flows among and between all present in the context of authentic inter-dependence.

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28 Another source of information and education is the theology of humility, which is an earmark of the John Templeton Foundation (see “The Philosophy and Theology of Intellectual Humility”; https://www.templeton.org/what-we-fund/grants/the-philosophy-and-theology-of-
SAFE SPACE VS. “CODDLING THE ADDICTS”

In order to design a gender-responsive and trauma-sensitive support group for the women of CATS, the work of Dr. Stephanie Covington was again reviewed and utilized. Covington and her colleagues have published extensively regarding gender-responsive clinical care for the treatment of women and girls with histories of serious traumatic experiences linked with substance-use disorders. Multiple studies demonstrate that a history of violence, physical and sexual abuse, and other stressors (such as generational poverty with its lack of access to quality public education, medical care, and mental health services), exponentially increase the risk of developing substance-use disorders.29 This is in addition to the now known genetic link between parents and their offspring, which demonstrates an increase in the frequency of substance use disorders among biological family members.30 Covington’s work, especially her research supporting the need for emotionally safe settings for women already traumatized due to abuse, was

intellectual-humility). Today, we see in this theology of humility an intersection with science to provide best practices for companioning the historically oppressed, the outcast, the impoverished, the traumatized, and addicted. These marginalized, voiceless wanderers are rarely seen or heard, until their bodies are counted among the statistics in the growing opioid crisis that is now the leading cause of accidental death in Cuyahoga County. These are the poor in “the lonely place,” whom Jesus, the compassionate and good shepherd, longs to gather to himself.


foundational in planning the group. I relied on Covington’s research to create programming and a physical space that addressed the spiritual, mental, and physical needs of the women at CATS.\textsuperscript{31}

\textit{Gender-Responsive Project Design}

Covington’s Gender-Responsive Program Assessment\textsuperscript{32} was the tool used to inform the design of the grief and loss group programming. This assessment includes six foundational precepts, each of which is necessary when providing care to traumatized women:

\begin{itemize}
  \item \textbf{Gender}—Acknowledge that gender makes a difference.
  \item \textbf{Environment}—Create an environment based on safety, respect, and dignity.
  \item \textbf{Relationships}—Develop policies, practices and programs that are relational and promote healthy connections to children, family, significant others, and the community.
  \item \textbf{Services}—Address substance abuse, trauma, and mental health issues through comprehensive, integrated, culturally relevant services.
\end{itemize}


**Socioeconomic Status**—Provide women with opportunities to improve their socioeconomic conditions.

**Community**—Establish a system of community supervision and reentry with comprehensive, collaborative services.33

After completing the IRB process at John Carroll University and gaining approval to proceed,34 I began interviewing potential group members. The women I interviewed had requested the group or were referred by their individual counselors. The counselor-referred women were perceived as potentially benefiting from additional support and individualized attention to help them better understand and process their grief and losses. This type of support group is crucial to the treatment process of those with substance-use disorders, since frequently the unaddressed grief and trauma trigger relapses for addicts.

I interviewed two potential group members at a time, and explained both verbally and in simple written language the purposes of the group and the kinds of things we would be doing. I then asked each woman if she thought the group “sounded as if it would be beneficial to her at this time.” This language was intentionally chosen. Covington’s work with incarcerated women indicates the importance of empowering them to take some control over their own life and circumstances, even in court-mandated programs.35 It was of primary importance to me as the group facilitator that no woman

33 Covington and Bloom, “Gender-Responsive Treatment,” 1.

34 See Appendix, page 111.

35 For the women of CATS, who have entered into treatment in lieu of incarceration, “failing” in the treatment program likely would result in immediately being remanded to the Cuyahoga County Jail.
feel forced or coerced to participate if she herself did not believe the group would be helpful for her. In the end, ten women chose to participate in the group, which would meet for six weeks, once each week for two hours.36

Complicating Dynamics of Generational Poverty

If one studied the list of markers indicating “generational poverty,” all of the women with whom I worked at CATS would qualify. Situational poverty37 is generally caused by a sudden crisis or loss and is often temporary, whereas generational poverty is marked by “at least two generations born into poverty.”38 Generational poverty often results in multiple generations of a family being unable to identify even one of their number who has succeeded in moving to the more stable milieu of the working poor or middle-class.

Because generational poverty results in characteristics that appear in multiple and diverse settings, it is worth noting some characteristics which may be observed in those who have endured this type of systemic, pervasive poverty.39

36 Actually, eleven women wanted to participate, but one was prevented doing so because it conflicted with another group in which she was already participating.


39 Payne, *Framework*, 51–53. Listed are those characteristics of generational poverty which presented in the Grief and Loss support group and which affected the functionality of the group and process.
**Incessant background “noise.”** This is literal noise—constant television on, even when not watching. Conversation is participatory, often with more than one person speaking at a time.

**Importance of personality.** Individual personality is what one brings to the setting—because money (or the things money can buy that establish status) is not brought. The ability to entertain, tell stories, demonstrate sense of humor is highly valued.

**Oral-language tradition.** Casual register is used for everything. Reading/writing are eschewed and strong resistance is felt to interventions/processes that require reading and/or writing. All professionals in the treatment setting are highly suspect and not to be trusted if they are not also recovering addicts/alcoholics. This is especially strong and appears to cross genders.

**Survival orientation.** Discussion of academic topics is generally not prized. There is little room for the abstract. Discussions center around people and relationship. A job is about making enough money to survive; it is not a career.

**Identity tied to rescuer/martyr role for women.** A “good” woman is expected to take care of and rescue her man and children as needed, often following criminal activities.

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Ownership of people. People are possessions. There is a great deal of fear and comment about leaving one’s culture and/or “forgetting where you came from.” “Having favorites” among family members, including children, is common and fluid; favorites change frequently, depending upon who has something of value to offer today.

Negative orientation. Failure at anything is the source of stories and belittling comments such as “I’m just no good at….” This belies any thought toward additional education/training, etc., which would assist one to become better at the task(s).

Discipline. Punishment is about penance and forgiveness, not change.

Belief in fate. Destiny and fate are the major tenets of the belief system. Choice is seldom considered.

Polarized thinking. Options are hardly ever examined. Either/Or thinking is common and requires multiple suggestions for participants to re-frame thinking, consider options, etc.

Time. Time occurs only in the present. There is limited or no planning, foresight, goal-setting, etc.

Sense of humor. A sense of humor is highly valued and is a key aspect of alleviating the pain of poverty. Humor is almost always about people—either situations people encounter or things people do to other people.

Lack of order/organization. Group members were unfamiliar with “daily organizers”; devices for organization (files, planners, computers, smart phones) are few or non-existent in the setting.
Lives in the moment. Being proactive, setting goals, and planning ahead are not part of generational poverty. Most of what occurs is reactive and in the moment. Future implications of present actions are seldom considered.

Designing & Implementing the Intervention

If I had read these characteristics prior to working for six years with hundreds of men and women who had grown up in generational poverty, or if I had never experienced this sort of poverty within my own family of origin, I think I would view Payne’s work as tainted with subtle racism and classism. I might reject it outright on those grounds. However, my own life and work experience have held in tension many of the characteristics she describes. I used Payne’s research to help me respectfully navigate the characteristics of the women with whom I worked in the Grief and Loss group.

Group Week 1

The first week of the group is a good example. Week one of the Grief and Loss group began when I was “buzzed” into the locked corridor where the women waited in their bunk areas until I came to get them. Finding the women and getting them lined up to leave the unit was chaotic and noisy. Finally we walked out of the locked steel door and made our way to a small room with a rectangular table and eight chairs. I brought a folding table and four chairs from home in order to have enough room for all ten women to sit.

When we entered the room, the women responded positively to the simple objects I had placed on the tables. There were colorful quilted runners on each table and

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41 See Appendix, pages 64–70.
twinkling lights in lieu of candles (which are not allowed). I intentionally spritzed the room with perfume to make it smell clean and fresh, and to differentiate it from other areas which were utilitarian and smelled like fifty-plus women’s bodies. The women loudly talked as they entered and found a chair. There were ten women present but in the small room—the only room available that was not occupied to overflowing by mandatory CATS groups—it felt like there were thirty women present.

I hoped to begin promptly, as I had planned activities to fill our allotted two hours. The format of Group 1 was designed as follows:

**Introduction and Welcome by Facilitator**
**Review of Confidentiality Statement - Return signed agreement to each woman**
**First Handout: What Not to Say, What Not to Do - Listening to Grief**
**Getting to Know You: Women introduce themselves**
**Emotional “Weather Report”: Feelings Sheet - Women share how they feel**
**BREAK (10 minutes)**
**Definitions of Grief & Loss: Intangible and Tangible Losses**
“I Wish You Would… I Wish You Would Not…” feedback sheet
**What Every Grieving Person Needs to Know - Week 1 take-away**
**Close with Serenity Prayer (a copy was included in each woman’s folder)**

Instead of the planned session, the first thirty or forty minutes were dominated by a new crisis. The participants were grieving after learning of the death of a friend. The deceased woman had been their classmate and had graduated from CATS the preceding week. She died of an opiate overdose the day before our first group meeting. The women
were anxious to process her death and found it difficult to concentrate on the materials I had brought.

One woman in particular appeared to be especially upset due to her personal losses. While others spoke of the woman who overdosed, Jackie cried while passing around newspaper clippings of two recently-murdered family members. I quickly realized that a group of ten women, while clinically an “appropriate” size, did not work when participants had endured such historic, recent, and on-going crises and traumatic experiences.

We made it through the first week of group, but I knew I would need to make alternative arrangements going forward. I was concerned the women would be re-traumatized by the group itself, with its focus on processing historic events related to grief and loss, while they were enduring new losses that they needed to grieve.42

Following group, I collected the feedback sheets for comments related to “I wish you would…” and “I wish you would not….” Nearly every woman wrote a version of “I wish you would have one-on-one sessions every week,” and “I wish you would bring things to do every time.” There was one outlier: “I wish you would change that music. Get some water sounds … PLEASE.” Week one was complete, and in the spirit of co-creating, I was off to find (1) art supplies and (2) new music.

42 I spoke with individual counselors and the women themselves before the next group session in order to make more helpful and appropriate arrangements for individual counseling for the women who appeared to be in acute grief and were re-traumatized by the size and scope of the group. Counselors were attentive and understanding and concurred that individual counseling would be more beneficial for these women than was the group setting.
It is not unusual that the women in the grief and loss support group requested additional support and individualized care while in treatment. Due to the trauma endured by the women prior to involvement with the criminal justice system, trauma-informed care—including greater access to clinicians who are trained to work with trauma survivors—is a best-practice standard. Additionally, due to the long-standing and complex psychological, physical, and spiritual damage survivors have endured, organizations that receive federal and state funding should be required to provide evidence-based trauma-informed care.\textsuperscript{43} Currently, this is not the case.\textsuperscript{44}

It was alarming to see women with such complex cases of trauma, addiction, depression, and other life-threatening medical conditions, spending the majority of their days in large groups with insufficient opportunities for individual care from master- or doctoral-level clinicians. Such care can be found at expensive, private facilities where individual sessions are scheduled more frequently. Due to such care being perceived as “too expensive” and requiring the licensure of staff at a minimum of the master’s level, it is often the most vulnerable who do not receive what Covington (among others)


\textsuperscript{44} While many treatment center brochures describe their care as “trauma-informed” and “gender-responsive,” this often is not what is delivered onsite. There may be recognition that clients have been affected by traumatic experiences, however, such care often is deemed too expensive to deliver. Costs for staff would skyrocket if all those who work directly with clients were required to have the education and licensure commonly found in private, expensive facilities, such as Hazelden and Betty Ford, or Sierra Tuscan in Arizona.
demonstrates is crucial: gender-responsive and trauma-informed care. Like Mark’s disciples thought when Jesus directed them to feed the crowd, the amount of money required to meet the need is deemed to be too much.

Prior emotional, physical, and mental trauma is rampant in the population served. Data on poor women who are in the criminal justice system due to non-violent activities related to drug use and paraphernalia, as well as prostitution and/or so-called “survival sex,” reveal that coercion of impoverished women by those they describe as boyfriends, husbands, partners, in addition to male strangers, is common. Some women report being prostituted by family members, including parents, prior to their first illicit drug use or involvement in the criminal justice system. Many women report leaving home as teens in order to escape the sexual and domestic violence present in their childhood homes. Due to living in generational poverty with extremely limited opportunities for engagement in fully-functional family, education, and/or community systems, and without access to mental health and substances abuse treatment services, these girls, women, and

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eventually their children become vulnerable to sexual predators in their communities—beginning with those in, or affiliated with, their own families.

Over time, I observed the women in group seemed never to have had opportunities to experience examples of successful interactions with the unwritten “middle-class” rules of behaviors and expectations. I witnessed women labeled as treatment failures when they unsuccessfully navigated territory unknown to them. Too often, they seemed to be triggered beyond their capacity to cope by the treatment setting itself, which was often noisy and crowded. On two occasions, women came to group very upset, due to being bitten by bedbugs. The facility was heat-treated for bedbugs near the last session of our group. While I was encouraged by support staff not to go into the women’s area because of the tremendous heat, the women on site had nowhere cooler to wait while the service was completed. These types of stressful events are perhaps to be expected in jail, but not in a treatment setting for a medical disease. Imagine the same thing happening on the entire wing of a hospital … with patients present. The women in group navigated these circumstances with more grace than I can imagine under such circumstances, and a gritty determination to successfully complete treatment.

Consider Allison, a 29-year-old woman who grew up in a suburb of Cleveland, in a home where her earliest memories include her alcoholic father beating her mother, her five siblings, and herself. Allison’s family rented in several different areas and school districts, moving each time her father lost his job. Her mother, according to Allison’s description, “took care of us no matter what” until, in Allison’s early teens, her mom began using heroin. This was devastating for Allison, who “lost hope” after her mom became addicted. “We didn’t have a parent after my mom started using heroin.” Allison
came to the Grief and Loss support group because “… I lost my dad, aunt, Nana, and uncle all in a two-year span.” In response to what she most desired from a support group, Allison wrote, “To learn how to be able to live with grief and cope with my loss.”

Allison was forthcoming about her own addiction. “I’ve been using for almost twelve years. My parents are both addicts and so are my brothers and sisters. I live to shop.” Group was in session for four weeks when Allison casually mentioned the domestic violence in her childhood home. “The police came to our house so much they started bringing stuffed animals for us kids,” she commented. The other women in group nodded sympathetically; no one seemed surprised. Allison continued, “When I left home, I started dancing. … I guess I was seventeen.”

Allison then described the night two police officers from her childhood city came into the club where she worked. Upon recognizing Allison, one of the officers went outside and returned with a small teddy bear like the ones they had brought to her childhood home years before. Allison seemed numb to the import of her words while describing this situation; the women listening nodded their heads sympathetically but showed no surprise.

“I’m here,” she continued, “because losing my dad just pushed me over the edge. He died in a car accident a few months ago. He was drunk. I just can’t believe this happened because he drove drunk all the time and nothing ever happened.” Later she told the group, “My mom blames me for my dad being dead.” Someone asked Allison if she knew this for a fact, or if she assumed her mom blamed her: “My mom said, ‘He’s dead because of you.’” With this, Allison’s numbness broke for a moment and her eyes teared up. I felt an interior shift toward the sort of compassion expressed by Father Greg Boyle,

48 “Dancing” is a euphemism for working at a strip club.
SJ, a Jesuit in an impoverished area of Los Angeles and founder of Homeboy and Homegirl Industries which employs former gang members, “...we seek really a compassion that can stand in awe at what people have to carry rather than stand in judgment at how they carry it.”

The grief and loss group was designed with a particular weekly format, however I found it beneficial to be flexible and digress from the schedule when women came to group in crisis.

Ami was a stoic and seemingly hardened woman in her thirties. In her “what you need to know about me” paper, she wrote two sentences: “I need help ‘cause my daughter died. She was eleven.” Ami’s daughter, Sammi, was killed in a car accident while Ami was in jail on drug charges. “I don’t have the right to grieve her,” Ami said through clenched teeth, her face a stony blank. “I know I’m a bad mom. I don’t want to be disrespectful.” There was a naked honesty in her words. “I know I’m a bad mom.” Ami was born into poverty, and became a mother at fourteen. Based on the handouts she turned in, she wrote and read at what could be described as a functionally-literate level. I learned she was a survivor of sexual trauma in both childhood and as an adult, and had served multiple jail stints as she, in her words, “could not stay sober.” These were some of the things she carried when she stated she had no right to grieve her child’s death.

“You know, Ami,” I said, “I don’t think it’s a matter of if you have a ‘right.’ I think your heart is broken, and that means—no matter what you’ve done or not done for

your children—you’re grieving.” Blessedly, the other women started talking, encouraging Ami to forgive herself, to let herself “heal,” assuring her that “we all make mistakes.” I wondered if any of these women had ever heard such encouragement themselves when they were children in families frequently involved with DCFS. Thalia, another group member reminded Ami, “We can only move forward,” a painful, but true, observation for those with regrets. The women seemed to have compassionate natures, and they were willing to throw an emotional lifeline to another woman in the group.

**Group Week 2**

Beginning with Group Session 2, I brought therapeutic art materials, as the women had requested. I translated the more wordy handouts into artistic expressions that the women could engage using fewer words, with less reading. In Group 2, we had our regular “Emotional Weather Report” using the Feelings Sheet. I then presented a Venn diagram showing losses, including secondary losses. We went around the circle, giving each woman an opportunity to consider the diagram and talk about her own primary and secondary losses. Thalia used the diagram to identify her feelings about giving her baby girl to a couple in an open adoption. Her grief over missing her child was what brought Thalia to the group. She was torn because she “knew I couldn’t take care of her,” yet she felt she was a “selfish, bad mom” due to her choice to relinquish her baby for adoption. Using the Venn diagram, Thalia was able to identify that her primary loss was the loss of the physical presence of her baby, Anastasia.

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50 See Appendix, pages 71–76.
Again, using the diagram, Thalia was able to identify a secondary loss she felt, which was the loss of her identity as a mother. During group, she asked for feedback on something that had been troubling her. “I want to write my daughter a letter to tell her I love her. I gave her to a better home ‘cause I love her. Is it ok to do something like that? Write a letter she can have to open when she’s older?” Ami and the other women assured Thalia she could write such a letter and give it to the adoptive parents on behalf of baby Anastasia. Thalia tore a piece of notebook paper from her journal to begin the letter. As gently as possible, I encouraged her to wait until she had more time to think about what she wanted to write. I told her I would bring her pretty stationery and an envelope when I came the next week, and I did so. The truth, however, is that I was affected by Thalia’s deep desire to provide her daughter with such a letter. It hurt my heart to think that sometime in the future, Thalia’s daughter would receive her mother’s heart-felt letter on torn notebook paper. Perhaps this instinct on my part was wrong. Perhaps, to paraphrase Father Greg Boyle, I was ‘wrestling a simple cup from Jesus’ hands, and replacing it with a chalice.’

Following break, the women worked with simple art materials: lunch-sized paper bags, small cards on which were written each of the feelings on our “feeling sheet.” Having a sheet that identified words for feelings was important to these women. They often said, “I don’t know how I feel.” Each woman chose the cards for feelings that they

51 “I think we’re afraid of the incarnation. And part of it, the fear that drives us is that we have to have our sacred in a certain way. It has to be gold-plated and cost of millions and cast of thousands or something, I don’t know. So we’ve wrestled the cup out of Jesus’ hand and we’ve replaced it with a chalice because who doesn’t know that a chalice is more sacred than a cup, never mind that Jesus didn’t use a chalice?” Boyle, “The Calling of Delight.”
do NOT express to others, and put them inside their bag. Group members then taped to
the outside of the bag the feelings they DO express to others. Women were invited to
share their inside and outside feelings, which some did. If a woman was reluctant to share
her work, I noticed the other women were respectful of her decision.

The take-away for Group 2 was the bag itself. I encouraged the women to support
each other “in the back,” meaning in the locked unit where they lived. I explained that if
they found a safe person with whom to share an inside feeling, to place that feeling on the
outside of the bag, if they chose to do so. We ended group with the Serenity Prayer.

Group Week 3

I knew something was wrong when I encountered sheriff’s deputies as I went to
get the women from lock-down for our third group session.\textsuperscript{52} I felt a chill of apprehension
—and, frankly, revulsion—as I heard the overly familiar manner in which the officers
spoke to the women. “Hey, girl. Get on outta there,” one short, stocky officer said, in a
sing-song voice, gesturing at a woman he seemed to think was moving too slowly. As he
continued to “cat-call,” I was appalled to realize he was addressing the women by their
“street names,”\textsuperscript{53} not their given names. The women accepted this meekly or joked back;
after all, what could they say to a sheriff’s deputy? I hated how he was treating them and
thought, if this is how he and his partner are speaking to these women in a public setting,

\textsuperscript{52} See Appendix, pages 77–80, for the materials for Week Three.

\textsuperscript{53} “Street names” are names women use when being trafficked or prostituted. They are
deeply shameful about these activities, usually blaming themselves even when they are trafficked
and forced and/or coerced to engage in unwanted sexual acts for money. I learned that to call a
woman by her “street name” is deeply insulting and disrespectful.

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how might they behave when there are no witnesses? There was an undercurrent of sexual innuendo and mocking in the deputy’s tone: “C’mon outta there, girl. Hey, I remember you!” I felt my face flush with anger and embarrassment on behalf of the woman, as he was loudly signaling he remembered the woman from jail. The power differential was obvious, but the officer appeared to be unabashedly and unaware.

I gathered the women for group and we walked to “our” room at the end of the corridor. As always, the tables were set with objects made sacred by our use: the colorful table runner, the twinkle lights, the light scent of perfume. There was tremendous upset among the women, down to seven from our original ten, because sheriff’s deputies and K-9 dogs were onsite to conduct a surprise inspection. Police were responding to suspicions on the part of staff that some women may have relapsed.

Empathic Digression

I digress for a moment: Imagine if your own family member struggled with the life-threatening disease of addiction. Now imagine, instead of medical care in a clinical setting, your family member was either in jail, or a treatment center that—due to being affiliated with the criminal justice system—was inspected by police and K-9 dogs to determine whether or not your son, daughter, or other loved one, was adhering to their medical plan. Imagine if you yourself had a chronic, lifelong disease that—if you failed to manage it “perfectly”—resulted in your incarceration.

This situation is endured daily by poor women with addiction. None of the women with whom I worked were in the criminal justice system for violent offenses. In all cases, these women had substance-use disorders, were survivors of sexual trafficking
and abuse, and were too poor to get help from the centers that exist for those who have the money to buy their services.

Think of the renowned Betty Ford Center, co-founded by Betty Ford, former First Lady of the United States. Mrs. Ford described herself in interviews as an alcoholic with a co-occurring addiction to prescription medication.\(^{54}\) I have found little difference between the people I meet who utilize services at expensive treatment facilities and the women at CATS, except the later have been affected by poverty since birth and so have not had access to the monetary resources and social structures available to people like Mrs. Ford.

I do not diminish the grace exhibited by those with addiction who find hope and health at expensive treatment centers such as the Betty Ford Center, Hazelden, and Sierra Tuscan. Rather, I hope to reveal to those who may not have experience with people affected by generational poverty that, like addiction itself, there is a long tail of consequences for those born into poverty—and lack of access to the holistic and extensive mental health and treatment services available to treat the addictions of the wealthy is one of them.

Return to Group 3

Due to the police and K-9 dogs being onsite, there was no way to conduct group as planned. I tried to facilitate one woman speaking at a time and encourage the group to stick, as best we could, to sharing our feelings. The women were too upset to do our regular “emotional weather report,” so we went directly into our “mindfulness

meditation” bowing our heads and breathing as normally as possible, concentrating on each in and out breath. After one minute, we began, “God, grant me the serenity to accept the things I cannot change,” the first line of the beloved Serenity Prayer we used to begin and end our weekly group.

Suddenly, the door banged open and the rude deputy brusquely walked in. “Martha! Which one’s Martha?” Martha, sitting to my left, stood up, now weeping openly and trembling. The officer handcuffed her and led her out of the group. The women immediately began wailing and talking at once. “Oh no, oh no, oh no,” someone cried. “Oh God, not Martha. Not Martha!” Thankfully, Sister Dion Horrigan, SND, was with me this day as she was observing the group. Sister Dion knows the women and is the facilitator of the “Emotional Healing” group at CATS, which she created. It was a gift to have her there, both to offer comfort to the women and also to observe exactly what happened before, during, and after group. The events were disturbing to the women and us, and Sr. Dion and I had to be calm and centered in the middle of the emotional storm that raged around us. Events that would rattle the healthiest of psyches happened more than once I during the weeks I volunteered.

Lack of respect by law enforcement, the palpable fear experienced by the women due to the constant threat of returning to jail and losing custody of children—some part of these are daily occurrences for poor women in treatment in lieu of incarceration. Repeatedly, the way the systems work, which are presumably clinical and medical in nature, operate more like “jail lite.” In actuality, we see a monumental breakdown of

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55 CATS is not alone in traumatic experiences endured by clients as a result of criminalization of addiction.
healthy resources and opportunities for these women before they encounter a program “in lieu of” jail time.

Martha, for instance, had a dual-diagnosis of schizoaffective disorder and chemical dependency, with PTSD and a history of rape in her childhood. Furthermore, she was in the Grief and Loss group “to try and get better myself, and I have grief over my child getting molested and raped” at age seven. Due to this rape, she was in danger with DCFS of losing custody of her son. On her “Introducing Yourself to Me…” paper, Martha had written, “What I most desire from this grief and loss support group is healthy ways to cope with pain.”

Following group that day, Sr. Dion and I had an unexpected meeting with a clinician on site. We learned that, while what happened was “very sad,” it was important that staff enforce the rules of behavior. Martha had been caught smoking a cigarette in the tiny outdoor space the women used to get fresh air. This was a serious infraction, and one of the rules that could cause a woman to lose privileges. It might even land her back

56 Women expressed fear of navigating the crime and poverty in their communities while attempting to recover from addiction, including their concerns about the drug sellers who, women reported, accosted them on the street, in their homes (if they had a home to which they could return), and on their phones, even after the women reported changing numbers or phones. Every woman with whom we worked wrote or spoke of the ease with which illicit drugs, including heroin, is distributed. While treatment services are difficult to access, are financially out of range for every woman in our group, are limited in services, and provide no or very limited re-entry programming, buying heroin and other illicit drugs is easier and cheaper than ever.

57 The women could only use this outdoor space to get fresh air as it was far too small for even one woman to engage in exercise requiring large movements such as rapid walking, running, or other cardio activities. A woman could, perhaps, do physical activities such as jumping jacks or other exercises that did not require much movement.
in the county jail. The specific privilege taken from Martha was contact with her family. When she heard this, we were told, “She cursed. Then she spat at a staff member.” What Martha was reported to have done is serious, but not uncommon for someone with Martha’s diagnosis. I have witnessed events such as those described on the psychiatric unit at St Vincent’s. Sister Dion and I were concerned, as Cuyahoga County Jail, where Martha was taken, is not known to have appropriate mental health services for someone with schizoaffective disorder. (We know this because Sr. Dion is in the jail each week to meet with women and encourage them to engage in further treatment.) We have not seen or heard from Martha since the day the deputy handcuffed her and led her away from group.

Group Week 4

Group 4\textsuperscript{58}. Two women, each with severe ADHD, leave the group following break; only one returns. Nona and Jamie are a tag-team of sorts: two cut-ups who talk a mile-a-minute. Unfortunately, they could not manage to curb this behavior in group when other women were sharing. During mid-group break, I took the women aside and explained that the other women were having difficulty trusting the group process because the two of them were laughing and talking to each other instead of listening.

Nona and Jamie each listened (sort of) and half-heartedly said they would “try” to pay attention, but I should know that they need “lots of meds” for their ADHD, which neither was being provided. Following break, only Nona returned. There seemed to be no hard feelings; Jamie simply had decided that she would prefer to be in the group room

\textsuperscript{58} See Appendix, pages 81–89.
where she could draw rather than have to listen to others in group or share her own grief and loss experiences.

After group, I found Jamie and knelt down next to her in the corner where her head was bent over a worn notebook. She was creating a family portrait for another woman in CATS who recently had a family visit. I was truly surprised. “Jamie, your work is really good.” Unlike any other time I was with her, Jamie seemed focused, calm, and capable. “Yeah, I taught myself to do this when I went to school. I would draw, ‘cause I couldn’t focus (on what the teacher was saying) anyway.” She had only a stub of a #2 pencil to work with, but her work was life-like, with shading and subtle expressions captured on each face. We never spoke of group or of her leaving. She continued to draw, and I left her, but not before I asked her permission to take a picture of her work. “Sure,” she said. “Take a picture of this one.” She offered a drawing of a girl with long dark hair, similar to Jamie herself. “I put a poem with this one,” she said. I read the poem which seemed to fit well with the mood of the sketch. I did not recognize the poet, but asked Jamie who wrote it. “Oh,” she said casually, “I wrote it. I just write this stuff sometimes and put it with my drawings.” I thought of children I know, some the same age as Jamie (nineteen) who went to excellent schools in communities with little violence and art classes, unlike the school Jamie attended prior to dropping out and having a child at 16. Where, I wondered, might this young woman be if she had similar opportunities? I walked out to my car shaking my head and drove home in silence.

As of 2016, St. Vincent Charity Medical Center in Cleveland has the only inpatient medically-assisted detoxification program which will accept the poor without
insurance in Cuyahoga County.59 Rosary Hall, located in St. Vincent’s, often has a waiting list for patients to enter the 27-bed detoxification unit.60 Meanwhile, Cuyahoga County is staggering under the epidemic of addiction, including heroin use and overdose, without sufficient resources to treat those affected.61 According to the Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) board, heroin overdoses in Cuyahoga County (exacerbated by “pill mill” prescription drug peddlers,62 run by unscrupulous


62 During my six-year tenure working in Rosary Hall at St. Vincent Charity Medical Center, I have repeatedly heard from clients about the “drug boys” (as of this writing I have not heard the expression “drug girls”) who quickly adapt and use the latest technology to contact clients (or former clients) and make home deliveries 24/7. While those with addiction wait days and sometimes weeks for detoxification and/or treatment services, drug sellers deliver directly to buyers and respond to phone requests to purchase drugs day and night. This constant accessibility often waylays those who deeply desire to obtain treatment services from actually making it to treatment. Many people who are chemically dependent are eaten alive by the voracious appetite of the unscrupulous—and in many cases themselves poverty-stricken—low-level drug sellers, before they are accepted into one of the few treatment centers for the poor that has an available bed. This was surprising to me, as prior to ‘going and seeing,’ I had no idea how difficult it is for these very sick people to obtain life-saving treatment services. As all of our women reported, it is far easier for a poor woman to get arrested for drug use and land in Cuyahoga county jail or Marysville prison for women, than to access treatment for addiction or mental health issues.
medical doctors) have quadrupled since 2007. Now that heroin has moved into the whiter and more economically viable suburbs, a $100,000 grant is being implemented in outreach to “suburban youth.”

Because it is a brain disease, addiction affects people in all communities, all races, ethnicities, and genders. Like other diseases, there are risk factors for addiction that are both genetic and social. In fact, systemic and generational poverty itself is a risk factor for developing addiction. While addiction affects all social classes, ethnicities, genders, races, and so forth, the “war on drugs” is concentrated among the poor and sick, the impoverished without lawyers or options, in geographies where many people fear to go.

In many communities and neighborhoods, those who are able to do so isolate themselves from people who live amid the conditions which are risk factors for developing mental, physical and spiritual illnesses. We do not “go and see” because we are concerned for our safety. Yet, small children and others of all ages cope daily with the perilous geographies that we are able to avoid. When we become aware, by going to see and listen to those who live in economically oppressed and violent neighborhoods, with crumbling infrastructure and poorly performing schools, our compassion leading to just

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64 ADAMHS, “Heroin Addiction & Help.”

actions, alongside and on behalf of the people deserted there, grows. Perhaps this is why Jesus commands, rather than suggests: “Go and see.”

Citizens who do not live in a “war zone” 66 sometimes believe that all those who end up in jail are threats to public safety. The people incarcerated may seem to be other than oneself—and therefore in need of heavier policing. This is not always the case.

Nicholas Turner, President and Director of the Vera Institute of Justice, summarized the situation in “Incarceration’s Front Door: The Misuse of Jails in America,” the Institute’s 2015 study on the overuse of local jails:

I suspect that many readers will come to this report thinking that jail is reserved only for those too dangerous to be released while awaiting trial or those deemed likely to flee rather than face prosecution. Indeed, jails are necessary for some people. Yet too often we see ordinary people, some even our neighbors, held for minor violations such as driving with a suspended license, public intoxication, or shoplifting because they cannot afford bail as low as $500. Single parents may lose custody of their children, sole wage-earners in families, their jobs—while all of us, the taxpayers, pay for them to stay in jail. 67

For human rights advocates, spiritual leaders, and those distressed about the overuse of jails, it is encouraging to hear that Cuyahoga County has implemented “treatment in lieu of incarceration” for some people convicted of nonviolent drug crimes.

While it is heartening to see treatment options made available to those with the disease of

66 I.e., a community that is impoverished and over-policed.

addiction (instead of only a jail cell), these options are too little too late, as evidenced by the opioid epidemic leaving a trail of bodies across Cuyahoga County and many other areas of Ohio. Dr. Theodore Parran, Associate Medical Director of Rosary Hall and Isabel and Carter Wang Professor and Chair in Medical Education, CWRU School of Medicine, noted in a Zella Hall lecture at St. Vincent Charity Medical Center: “Jail and prison are good for some things. Treating addiction is not one of them.” In fact, because jail itself is profoundly traumatizing for many women, it causes further harm to those who enter cells with personal histories filled with trauma, physical and sexual violations, and mental illness—many beginning in childhood. Clients/patients in treatment in lieu of incarceration require the same clinical care as other citizens who are diagnosed with these mental and physical health conditions.

The women in the Grief and Loss group had never had options such as one might receive with private resources or very good insurance. In a few cases, they had received very limited “treatment” for dual-diagnoses of substance use disorder and mental illness. Allison herself had been diagnosed with depression and post-traumatic stress disorder (PTSD), much of the latter linked to the violence in her childhood home and the violence she experienced as a teen on the streets. Allison was not sure she believed this assessment of her physical and mental health: “I know I’m an addict,” she said, “but PTSD? I mean, I’m not a soldier.” Although she grew up in generational poverty, in an addicted family system, with regular violence against her mother, herself, and her siblings, was a high

school dropout, and had begun stripping at seventeen to support herself … now in her mid-twenties, Allison had difficulty believing she had been affected by these factors. Instead, she spoke of mistakes she had made in life, and wondered aloud why she could not “make something” of herself.

Allison was not alone in blaming herself for being unable to get out of poverty, unable to stop using, unable to “get ahead.” It was not lack of taking responsibility for their “poor choices” that I witnessed within the group; rather, it was a lack of knowledge regarding the difficulty of escaping from the after-effects of a lifetime steeped in multiple risk-factors for addiction, ongoing poverty, domestic violence, and mental illness. To a woman, I observed people who blamed and shamed themselves for not being able to “lift themselves up by their bootstraps” to escape their poverty and addiction—which every woman repeatedly had tried and failed to do. Each of the women believed, based on comments made in group, that she had made poor choices at various points in her life. However,

The thing about choices … is that the contexts in which they take place matter in important ways. And the consequences of such choices are different for different people. Furthermore, the context and consequences are often not random, but rather tend to align themselves with existing injustices. For the women...availability of hard drugs, their previous encounters with abuse, and the consequences for mostly poor...women using crack cocaine and heroin meant that their life experiences, their disease, and the choices they made led to particularly devastating results.69

If, as Christians, we say we recognize all creation as the living Body of Christ, we must ask ourselves—what are we doing to the Body when we declare the bodies of poor and sick people to be inherently bankrupt, and therefore, disposable: worthy only of incarceration or treatment in facilities which the government pays for only because they are cheaper than private care? Further, what are we doing when we ignore the body politic and disregard its illness, oppression, and injury due to the injustice of laws that criminalize poor people due to a medical disease, which counts poverty itself among its risk factors?70

The United States is being offered tangible hope in the form of a new initiative to curb the misuse of county jails. The MacArthur Foundation is providing an initial $75 million dollars in their “Safety and Justice Challenge” to address the injustice and inefficiency of the overuse of America’s jails for poor, nonviolent, and physically and/or mentally ill people, especially in America’s cities.

For too long America has incarcerated too many people unnecessarily, spending too much money without improving public safety. Jails are where our nation’s incarceration problem begins; there are nearly 12 million jail admissions every year, and jails too often serve as warehouses for those too poor to post bail, nonviolent offenders, or people with mental illness. With this substantial, long-term commitment and investment, MacArthur hopes to support and demonstrate alternatives

to incarceration as usual, and to create demand and momentum for change across the country.\textsuperscript{71}

For a “Safety and Justice Challenge” to be necessary, one must have a lack of safety and lack of justice which is being “challenged.” The MacArthur Foundation has found that criminalizing addiction and non-violent crime which results in the mass-incarceration of the poor is unsustainable and unjust. Christians and others can join with them to implement a better way—led by evidence-based medical outcomes—to address and manage chronic illness, especially among “the least of these”—the poor and the sick.

It is unconscionable to allow the system created to support “the war on drugs” to remain unchecked any longer. It is past time to allow the poor and ill to “surrender,” that is, seek medical attention without fear of being detained in the criminal justice system, because their disease is deemed to be an illegal activity rather than a medical crisis.

Group Week 5

By the fifth week of group,\textsuperscript{72} the women who remained had developed a bond of trust that allowed us to engage in a sharing exercise that was, perhaps, both the sweetest and most therapeutic of our time together.

Using “memory prompts” in an exercise adapted from one I have used as a volunteer with Hospice of the Western Reserve, we shared memories of people loved and lost, places no longer appropriate for a woman in recovery, and other losses, tangible and

\textsuperscript{71}“Macarthur Foundation Launches $75m Initiative to Reduce America’s Use of Jails” (press release February 10, 2015); \texttt{http://www.safetyandjusticechallenge.org/2015/02/press-release/}; accessed May 21, 2015); emphasis added.

\textsuperscript{72}See Appendix, pages 90–94, for materials for Week Five.
intangible, the women were grieving. I demonstrated by choosing a card, then sharing a memory of, for example, “a funny thing my loved one used to do,” or “my favorite memory of my own childhood is,” or even “the most difficult thing about my loved one was….” I then placed my card in a large glass jar. We went around the circle, and each woman chose a card, shared her story related to the “memory prompt,” then she placed the memory prompt in the jar. There were enough cards to go around the circle several times, with women choosing new cards with new subjects each time.

After all the cards were used, we looked at the glass jar and I asked the women to consider what they were seeing when they looked at the jar. Plainly evident was the tangible evidence of all our memories held safe in the jar, no longer alone, but together: “my dad’s favorite sports team was…”; and “the funniest thing my daughter and I did together was…”; or “what I remember most about my baby is….,” In this exercise, the unspeakable was spoken and then, because it was shared, the women said their grief was somewhat lessened. Allison showed real excitement as she exclaimed, “Oh my G-d! Look at the jar,” which was filled with their memory prompts. “I’m not alone!” Another woman reminded us of an anonymous quote that was in the welcome packet given to each woman at the beginning of the Grief and Loss group: “Life is not fair, but pain is always lessened by love and connection.” I have never known the author of the quote, but being with the women as we shared our grief with each other by speaking our losses aloud, I knew with renewed certainty that it is true.
Group Week 6

“Like a seed I grow because I am lovingly cared for.”

In Group Session 6, I provided a feedback sheet that prompted the women to identify what they believed was the most important thing they received from the grief and loss support group. Ami, mother of 11 year old Sammi who died in a car accident, said to Thalia, “I learned we both lost our daughters: mine died, and yours was adopted out. The biggest thing I got out of group is knowing I’m not alone.” In six weeks of group, it was the most vulnerable words I had heard Ami speak.

Thalia, the mother who allowed her newborn to be adopted, wrote: “I have new understanding that what I did for Anastasia was for the best. I will keep moving forward each day. I have realized this life (meaning addiction and its consequences) is not for me.”

Allison, who had teddy bears brought to her and her siblings by police responding to domestic violence calls, was not present for group. I learned from Thalia that Allison was caught smoking a cigarette. She then hesitated to provide a urine sample to check if she had relapsed. About an hour before group was to begin, Allison was arrested and taken back to the county jail (where she had been incarcerated prior to being transferred to CATS).

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73 Sandra Magsamen, Dear Mom, Thank You with All my Heart, Gestures of Kindness (New York: Stewart, Tabori, & Chang, 1999), 7. Quote with graphics provided in Week Six.

74 See Appendix, pages 95–109, for materials for Week Six.
As we had done on other weeks when fresh losses occurred, we gathered around the table and began the grief and loss support group. After we closed group with the Serenity Prayer—perhaps to linger longer with the women—I shared how much I rely on the prayer as a personal mantra, using mindful breathing to chant the prayer interiorly. Referring to the chaos present in our third class due to the sheriff deputy’s interruption, Ami said, “I bet you was interiorly chanting the Serenity prayer that day!” We all burst out laughing, and the feeling of community—perhaps even kinship—overcame the little room.

Many researchers who have worked extensively with incarcerated and formerly incarcerated women write of the qualities of spirit the women exude, in spite of multiple barriers to a healthy environment. As Dr. Covington and colleague Gina Fedock write of women such as those at CATS, these women have “demonstrated incredible resilience … They are a testament to the survival capacity of the human spirit.”\footnote{Stephanie Covington and Gina Fedock, “Beyond Violence: Women in Prison Find Meaning, Hope, and Healing,” \textit{Trauma Matters, A publication produced by the CT Women’s Consortium and the CT Department of Mental Health and Addiction Services in support of the CT Trauma Initiative}, Hamden, CT (Fall 2015), 2.} Again, we hear Jesus’ command to “go and see,” and have a glimmer of all that is lost if we do not act on his injunction. Heeding his command, we experience the risen Christ lifting and consecrating the gifts of the wanderers in the lonely place, and our own tiny hearts may be transformed into hearts bursting with love.

I experienced a moment in detox at St. Vincent’s that stays with me. A patient, Mindy, was detoxing from heroin and suffering from generalized pain and anxiety due to the process. Mindy’s limbs tremored as she participated in an “art and spirituality” group.
Each patient used simple art supplies such as paper, glue sticks, and magazine clippings to create a collage representing their “best lives.”

After group, Mindy stopped me as I was leaving. “You ever go to the Workhouse?” she asked me. “No, I’ve never been there,” I told her. The Workhouse is a facility in Cleveland’s criminal justice system where people can be sentenced for up to ninety days. I have had patients sentenced to the Workhouse, but had never been there myself. These are the inmates one might see in orange jumpsuits picking up trash on the side of the road. “You should go,” she told me flatly. “I been there and it’s a hell-hole, especially for the women. We’d get mandated to our bunks for seven hours a day and sometimes they didn’t even tell us why. There’s no women programs. And it’s full of bedbugs.” Another woman in detox overheard us and concurred with Mindy. This second patient had been there, too.

The two women, one tethered to an IV line, so ill she could not stand, and Mindy, her limbs trembling, urged me to visit the women at the Workhouse as soon as possible: “You could be helpful. You need to go see them.” I promised Mindy and the other patient I would look into it and go as soon as possible. “Go this week!” Mindy advocated. Mindy became for me, in that moment, the voice of Jesus urging me not to put it off, but to “go and see” the forgotten women she felt so certain I could “help.”

There is perhaps no group at this time that is more crushed than poor, addicted women. Christians and others advocating for justice for all people can support cultural humility—which includes personal humility—and an ethics of care, rather than punishment.

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76 See image in Appendix, page 113.
“For I was hungry … I was sick … I was in prison,” says Jesus, “… and you came to Me.”

Thus does Jesus impress upon those who follow him that the way in which one treats the humans among whom one lives, is received by God as loving and revering God’s Self. Perhaps this is what really happens when we “go and see,” we experience what Jesus meant when he said, “Truly I say to you, to the extent that you did it to one of these … even the least of them, you did it to Me.”

As theologian Ronald Rolheiser wrote regarding Christian praxis in this world: “One cannot bypass a flawed family on earth in order to love a perfect God in heaven,” because, “We are Christians, not theists. God is not just in heaven, God is also on earth.”

Having broken into creation’s historicity, God is living in and among creation through the living Body of Christ, and it is “up to us, if we claim to know that Christ, to look for him where he himself has said he can be found”—among the sick, the prisoner, the vulnerable, and the poor.

When we “go and see,” we find ourselves inter-dependent, as one of many vulnerable human bodies inextricably linked with God’s Self, through the Body of the Christ, which entwines us all.

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77 Matthew 25:34–39; emphasis added.

78 Matt 25:40; emphasis added.


Conclusions and Results of Intervention

The Emotional Healing group, with an emphasis on Grief and Loss support, has now completed its first six-week cycle. The group began with ten women who had requested to be in such a group, had interviewed prior to joining in order to fully understand the content and intent of the group, and signed release forms of their own volition in order to participate. It saddens me that of the seven women who remained after the first group meeting, only two completed all six sessions. Based on the outcomes for the Emotional Healing groups without emphasis on grief and loss support, this outcome was unexpected. However, considering the many barriers women faced in order to attend the grief and loss group, more is revealed and some of these dynamics can be explained.

Three women were referred to their counselors for individual care following the first group meeting, in which they appeared to be emotionally overwhelmed by the group process. Their carried grief and loss was too fresh for the group setting to be helpful. They required a higher level of care for the symptoms of open trauma they exhibited in the first group session. Seven women continued in the group, until the fourth session, when we lost Jamie to the group room where she could draw (and not process her feelings of grief and loss in a group setting). She later successfully completed the CATS program and returned to her family home, where she hoped to be reunited with her three-year-old son, currently in the care of foster parents.

One woman, Elizabeth (who grieved the loss of her teeth), successfully completed treatment prior to all six sessions of the group, and left to live in a women’s shelter, where she told us she desired to continue her recovery by engaging with a sponsor and a
Twelve-Step groups. Elizabeth shared she had permanently lost custody of her children. She hoped her Twelve-Step sponsor could help her deal with the pain she felt over this, especially since she did not have access to other sources of support such as a private counselor might provide. Nona attended several doctor appointments while at CATS, all of which conflicted with the Grief and Loss group. She had only one day a week on which she was allowed to make doctor appointments—Thursday, the same day as group. Because Nona had mandated CATS groups on the other days, she had no choice as to which group she felt was most beneficial to her. Nona was required to attend specific CATS groups (for which CATS receives compensation) in order to be considered a success in her treatment in lieu of incarceration. Therefore, she was left with the choice of seeing her doctors (to try and catch up on the years she had not had access to a doctor for even preventative care) or completing the grief and loss group. I assured her we all understood her choice.

Martha, who was grieving her own abusive history beginning in childhood, the violence she lived in currently, and the sexual abuse of her little boy, was handcuffed in group session three and taken to Cuyahoga County Jail. We remain deeply concerned about her well-being.

Allison, who attended every group session and was given teddy bears by local police (and was so delighted by the glass jar full of “memory prompts” because they reminded her she was “not alone”), was arrested at CATS for breaking rules and taken to Cuyahoga County Jail one hour before the start of our final class. She remains in jail as I write this paper.
Thalia, who grieved placing her baby girl, Anastasia, for adoption, and Ami, whose daughter had died, completed all six sessions of the Grief and Loss group. It was Thalia who told me about Allison’s arrest, which happened just an hour before I arrived. Thalia and Ami also attended a Saturday Women’s Recovery Retreat in Rosary Hall, which was their first experience of a spiritual retreat. They participated fully and told the other CATS women in “the back” that they, too, needed to sign up for the next six-week group and go to the Recovery Retreat. In essence, it is Thalia and Ami who carried the message of the healing mission of Jesus to the other women with whom they shared the locked unit. Perhaps each responded to the Call and Caller who commands we “go and see” and gather the gifts of all the people we find.

Because Thalia and Ami carried the message, and the women in “the back” locked unit have requested it, the Grief and Loss group will begin another six-week cycle followed by a women’s Recovery Retreat in April 2016.

**AVENUES FOR FURTHER STUDY**

Topics worthy of further study include the ways in which a program informed by gender-responsiveness correlates with the skills of certified spiritual directors and pastoral-care providers who also are trained in the Twelve-Step tradition (of Alcoholics Anonymous and Al-Anon). Certified spiritual directors who have the necessary additional training in the wisdom and methodology of the Twelve-Step tradition may do well to provide programs and mentoring to impoverished women in the community treatment setting. Both Ignatian Spirituality, with its Spiritual Exercises and emphasis on finding God in all things, and the Twelve-Step tradition provide incarnational messages
of hope and healing to those who are struggling with connecting their bodies and brains in new and healthier ways in order to interrupt the addictive cycle.

Another promising path for mental and spiritual healing are Recovery Retreats provided by master's-level clinicians along with religious from a variety of orders. Currently, these women-only retreats are held approximately every two months in Rosary Hall at SVCMC, and provide an all-day experience for homeless women of a spiritual retreat in the Ignatian tradition. Combining Twelve-Step wisdom with Ignatian Spirituality creates a potent context in which to provide women who seek a felt experience of the Holy a spiritual retreat steeped in language familiar to many of them. This provides an avenue for further spiritual exploration, if a woman so desires. Also, by providing such ecumenical and non-”religious” retreats at a site already familiar to many of the women (i.e., Rosary Hall), one creates a path for continuing relationship with women who often are lost to those who care deeply about them when they leave treatment and return to unstable housing, financial, and familial situations.

Postscript

Just as John Carroll University, where I write this essay, uses teacher recommendations and education transcripts to evaluate students who desire to attend, the women at CATS come with a paper-trail provided by various sources. Most of the women have endured childhood involvement with the Department of Children and Family Services (DCFS) and the Juvenile Detention facility as young teens. By the fourth session of the Grief and Loss support group, the women were sharing more of their personal stories. At times, being attentive and present in order to hear and receive their
stories was difficult, as the personal histories of all ten women who began in our group were almost unbelievable in their pathology, dysfunction, loss, and systemic poverty. One might be inclined to disbelieve portions of their stories, except these women were very real and their histories were documented in case files and corroborated by their individual counselors. Each woman came to jail, then CATS, having had a history of involvement with failed systems, or a lack of clinically-based medical and mental health interventions to address her medical needs. From childhood, to pre-teen, teen, and adult, the women brought a paper trail that codified all the ways in which impoverished communities, family systems, and others had grievously failed them.

The women also had been failed by those who could have helped, but chose not to. Many years ago, I saw a sign in a minister’s office that read “A cry in the city begins with a yawn in the suburbs.” It has haunted me ever since.

Stephanie Covington’s model of Gender-Responsive/Trauma Informed treatment was provided on four counts: Gender, environment, relationships, and services were possible to address—with limitations—within the delivery of programs and services provided by myself and other vetted facilitators at CATS.

However, in order to begin improving the women’s socio-economic status and continuing community (points 5 and 6 of Covington’s model), it is necessary to create paths and opportunities to companion the women following their completion of the CATS program. All of the women in the Grief and Loss support group expressed fear, anxiety, and financial concerns related to leaving the perceived safety of partial lockdown at CATS and reentering their home communities. This is due to the violence, drug
availability, and lack of access to legal employment, which the women describe as being prevalent where they live or where they can afford to move.

In order to companion the women when they left CATS, a non-profit corporation and website was created so we can stay in contact. MiddleWayMinistries.org is meant to be a platform for women like those in the CATS group as well as others who are leaving residential treatment settings and re-entering the Greater Cleveland community.

MiddleWay Ministries empowers women in NE Ohio who have survived childhood and adult abuse, sexual trafficking, addiction, and generational poverty to improve their spiritual, mental, physical and financial health. We provide evidence-based programs, mentoring, and training which assists women to thrive, not just survive. All services are provided free of charge to the women we serve. We are 100% supported by private donations, foundations, and grants. No woman in need is turned away because of being poor.

MiddleWayMinistries.org provides an interactive platform where women who are re-entering the community, treatment providers, and volunteers can find links to services including job referrals, housing, mental health treatment, further education, and clinical care by master-level clinicians and spiritual directors and/or religious women who are MiddleWay facilitators. Our goal is to provide evidence-based programming to women who otherwise would not have access to such resources.

It is our desire at MiddleWayMinistries.org to be in relationship with the women of NE Ohio who are creating lives they wish to live in. We do not create clients; rather, we are creating a community in which we walk together in authentic friendship and care. We envision a community created with women who have formerly had limited access to
opportunities; one in which we allow God to use our entire selves to empower all women to not only survive, but to thrive.


Cuyahoga County Opiate Task Force. “Treatment Resources.”


Kessler, Ronald C., Christopher B. Nelson, Katherine A. McGonagle, et al., “The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for


APPENDIX OF INTERVENTION DOCUMENTS
MATERIALS FROM WEEK 1

1. Introduction and Welcome by Facilitator
2. Review of Confidentiality Statement — Return signed agreement to each woman
3. First Handout: What Not to Say, What Not to Do — Listening to Grief
4. Getting to Know You: Women introduce themselves
5. Emotional “Weather Report”: Feelings Sheet — Women share how they feel

BREAK (10 minutes)

6. Definitions of Grief & Loss: Intangible and Tangible Losses
7. “I Wish You Would... I Wish You Would Not...” feedback sheet
8. What Every Grieving Person Needs to Know — Week 1 takeaway
9. Close with Serenity Prayer — Print copy provided in each woman’s folder
Confidentiality Statement

As a member of the Emotional Healing support group (also known as the Grief and Loss support group) I agree to keep in confidence any and all personal information that is shared by other women in our group. This means I will not share personal information with people outside of the group meetings.

I promise to honor the privacy of other women by refusing to gossip about or repeat another person’s story or personal experience. I will do my part to make the group feel safe to share our struggles, feelings, and concerns around our personal issues.

Signature:

Printed Name:

Date:

Facilitator Signature:
What NOT to Say...What NOT to do...

Sometimes well-meaning friends and family will hurt you unknowingly with their words. They may tell you:

"I know how you feel." (They don't.)

"Get on with your life." (You're not ready.)

"Don't be sad." (You have the right to feel ALL your feelings...including sadness.)

"Time heals all wounds." (Time can help, but time alone does not heal.)

"He/she wouldn't want you to be sad." (Maybe true; maybe not true - but he/she would understand why you are sad!)

IMPORTANT TRUTHS ABOUT GRIEVING IN OUR CULTURE:

Some people are uncomfortable with grieving or 'sad' people. That is their issue, not yours. Some people are more comfortable believing in tidy answers in order to not experience grief. These people have an "answer" to every question. This is NOT because they actually have the "answer" to your grief; it is because they are UNCOMFORTABLE with UNCERTAINTY. They are uncomfortable with grieving people who are sharing their feelings honestly.

WE ARE NOT 'THOSE' PEOPLE. We will learn and practice acceptance of others' feelings exactly as they are...without offering 'answers,' assurance, our own ideas about 'God's will,' or other comments that discourage someone from feeling what they feel. We will learn to be a compassionate 'presence' to the other women in our group. You are doing "enough" if you are silently listening to another woman share, or simply 'being with' her in her grief so that she knows, "I am not alone. I am seen, I am heard, I am safe to feel what I feel."

ALL FEELINGS ARE NORMAL. They are part of being human. They are our right. You get to feel what you feel, instead of what you "should" feel.

Adapted from The Understanding Your Grief Journal, 2004, by Alan D. Wolfelt, Ph.D.
**FEELINGS CHART**

<table>
<thead>
<tr>
<th>HAPPY</th>
<th>SAR</th>
<th>ANGRY</th>
<th>SCARED</th>
<th>CONFUSED</th>
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<td>Superior</td>
<td>Fearful</td>
<td>Bewildered</td>
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<tr>
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<td>Hopeless</td>
<td>Furious</td>
<td>Panicky</td>
<td>Trapped</td>
</tr>
<tr>
<td>Overjoyed</td>
<td>Sorrowful</td>
<td>Seething</td>
<td>Afraid</td>
<td>Troubled</td>
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<tr>
<td>Proud</td>
<td>Depressed</td>
<td>Enraged</td>
<td>Distraught</td>
<td>Torn/Split</td>
</tr>
<tr>
<td>Together</td>
<td>Rejected</td>
<td>Victimized</td>
<td>Miserable</td>
<td>Disorganized</td>
</tr>
<tr>
<td>Complete</td>
<td>Unwanted</td>
<td>Drained</td>
<td>Frightened</td>
<td>Mixed-up</td>
</tr>
<tr>
<td>Free/Joy</td>
<td>Grief</td>
<td>Jealous</td>
<td>Threatened</td>
<td>Foggy</td>
</tr>
<tr>
<td>Cheerful</td>
<td>Ashamed</td>
<td>Remorseful</td>
<td>Insecure</td>
<td>Disoriented</td>
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<td>Up</td>
<td>Upset</td>
<td>Annoyed</td>
<td>Uneasy</td>
<td>Uncertain</td>
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<td>Good</td>
<td>Distressed</td>
<td>Frustrated</td>
<td>Very Strained</td>
<td>Divided</td>
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<tr>
<td>Hopeful</td>
<td>Down</td>
<td>Agitated</td>
<td>Shy</td>
<td>Torn</td>
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<tr>
<td>Peaceful</td>
<td>Defeated</td>
<td>Tense</td>
<td>Timid</td>
<td>Bothered</td>
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<tr>
<td>Loving</td>
<td>Beaten</td>
<td>Defensive</td>
<td>Unsure</td>
<td>Uncomfortable</td>
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<tr>
<td>Glad</td>
<td>Lonely</td>
<td>Fed Up</td>
<td>Nervous</td>
<td>Undecided</td>
</tr>
<tr>
<td>Content</td>
<td>Sorry</td>
<td>Uptight</td>
<td>Stressed</td>
<td>Anxious</td>
</tr>
<tr>
<td>Satisfied</td>
<td>Lost</td>
<td>Aggressive</td>
<td>Reluctant</td>
<td>Tired</td>
</tr>
<tr>
<td>Relief</td>
<td>Guilty</td>
<td>Enraged</td>
<td>Anxious</td>
<td>Confused</td>
</tr>
</tbody>
</table>
KINDS OF LOSSES: Life, Physical, Material, Intangible

**INTANGIBLE LOSSES:**

*Loss of trust:* Perhaps in God and others. Loss of being able to trust and view the world as a relatively safe place

Loss of hope

Loss of freedom

Loss of faith: In God and the goodness of others

Loss of innocence: your safety/your invulnerability

Loss of a past, future, or the present

Loss of identity

Loss of values

Loss of a role: as mother/daughter/aunt/cousin/girlfriend

Loss of will

Loss of feeling

Loss of love/relationships

Loss of respect

Loss of opportunities

Loss of self-esteem

Loss of a happy childhood

If you are in recovery, the loss of the object of your addiction
7 Things a Grieving Person Needs to Know

1. You are lovable even when you are a confused mess.
2. Crying is a gift.
3. Almost every thought, behavior, and feeling is normal.
4. You are not alone.
5. People are uncomfortable with grieving people.
6. No matter how bad you feel, you will survive.
7. It takes as long as it takes.

By Earl Hipp
When you start to CRACK open, don't waste a moment gathering your old self up into something like you knew BEFORE. Let your NEW self SPLASH like sunlight into every dark place & LAUGH & CRY & make sounds you never made & THANK all that is holy for the GIFT, because now you have no choice but to let all your LOVE spill out into the world.

"the Gift of You" ©2014
Grieving is a Process — It Takes as Long as It Takes

1. Mindfulness meditation with ocean sounds
2. Review Confidentiality Agreement
4. The Loss Cycle

BREAK (10 minutes)

5. VENN Diagram Primary and Secondary Losses: Where am I?
6. Therapeutic Art Experience Inside/Outside Feelings
7. Serenity Prayer
Feelings are neither negative nor destructive. They are simply truths. How you express your truth is what matters. Neale Donald Walsch
The Loss Cycle
The Normal Cycle for All Losses

**Losses:**
- Loved one dies
- A relationship ends
- Lose a job, or...
- Give-up chemicals

**LIFE**
- Plan
- Acceptance
- (Admission)
- Depression
  - Hopeless
  - Helpless
  - Grief
- Denial
  - Shock
  - Disbelief
- Bartering
  - If you'll, I'll...
- Anger
  - At self
  - At person
  - At others
  - At God
- New Life - Stronger
- Repetition
Week 2: Therapeutic Arts Project – Inside/Outside Feelings

*Ask group members to:*

1. Write down or draw a picture of all the feelings they have felt since the loss or losses they have experienced.

2. Ask group members to think about which feelings they express to others and explain that they are called “outside feelings.”

3. Ask group members to think about which of these feelings they do NOT express to others but keep on the inside of themselves and explain these are called “inside feelings.”

4. Ask group members to tape outside feelings to outside of paper bag and put inside feelings inside the bag.

5. Invite each participant to share their inside and outside feelings.

**CONCLUSION:** Instruct members of group to keep their bags. Let group members know that if you decide to share what you’re feeling inside with someone, consider putting the feelings you choose to share on the outside of your bag (after sharing).
“There are things that we don’t want to happen but have to accept, things we don’t want to know but have to learn, and people we can’t live without but have to let go.”
Secondary Loss

- Loss of Income
- Loss of Support System
- Loss of Financial Security
- Loss of Confidence
- Primary Loss of Person Who Died
- Loss of Identity
- Loss of Dreams for the Future
- Loss of Faith

http://whatyouangrief.com


**MATERIALS FOR WEEK 3**

**Grief and Gratitude**

1. Review of Confidentiality Statement
3. Reframing Grief and Loss Grief as the price of love and connection
4. If I could talk to you...

**BREAK (10 minutes)**

5. Practicing Gratitude: Carrying grief and gratitude together
6. Serenity Prayer
Dear Loss -

I am writing to you today because I need to tell you...

Since you happened, I feel...

What I most want to say to you, Loss, if you were right here, right now, is this:

What do you want to say to me, Loss?
"Grief is NOT a disorder, a disease or sign of weakness. It is an emotional, physical and spiritual necessity, the price you pay for love. The only cure for grief is to grieve" -- Earl Grollman

unspokengrief.com
The work of the human person is to carry grief in one hand and gratitude in the other... at the same time. This is how we are broken open to all of life — by feeling both; by living with both.

Am I recognizing the daily things in my life for which I am grateful? I will write down at least 1 thing each day for which I am truly grateful. Not what I “should be” grateful for, but what I genuinely am grateful for.

I will write something I’m grateful for each day for 7 days and bring to our next group.

1.
2.
3.
4.
5.
6.
7.
MATERIALS FOR WEEK 4

Letting Go of Regrets

1. Review Confidentiality Agreement
2. "Emotional Weather Report" Feelings Sheet
3. Quote: “The worst regret...”
4. Quote: “There are things we don't want to...”
5. Processing of feelings related to quotes

BREAK (10 minutes)

6. Therapeutic Art Experience: Ritual of creating wreaths representing those people or things we have lost and are grieving
7. Serenity Prayer
the worst regret we have in life is not for the wrong things we did, but for the right things we could have done but never did.
Grief is in two parts.

The first is loss.

The second is the remaking of life.

- Anne Roiphe
I wish you would...

I wish you would not...
Jamie’s pencil sketch made when she left group to draw.
MATERIALS FOR WEEK 5

Week 5 Grieving While Rebuilding Our Lives

1. Review Confidentiality Statement
3. “We are a product of our experiences...”
4. Memory prompts placed in glass jar as each woman shares

BREAK (10 minutes)

5. Process the glass jar contents
6. Journaling with memory prompts — Sharing journal experience
7. Serenity Prayer
Group 5 Memory Prompts

A funny/fun time with my loved one was when

The hardest thing for me about my loved one was

My loved one’s favorite food (scent, events, sports team, holiday, color, clothing, person, etc.) was

The best way I can honor my loved one is
Week Five – We are a product of our experiences and these need not die when a participant in that event dies. Grieving individuals may need to be encouraged to:

- Recall humorous events
- List qualities of the deceased person that impacted them
- Review the time/events important to both
- Review the struggles in the relationship
- Identify change in self due to that other individual in their life...how I changed for the good.
- Identify how the deceased/lost changed for the good because I was part of their life.
- List favorite foods, scents, events, (sports) teams, holidays, colors, clothing, of the deceased, so you never forget; and to share the history of that person with others (possibly children and/or grandchildren).

**ACTIVITY:** Write each of the bullet points (above) on pieces of cardstock. Make enough of each one so that each participant can access each sentence. (5 group members; 5 of each sentence.)

- Read the statement above before beginning activity to place activity in context.
- Place all cardstock in center of table, accessible to all participants.
- Have 1 woman choose a card and share her experience while group members listen.
- Go around the circle/table and let women keep choosing then sharing until all have shared. Keep choosing and sharing for the time allotted.

**BREAK**

Upon return from break, journaling exercise in which women write how they were changed and how they changed their loved one 'for the better” due to being in each others’ lives.

Process with group.
Week Five – Grief & Loss Support Group

Dear ________________________________,

I am thinking about you right now. I remember lots of things about our time together. I am going to write about some of them now and share with my counselor or the group. I’m going to do this, because sharing about our time together, and how much I hurt since you’ve gone, is healing to me. Sometimes I believe this, and sometimes I don’t, but people who support me say: “Life is unfair, and pain is always lessened by love and connection.” I am going to believe that today and share a little of my grief because I want to be honest about how I feel with others who understand. I want to support other people, and I want to receive their support for me.

I love you and thank you for our time together and all the memories we made which strengthen me today. Love;

Having you in my life changed me in many ways. One way I changed for the better is

Having me in your life changed you in many ways. One way you were changed for the better because of me is
Where I Was...Where I Am Now

1. “Emotional Weather Report” Feelings Sheet
2. Grief is a Process — It takes as long as it takes
3. Therapeutic Art Experience: A House, a Tree, A Person
4. Processing and sharing

BREAK (10 minutes)

5. How have I grown? How will I continue to care for myself?
6. Handouts of MiddleWay Ministries card and information. Explain how to stay in touch, should they desire to do so. Provide website, MiddleWayMinistries.org
7. Graduation with cupcakes, drinks, and gift bags with toiletries for women
8. Serenity Prayer
Supplementary Materials for Grief & Loss Group

1. **Draw a picture of your relationship with your grief & loss when you began the Grief & Loss group.**

   *Include a House, Tree, & a Person.*
   This is not an art-test. Use the materials in any way you desire to represent your feelings.

2. **Draw a picture of your relationship with your grief & loss as of today.**

   *Include a House, Tree, & a Person.*
   This is not an art-test. Use the materials in any way you desire to represent your feelings.

The women were provided color pencils and white rectangular paper for drawing.

Ocean sounds played as the women worked.

Each woman was given the instructions (above.)

**Following activity, we processed feelings, changes, etc. which the women noticed in themselves and in their drawings.**
and like a seed I grow because I am lovingly cared for.

How have I grown in understanding myself and my grief because I chose to be part of the Grief and Loss support group?

I pledge to "lovingly care for myself" each day by...
peace.

It does not mean to be in a place where there is no noise, trouble or hard work. It means to be in the midst of those things and still be calm in your heart.

(unknown)
“When I had grief and loss with no healing, I carried the weight of the world on my shoulders. Even my tree is stunted and crying...and the roots are dying.”
"After I recovered myself, I no longer held the weight of the world on my shoulders. My tree is thriving and there are lights on in my home. My arms are open wide."
When I began group, everything was black in my world. I felt suicidal and homicidal. My hair was blue...because I don't like blue.

After coming to group, there is sun coming through a cloud. The tree is alive. I’m not ‘happy,’ but I’m neutral. My hair is pink, because I like pink. I guess I have hope.
“I feel the same. I don’t know how I feel.”

(Group members commented that the tree is alive in the second drawing and the person has eyes, nose, and mouth. She is also smiling. The woman who created the drawings was then able to notice the differences).
Thank you in advance for providing your feedback. Your responses and insights help us create programs which are truly helpful to women in the NE Ohio community.

The most important thing I got out of being in this group is…

Being able to open up

Something I still want to work on for the next three classes is...(be specific):

Talking more about my loss

I wish I could have found more healing/support for myself around this specific issue...

My daughter’s death

If I recommend this group to another woman at CATS, I would tell her...(be specific):

That it is a helpful group and safe
A collage from the Art & Spirituality group
Women's Wisdom Circle
Facilitator’s Response to the CATS Women Praying in Color
Higher Power

Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.

"The Sacred Art of Living & Dying is necessary because spiritual suffering is the least diagnosed cause of pain."
Dana Claye, Sourcebook
IRB Approval Notification

JOHN CARROLL UNIVERSITY
THE JESUIT UNIVERSITY IN CLEVELAND

NOTICE OF APPROVAL.

Responsible Investigator: Pam Charney
Faculty Sponsor: Sheila McGinn
Department: Theology and Religious Studies
IRB Log Number: 2016-044
Title: "Houses of Healing at C.A.T.S."

Approval Date: 2/3/2016
Continuing Review Notice Due: 1/2/2017
Expiration Date: 2/2/2017

Thank you for submitting the IRB Application for Human Subject Research. Your application has been reviewed and approved via Full Board Review.

Please adhere to the following IRB policies as appropriate:

- If changes are made in the method of handling human subjects, please inform the IRB Administrator immediately. Changes may not be initiated prior to receiving IRB approval.
- Any adverse reactions/incidents should be reported immediately to your department chair/supervisor and the IRB Administrator.
- IRB approval is given for not more than 12 months. If your project will be active for longer than one year, please submit a memo to the IRB chair requesting a continuance prior to the end of the 12 month period along with current consent forms and research instruments.
- Consent forms should be kept for a period of three years after the end of the project.

You can access the IRB web site at http://sites.jcu.edu/research/pages/irb/ for additional information. If you have questions, please contact:

Carole Kraus, IRB Administrator
(216) 397-1527 or ckrus@jcu.edu

Dr. Elizabeth Swenson, IRB Chair
(216) 397-4434 or swenson@jcu.edu

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