Bronx Community Action for Prenatal Care (CAPC) Initiative Annual Conference

The Future of Healthcare: Challenges of Healing Women In the Urban Setting

March 21, 2012
Villa Baron Manor, The Bronx

Conference Proceedings Report

Report prepared by The Bronx Health Link, Inc.

Sponsored by: NYS Department of Health / AIDS Institute, Bronx Lebanon Hospital Center/Department of Obstetrics & Gynecology, BLHC/Office of Development and External Affairs, the NYC Department of Health/Infant Mortality Reduction Initiative, Bio Scrip, and Abbott Laboratories

About the Bronx Health Link, Inc.

The Bronx Health Link, Inc. (TBHL) is a unique collaboration created in 1998 by Bronx-Lebanon Hospital Center, Montefiore Medical Center, Our Lady of Mercy Medical Center, and St. Barnabas Hospital—and the office of the Bronx Borough President. The shared vision was to build an organization that addresses community concerns by creating linkages between the different providers, organizations, coalitions and stakeholders that serve Bronx communities. The goal of TBHL is to create a platform for the involvement of residents and other stakeholders in public health planning, programming and decision-making. TBHL currently works with over 150 community organizations and providers. While TBHL serves the entire borough, the focus is on low-income neighborhoods with the highest-risk poor health outcomes, many located in the 16th Congressional District, the poorest urban Congressional District in the United States.

The Bronx Health Link, Inc. is an organization that serves as a clearinghouse for the members of the health and human service delivery system of the Bronx. In this capacity, we reach over 1100 members and agencies that actively participate in an electronic mailing list and numerous workgroups, advisory boards and task forces. We also coordinate the Perinatal Information Network and thus work extensively with the community and health care providers with the aim of improving birth outcomes, prenatal care and the reproductive health of women in the Bronx. The Bronx Health Link works with many community partners to improve the overall health of Bronx women, children and families.

Copies of this report can be obtained by calling The Bronx Health Link at (718) 590-2648 or emailing info@bronxhealthlink.org.

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Finally, thanks to the conference sponsors: NYS Department of Health / AIDS Institute, Bronx Lebanon Hospital Center/Department of Obstetrics & Gynecology, BLHC/Office of Development and External Affairs, the NYC Department of Health/Infant Mortality Reduction Initiative, Bio Scrip, and Abbott Laboratories.

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Purpose of the Conference

The 2012 annual conference of the Bronx Community Action for Prenatal Care (CAPC) Initiative, held on March 21, 2012, was titled *The Future of Healthcare: Challenges of Healing Women in the Urban Setting,* which explored effective interventions geared at CAPC women. The forum provided attendees with the latest HIV perinatal transmission facts and guidelines. This one-day forum encouraged networking, collaboration and sharing of information and resources. Strategies for keeping women in care and utilization of the Bronx Community Action for Prenatal Care program (CAPC) were promoted.

The forum engaged physicians, midwives, nurses, social workers, case managers, outreach workers, consumers, faith-based community members, administrators and police officers from organizations and programs that care for women, children and families.

Objectives were to:
• Increase awareness of the challenges of healing women in the urban setting.
• Review HIV perinatal transmission, treatment guidelines and statistics.
• Explore effective interventions geared at women with histories of trauma, substance abuse, domestic violence, and developmental delays.
• Discuss the coordination and collaboration of coalition resources.

The morning session included a panel discussion on challenges in the service delivery in providing trauma, advocacy, housing, domestic violence, substance abuse services, and consumer involvement. Workshops were offered in the afternoon.

Conference Program:
The Future of Healthcare: Challenges of Healing Women in the Urban Setting

Morning Session

8:30 *Registration, Exhibits, Networking, Continental Breakfast*

9:30 **Greeting –** *Pastor Que, Bronx Clergy Round Table*

9:45 **Welcome –** *Magdy Mikhail, MD, Rodney Wright, MD, and Tess Timoney, CNM*

10:00 **Bronx CAPC Statistics & Accomplishments –** *Nancy Genova, MPA*

10:15 *Break, Exhibits, Networking, Refreshments*

10:30 **The Real Housewives of the South Bronx –** *Rodney Wright, MD*

11:00 **Keynote Address –** *Marsha Woodland, author of* Doomed to be Nothing; Destined to be Something

11:30 **Panel Discussion: Challenges in Healing Women in the Urban Setting**
Panelists: earlier speakers plus Tanya McLeod, Voices of Women Organizing Project, and Dita Dobroshi, LMSW, Steinway Child and Family Services

Afternoon Session

12:30 *Buffet Lunch, Exhibits, Networking*

1:30 **Special Presentation**

1:45 **Workshops:**
- **Trauma and Domestic Violence**
- **New Challenges to Perinatal HIV Prevention: Working with Perinatally Infected Youth & Pregnant Women**
- **Hepatitis**
- **Incorporating Complementary Medicine Toward Healing**

3:45 *Break, Networking, Submission of Evaluations*

Morning Session

The conference opened with greetings from **Pastor Que** of the Bronx Clergy Roundtable. She stated that given the Bronx's high rate of recidivism, will important to expand the partnership his group has created between faith-based and community-based organizations (CBOs). She said the Roundtable is a cross-denominational group that has been working with state legislators on this issue and wants to partner with more CBOs. She urged attendees to "strategize outside our own box."

Magdy Mikhail, MD, Rodney Wright, MD, and **Tess Timoney, CNM,** welcomed the group and thanked the staff of Bronx CAPC for its hard work in bringing the conference to fruition, as well as all of the funders who contributed. Ms. Timoney added that every child deserves to be born in dignity and thus every pregnant woman deserves to be treated with dignity. But she expressed concern that health-care institutions do not always do this; they are not always welcoming. For example, during labor, if a woman's urine toxicology is positive for drugs, she is at terrible risk of being treated very harshly. The Bronx CAPC's work is to bring women in for care before that moment. CAPC tries to build a bridge to the woman who has not felt entitled to access care.

CAPC Statistics and Accomplishments
by Nancy Genova, MPA, Program Director of Bronx CAPC

Ms. Genova began by reporting that in the past year, Bronx CAPC had lost 10 outreach workers (from 34 to 24) due to budget cuts, so referrals from CBOs decreased significantly, and some CBOs ceased being partners. For the same reasons, in 2011 a higher percentage of clients were pregnant adolescents. Meanwhile CAPC continued to help clients overcome barriers to medical access by providing transportation help (which became more expensive due to a fare hike), case management, and referrals to substance abuse treatment.

At a time when the state government is moving to embrace "health homes" for care delivery, that is precisely the CAPC model and it works well. Other health homes that have been approved in the Bronx include Montefiore Medical Center, Bronx-Lebanon Hospital Center, Health and Hospitals Corporation, and Visiting Nurse Service.

As to the future of CAPC, Ms. Genova said that it will probably have to restrict its targeting only to HIV-positive pregnant women, not those pregnant women more broadly at risk of adverse outcomes. Many HIV-negative women no longer stay in care after birth and then come back HIV-positive in their next pregnancy. Ms. Genova appealed to HIV advocates to team up with CAPC to advocate for more funding. If that cannot be achieved, women in the Bronx risk losing the gains that CAPC has made – and any future restoration of services will be more labor-intensive and costly.

The Real Housewives of the South Bronx
by Rodney Wright, MD

Dr. Wright began by observing that on the TV show, Real Housewives are all glamorous. But in the South Bronx, there is a different reality. As a real-world example, he cited "Patient X," a woman who presented as what staff called a "crackhead" (the very name creates a specific image). She was thin with bad skin and wore a wig; she was 30 years old and had been HIV-positive since age 15, acquired through sex. She had a history of cocaine abuse. She also had a large scar around her rectum, the result of being raped by her father with a broomstick when she was 5.

Using the federal poverty level ($14,710 annual income from a family of two) as a measure, the South Bronx is the poorest district in the U.S.—38% of all residents and 49% of children are below the poverty line; 75% of families in poverty are female-headed. Also 37% of residents reported that they couldn't afford to buy food at some point in the past 12 months. What's known as the "Bronx Hunger Paradox" is the fact that the South Bronx has the highest rates of obesity in New York City but also the highest rates of lack of adequate food ("food insecure"). This is because obesity results from reliance on poor quality food.

In addition, the Bronx has been found to be the unhealthiest county in New York State, including very high chlamydia rates and the state's worst role of particulate-matter air pollution (which can cause asthma) and the second highest number of smokers. Also there is a high rate of intimate partner violence (IPV), and the South Bronx has the highest rate of IPV homicide in NYC. In addition, hospitalization goes up for women during pregnancy due to IPV, which has been found to cause an increased rate of miscarriage. Dr. Wright cited a case of an African immigrant woman who was kicked and beaten and then lost her pregnancy.

Dr. Wright also discussed the profound effects of childhood neglect on adult women – one study found lower self-esteem, more opposition to using condoms, and more HIV-risk behavior. Another study found that early and chronic sexual abuse correlated with seven times the HIV-risky behavior; it also found that 51% of women engaging in such behaviors reported a history of childhood abuse.

South Bronx neighborhoods have among the highest HIV-positivity rates for women in NYC – overall around 2%. This is higher than the rate in Ethiopia, Rwanda, and Nigeria. Why? There is an interplay between low self-esteem, decreased condom use, living in poverty, and being born into a family with HIV-positive members.

Dr. Wright then discussed the additional problems generated by psychiatric conditions during pregnancy. Among those are lower participation in prenatal care, poorer birth and

infant outcomes, higher rates of postpartum psychiatric conditions, and increased rates of substance abuse. Many studies have found poverty to be linked with much higher infant mortality rates and increased levels of such conditions as pre-eclampsia, low birth weight and prematurity. There is a large racial disparity in these rates, as well as for stillbirth, for which Black people are at far higher risk. Dr. Wright noted that the film "Precious," about a young Black woman addicted to drugs who had a stillbirth, is a very real representation of many of the patients he and other doctors encounter in the South Bronx on a regular basis.

What can be done to reverse these problems? Dr. Wright made clear that the methods to have an impact are well-known. Efforts to address disparities are most effective when focused on improvement of maternal and perinatal health as a whole. Programs to counsel and support women in reducing obesity and stopping smoking are very important – but those very programs have recently been severely cut. Culturally appropriate prenatal care, delivered in a language the woman understands, is key. Such care programs need to be held accountable for high quality standards. A very important principle is "meeting patients where they are at"—particularly with patients seen as "difficult." Dr. Wright urged clinicians to "throw judgments out the door and keep an open mind." After all, he said, "you don't know them."

Another important area emphasized by Dr. Wright in caring for pregnant HIV-positive women is practicing trauma-informed care. That means having frank conversations about trauma, recognizing that many women carry a lot of shame. So creating a safe space for them is important. And more generally, Dr. Wright urged clinicians to provide psychosocial support to victims of trauma BEFORE they become HIV-positive. And for those victims who are positive, providing them with continued support to reduce risk behaviors. Finally, he urged the use of harm reduction programs and risk-reduction programs that specifically address trauma.

Dr. Wright explained the various ways that the CAPC program works on these issues. He explained that CAPC:

- Reduces perinatal HIV transmission and infant mortality
- Provides a comprehensive continuum of care for all childbearing age at risk women
- Assures care in culturally and linguistically appropriate settings
- Serves as a resource to providers and agencies and to the community at large
- Provides outreach to women in the community not linked to services
- Engages women to seek prenatal and women's health care
- Serves as a clearinghouse to help navigate patients to the correct services / agencies (since clinics are not always user-friendly).

Dr. Wright briefly summarized the history of prenatal care, going back a century. He said that its greatest benefits – including reduced risks of low-birth weight, pre-term birth, infant and maternal mortality – have been found to accrue to socially disadvantaged

women. Research has found that women who obtain late or no prenatal care tend to be younger and are more likely to be African American, immigrants, and non-graduates of high school. Among the challenges to keeping pregnant women in care, those most commonly cited by women are lack of insurance, lack of transportation, ambivalence about being pregnant, language barriers, and dislike of the way they were treated by clinic staff. (However, he noted, in New York State, virtually all pregnant women qualify for some type of health insurance.) CAPC can help women find care.

Treatment by clinic staff is an important barrier to care. One study found that 13% of pregnant women missed or delayed appointments because of their perceptions of how they were treated. Dr. Wright noted that since many of these patients are already dealing with shame and embarrassment from past trauma, if front-desk staff judge them and treat them harshly – which he said many do – it will seriously discourage women from returning. He advised that prenatal care programs educate their front-desk staffs in particular (and all staff) about the importance of treating people nonjudgementally. For clinicians, he again emphasized meeting patients "where they are at," learning to be a good listener, and being supportive. Given the diversity of Bronx patients, he advised taking advantage of available resources for applicable populations, such as the African Services Committee and Sauti Yetu Center for African Women.

Social workers and outreach workers are key to maintaining difficult patients in care by:

- Locating patients who have been difficult to contact
- Assisting patients in making and keeping appointments
- Assisting in communicating patient needs to medical providers
- Ensuring that patients are able to stay in care after birth.

In closing, Dr. Wright recommended that providers work for improved access to mental health services and substance abuse treatment (which have recently suffered budget cuts), family-centered care, and a CAPC-type one-stop-shopping approach to care.

Keynote Address
by Marsha Woodland
***author of* Doomed to be Nothing; Destined to be Something**

Ms. Woodland began by explaining that she is a trauma survivor, having endured domestic violence, substance abuse, and rape. She said, "I am that woman in 'Precious,'" adding, "Every woman and baby deserved to be treated with dignity." Her early childhood experiences, she said, had a lot to do with "why I said OK to no-condom and why I stayed with men who committed domestic violence." She said she had the mentality that a woman had to give a man what he wants when he wants it. She did it for years without getting anything out of it. She had been socialized to believe that it's more important to be in a relationship with a man than to take care of oneself. She placed more value on the man than on herself or her child – although none of this was conscious. She added, "If you are a provider and you don't understand this, you will give up on me the first time I drop the ball."

So her experiences have led her to give voice to victims of domestic violence and HIV. She travels around the country advocating for women who are HIV-positive and drug users. She said that these women often don't get treated right by their providers, who are often overwhelmed, overworked, and underpaid – and feel threatened by their clients. "How can you help me if you don't know me?" she asked. "It angered me – I was never invited to be part of my own journey. I am the expert on me." At the same time, she acknowledged that there are a lot of service providers who do share the power.

She described how she had two babies while on crack. In each case, she was depending on the baby to give her love. But she was too embarrassed about her circumstances to get prenatal care. With the first birth, the delivery nurse looked on her with disgust, and she was escorted out of the hospital. In the cab home, she hemorrhaged and the baby daughter was born as she rode back to the ER. But nobody told her for three days that the baby had actually died en route to the hospital. Adding insult to injury, her baby was cut up and put in a jar for study without consulting her. "What I learned," she observed, "was that I wasn't worth nothing."

During her second pregnancy, her doctor cursed her ("he was thinking, 'How dare she?"). She gave birth to a two-pound baby (who today is healthy at age 15). Taking crack was a form of adaptation to molestation at age 5 and gang rape at age 15. "If I could have stopped, I would have." She advised, "It's not enough to tell me how to do it." She had read books and gone to NA (Narcotics Anonymous). But someone had to show her how to stop killing herself with risky sex and sexual abuse. "Dying was better than living. I didn't know how to live another life without being taught." Fortunately, a case worker from child protection never gave up on her. "Eventually she caught me, because I was hurting bad enough to talk with her. She said, 'I'm afraid you're gonna die.' She treated me with love and respect, and took me to a drug treatment center. This shows the power

of love." Ms. Woodland said her case worker wanted her to enter an 18-month program, but she did not want to be separated from her daughter that long. So she ended up in a 28-day program. She said one of the useful exercises was being asked to reflect on her eulogy. "If you died today, what would people say about you, and what would you like them to say?" Her counselors and social workers nurtured her and helped her learn to be a better woman. She appreciated the fact that she was empowered to make her own decisions – the treatment was never coercive or manipulative. "I trusted no one."

Ms. Woodland urged programs to keep an open mind about new possibilities. Some women have no idea who they are, but providers can help them. "Give them an opportunity to be part of their own process." She recommended peer-run organizations. She also advised, "Don't be so programmatic that rules and regulations overpower the whole process."

As to domestic violence, she urged providers to realize that offenders are victims too. "Until we recognize that, we won't do anything." Some women don't feel worthy enough to be by themselves. She said that services need to start following women into the home and community. She remarked, "Treatment has taken me from the crackhouse to the Dean's list."

She advised providers, "I know it's difficult to deal with people like me – but we're not always being difficult or oppositional. You providers are a lifeline." She acknowledged that caregivers sometimes feel hopeless – "you hurt too" – and that they need support as well.

Ms. Woodland summarized a study of women at risk for HIV that had women list how many traumas they had experienced, from 1 to 10. The study found that women with a score of 4 or more were highly likely to become HIV-positive and an injection drug user. "I had a score of 10," she noted. "There's still a level of prejudice against many women, especially minority women," she said. That's why she founded the Building Bridges Foundation (http://building-b-foundationsproject.org).

In closing, Ms. Woodland offered advice to caregivers of women who have experienced trauma: "We have to start addressing causes of conditions. My mentality was 'I'm not about nothing, I'm doomed to be nothing, so I might as well be high." Check yourself: If your help diminishes hope, it's not help, it's hurt – you're exacerbating my pain. Use that as a yardstick in dealing with consumers."

During the question period, she added, "Invite the consumer into the process. Take the time to build some form of rapport."

Panel Discussion/ Challenges in Healing Women in the Urban Setting
Panelists:
Tess Timoney, CNM; Rodney Wright, MD; Nancy Genova, MPA; Marsha Woodland
Tanya McLeod, Voices of Women Organizing Project, initiative of Battered Women's Resource Center
Dita Dobroshi, LMSW, Steinway Child and Family Services

Ms. McLeod said her program, Voices of Women Organizing Project, provides services to women *after* they have left relationships in which they were subjected to domestic violence.

Ms. Genova said that CAPC's funders will be cutting back, and starting in 2014 will only fund programs serving HIV-positive pregnant women and HIV-positive women overall – no longer women at high risk of becoming infected. Yet past experience has shown that CAPC's services have helped these women to remain HIV-negative. She said that severely abused victims especially need the extra help to move forward. She added that women who are often referred to CAPC after doctors and social workers have failed to engage them, and commented, "Our workers work outside the box and go the extra mile – they understand all the dynamics of the women we serve."

In response to an audience question about how to deal with African women raised to believe that if a wife disobeys her husband, he is entitled to hit her, Ms. Woodland said, "Start with education of the woman. I was unaware that I didn't have to leave sex feeling dirty." Dr. Wright said women need to be taught that sometimes cultural practices are not right. He added that Cicatelli Associates offers trainings on trauma-informed care. There are also programs in the community that target men with the message that "loving your wife does not mean beating her." Ms. Woodland said, "Peer support is amazing. It made a difference to know that I wasn't the only one."

Ms. Timoney said it can be really painful to take care of a woman who has no say in her reproductive future. It is important to help providers understand that many African immigrant women don't see any other path. "We have to struggle not to sit in judgment, such as in the comment, 'What are they doing having another baby?'"

Ms. Woodland said she is working on an initiative in Maryland designed to determine what difference it would make to provide the same amount of attention and services to men engaged in domestic violence as to their women victims.

Ms. Genova said CAPC has a community partner called "Friends to Fathers," to which CAPC refers the male partners of its women patients. Many of these men have histories of incarceration, and the social workers at the program are men of color who can relate to them. This is in contrast to the norm in this field – most social workers and psychologists are women. She commented, "If you are a man of color and have a history of abuse and

repeating patterns, it can be challenging to tell your story to a female, especially a white female." Unfortunately, this is the only such program in the entire Bronx.

Dr. Wright urged participants to get out and vote. He also advised listening to what the other side (conservatives advocating budget cuts) is saying. He said, "We need to mobilize to make sure we still have the funding we need." Ms. Genova echoed this call, nothing that many programs won two decades ago are being slashed or disbanded – for example, Start Strong in the South Bronx. She said that even the best presentations of data will do nothing unless accompanied by pressure on elected officials. "Get in their faces til they get so angry they're willing to do something about it," she advised.

One audience member asked about the potential to alter men's behavior through faith-based organizations. She observed that she finds "subtle" advocacy of violence in the church through reinforcement of male supremacy. Dr. Wright added that the religious rightwing often claims the mantle of Christianity to justify men acting in that way.

Ms. Dobroshi said that male abusers often are suffered from PTSD. An audience member suggested that it is important to reach young men with education before they become fathers.

Ms. Woodland said, "I was as screwed up as my family dynamics made me. If I had permission to be screwed up without being judged, I would have accepted services. But I want to be involved in what's happening to me."

Dr. Wright advised that providers cannot rely on government, that they have to rely on themselves and their communities. Ms. McLeod observed that defunding can be an opportunity to re-strategize about the direction of programming. Ms. Genova noted that The Bronx Health Link is involved in advocacy and mobilizing, but that a bigger number of participants is needed.

A question was raised about domestic violence services for veterans. Dr. Wright said there are no programs in place, making the home of veterans' partners "a dangerous place." Ms. Dobroshi advised caregivers, "When a veteran comes in, let them talk, let them find ways to heal."

Afternoon Workshops

Trauma and Domestic Violence
Part I: by Dita Dobroshi, LMSW
Part II: by Sabra Jackson and Tanya McCloud

The breakout session centered on the trauma experienced by women who have undergone domestic violence and the journeys they took to heal from their experiences. The session was in two parts. The first half of the session consisted of a presentation by Ms. Dita Dobroshi, mental health therapist at the Steinway Child and Family Services (www.steinway.org) in the Bronx. The second half of the session was a presentation by Ms. Sabra Jackson and Ms. Tanya McCloud from the Voices of Women Organizing Project (VOW) (http://vowbwrc.org), lead initiative of the Battered Women's Resource Center.

Part I

In Part I, Ms. Dobroshi delivered a presentation consisting of testimonies about three of her clients. The clients represented people from different age groups who had survived domestic violence and were eventually healed from the trauma resulting from the violence. She divided her testimonies between a child, an adolescent and an adult, each of whom had survived domestic violence and was able to heal with the aid of therapy sessions with Ms. Dobroshi. (For excerpts from her presentation, see Appendix.)

At the end of her presentation, Ms. Dobroshi said that what is most important in dealing with trauma is to engage the client. "You have to kind of just absorb what they are saying, with a face of no judgment, such as ones who stay with their boyfriends who are so abusive and negative towards them. And try to find ways to help them build their strength." She added that a relationship with a therapist is very important with a good rapport and a place to feel safe. It is also important to have a good relationship with a mom and dad, or a sister -- someone with whom they can be comfortable. She noted that women develop a strong relationship with their therapists and feel safe in the space they create. "I have to listen through the horror and keep it and contain it. Be still with the client. Also just focus on their strengths and tap into their ability to be a mother, a sister, and that they can achieve and do anything they want to do."

Ms. Dobroshi observed that Post Traumatic Stress Syndrome is not just for the military; it can happen to children too. Sometimes we think that it happens because it is the South Bronx, but it could happen anywhere else.

Part II

The second part of the session focused on the work of Voices of Women Organizing Project (VOW), an organization that advocates against domestic violence and that works to improve family courts in NYC, insure housing options for victims of domestic violence and their children, and discourage false and malicious reports of child abuse to the Administration for Children's Services (ACS). VOW members are diverse and the organization serves all five boroughs.

Ms. Sabra Jackson and Ms. Tanya McCloud hosted the second half of the session. Ms. Jackson, herself a survivor of domestic violence, is a proud member of VOW since 2000, as well as a Board member. Tanya McCloud, also a survivor of domestic violence, is Senior Campaign Organizer at VOW. They showed a short video on the organization's work and its impact among women who survived domestic violence.

After the video, Ms. Jackson and Ms. McCloud each described her own experiences with domestic violence and the journeys they took to reach a state of healing from the trauma, while drawing upon points made in their presentation document (see Appendix).

To introduce their presentation, Ms. McCloud talked about the journey from victim to victor, noting that such a person experiences many milestones. The intimate partner relationship can continue through that person filing malicious reports to the courts. So how does one begin to heal? She said there are certain milestones that victims reach in dissolving fear which include: understanding your rights; knowing when to reroute; getting unstuck; and crafting your message for yourself and a wider audience. Oftentimes, victims are managing their abusive relationships. Mothers are able to function with a regular job, covering up defensive wounds and keeping children occupied so that they are safe.

Ms. McCloud spoke of her work "Tonya's Story" based on the domestic violence abuse she experienced. She then provided contact information for women who wish to become members of VOW.

Nancy Genova then thanked the VOW representatives for their presentation on the process of healing from the trauma of domestic violence, their ability to articulate it, and the audience for listening.

Questions from the audience:

Question 1: I have a question about the response from lawyers, judges and police. Do you think that some people are getting it?

Answer: I think it is an amazing response, especially from ACS. VOW did 2 presentations at ACS: one in October 2011; one recently in January of this year. We have another one scheduled in May. I do this with my sons. We actually put on a skit of a 60-day investigation. We called it a "Child Survival Speak-out". They share the actual story of the effects of false and malicious reports. And what has been amazing is hearing men speak up and speak out against domestic violence. For some reason, it's more effective to call on VOW to give presentations.

Question 2: You kept noting that you have to create a safe space for your clients and they have to feel safe. Even though it sounds like you have long extended time with your clients/patients, as clinicians, we have very short periods with our clients -- every 3 months if are lucky or maybe one or two contacts. How can you create this kind of space where the patient feels safe?

In the beginning there is paper after paper and question after question. So I allow the client to come in and tell me their story right away. I don't bog them down with the paperwork right away. I let them tell their story and whatever I can piece together from their story I put in the paperwork afterwards.

But the issues with being safe, I think how a person feels comfortable and relaxed are other words for "safe." When I have them in the room, I make them safe by listening to them and reflecting what they said to me, so that they feel heard. If they are giving me an emotion, describing emotion in ten different sentences, I just say, "It seems like it was painful for you. It seems like you were sad, like you were frustrated." Just this validation of something they were trying to get out in ten sentences. And sometimes, when kids or adults come, they don't feel it is OK to tell their secrets. They don't have the words to express their secrets.

To reassure them and to nudge them in a gentle way, and to make sure there is movement in the treatment, not necessarily that you start somewhere, they give you a story and you are stuck there. I ask them questions to make them feel comfortable enough to give movement in the therapy. And with movement comes the depth and that is where the true stories come. Some sessions are more difficult than others, but hopefully with time they get more comfortable. You are actually there to help them as best as you can.

Question 3: I understand the safe space from the provider's perspective: the safe space to meet them where they're at and everything in those days when they are giving you the dramatic situations. As a provider, how do you deal with that? Even if you have a poker face, you are there, you deal with them in that safe space. You can go back to something that happened to you. How do you deal with it? It can be very difficult.

Answer: Absolutely. In a word, it is a kind of transference. It triggers something of your own past history, and then comes the question: How do you not bring that into the room?

How do you stop and not bring that in the room and make it their own, the clients' space? So the answer is: supervision, therapy, and my outside relationships with family and friends. I don't share stories so much with family and friends, but definitely with supervision and therapy. That's my safe place. That's where I can decompress. And so, of course, we are all human. So we want to cry sometimes, or we want to scream or run out of the room, but being able to understand that that is sheer pain that you are hearing, you deal with it afterwards and try to handle it as best as you can in 45-minute increments.

Question 4: I am a worker in a non-profit organization in the South Bronx. And I have parents who sometimes come in – and they feel it is a safe house from their abuser – with their children, to seek help. They think if they come in to seek help, their kids will be taken away from them because they didn't do something about it before. So, what can be done? They feel,"If I go to get help, because I cannot leave because he is paying the rent, otherwise I won't be able to pay the rent. I don't want to be left without a house. How can I come and ask for help? I feel that getting help will end up with me losing my children." So there's a gap there, that most of the time is not addressed. Yes, we can empower them. Yes, we can give them all the information, but in leaving they feel that they will lose more than if they actually stayed.

Answer: I felt that same way. I lived in a luxury apartment I had obtained through the shelter and my rent was low. I am actually still in that apartment 23 years later, I was afraid of leaving my apartment and I lost my job due to domestic violence. So the first thing I would say to you is tell them what their options are.

You could provide some options for them, which could have me going to a domestic violence shelter and putting a spin on it because it can be life or death. Abusers often isolate and control the finances. Even though I was working, my husband controlled my money as well. So giving some realistic options and creating a safety plan with that person and to let them know what their rights are – that they have the right to be safe; they have the right to protect their child; and it might be difficult but it's not impossible.

Question 5: Does VOW serve undocumented individuals?

We do have members who are undocumented.

New Challenges to Perinatal HIV Prevention: Working with Perinatally Infected Youth and Pregnant Women
By Vicki Peters, MD

Dr. Peters first described the epidemiology (health-characteristics in a population) of youth who acquired HIV infection though prenatal transmission. She detailed the methods and history of the NYC Department of Health and Mental Hygiene's collection

of data on infants and children with HIV and AIDS. She noted that data were collected from medical records, not personal interviews. She observed, "It is important to remember that these data and case presentations represent unique individuals, and that HIV-infected individuals are *people.*"

The U.S. perinatal HIV epidemic was recorded as having began in 1977. At its height in the early 1990's, between 1,000 and 2,000 HIV-infected infants were born nationwide each year. But by 2005, due to the widespread testing of pregnant women and use of antiretroviral therapy, the estimated number of HIV-infected infants had dropped to 100-200. She said this was a gauge of the success of those prevention efforts. Today there are an estimated 8,700 annual births to HIV-infected women, and without prevention efforts 2,000 of these babies would have become HIV-positive.

In New York City, the number of perinatally-infected children (including both those who died and survived) peaked at 350 in 1990. Both number of perinatally-infected children and the number of deaths related to perinatal infection have dropped to very few in 2011. Among perinatally-infected children, 2,456 (62%) are alive, of whom 2,209 (90%) are 13-25 years of age, as of 12/2011. Many children survived perinatal infection and are now adolescents (aged 13-24).

Adolescents between the ages of 13 and 19 are more likely to have HIV than AIDS (over 2 of every 3), whereas those between 20 and 24 are more likely to have AIDS than HIV (over half).

In an analysis of perinatal HIV transmission between 2005-2011 at 16 NYC sites, it was found that 25% of children who were born to HIV-infected parent and did not receive antiretroviral treatment were infected with HIV. Among those women receiving treatment during pregnancy, transmission rates were lowest among deliveries with 3-arm treatment regimens prescribed during the prenatal, intrapartum, and neonatal periods – as opposed to just one or two of those periods. HIV transmission rates were highest among deliveries with maternal risk factor of injection drug use (4% of mothers) or their own perinatal HIV infection (7% of mothers). The highest HIV transmission rates were among deliveries with maternal HIV viral load above 1,000. A study of 1,885 deliveries to HIV+ positive women in NYC from 2005-11 found that **7%** (141) of such deliveries were cases of missed opportunities to prevent transmission.

There has been a spike of perinatally infected cases among the 20-24 age group, almost two thirds of which are in Men who have Sex with Men (MSM) and most of the rest are in heterosexual women. Perinatally infected women are most likely to be diagnosed before pregnancy.

A *New York Times* article on HIV-positive children (November 5, 2010) found that they can be susceptible to "yo-yo-ing" symptoms, developmental delays, and hostility toward

the HIV-positive parent. It contained personal testaments from perinatally infected children.

In summary, transmission rates are at an all-time low. But the first generation of children born with HIV are now of child-bearing age themselves. Failures include a lack of or inadequate prenatal care, substance abuse, problems with the antiretroviral therapy or with patient adherence to their treatment regimen.

Dr. Peters then walked the participants through a mock case to illustrate the best model of care. She took the example of a young woman in her mid-20s who seeks prenatal care. Her mother had died, so she went to live with her grandmother. Then her grandmother died, so she went to live with her former foster care family. While living there, she found out she was HIV positive. She had difficulty with adherence with her meds after high school. She was afraid to tell her boyfriend, and got pregnant. As an older teenager, she moved to NYC.

At the time she comes in for prenatal care, she had issues with:

- Compliance
- Disease progression
- Lack of family support
- Burn-out
- Unstable housing
- Lack of disclosure to partner/difficulty disclosing
- Cognitive impairment
- Acknowledgment of motivation to have healthy newborn

On her first medical examination, it is important to identify immediate health issues that need to be addressed. Of course this begins with a medical history, viral count, and other tests. Then the social worker should assess the situation, and, along with the community health worker, should link this person with the social services that she needs.

Dr. Peters observed that outreach and navigation to services are the key components. Especially important is targeting high-risk, hard-to-reach women in the community:

- Adolescents and young adults
- Homeless women
- Women who are vulnerable (living with an illness or lacking social support)
- Women experiencing intimate partner violence
- Women experiencing issues with partner notification.

Social support and partner disclosure are also important for prevention.

During the first six months after delivery, perinatally infected mothers and injection drug-using mothers were significantly less likely to have an HIV viral load. Can we identify a factor at birth that makes post-partum death more likely? Yes - viral load greater than or equal 10,000 coplies/mL and severe immuno suppression close to time of delivery. Other factors include being out of care after birth of child, non-compliance, and persistent HIV RNA levels greater than 100,000 copies/mL. Causes of death include: Mycobacterium Avium complex (MAC); lymphomas, both Hodgkin's and non-Hodgkin's; multifocal leukoencephalopathy; eclampsia with subsequent pregnancy; end-stage AIDS with candida esophagitis; and pneumocystis pneumonia.

Dr. Peters left the group with these questions to consider:

- Are the postpartum health outcomes for perinatally HIV-positive mothers different than for HIV-negative women?
- What is needed to ensure that postpartum women continue to receive care that they need for themselves and their newborn baby?
- What about fathers?

Hepatitis
By Helen Adams, PA

Ms. Helen Adams introduced herself a pharmaceutical representative and community health education worker. She then made a presentation about the different forms of hepatitis.

Hepatitis is a general term that means inflammation of the liver. The most common types in the U.S are hepatitis A, B, and C, all of which are viral infections.

Hepatitis A can spread through contact with food and water that has been contaminated with infected feces. It can last a few weeks to several months and does not lead to any chronic infections. The infection resolves itself spontaneously without any treatment and there is a preventive vaccine available.

Hepatitis B is spread mainly by exposure to infected blood or body secretions. In infected individuals, the virus can be found in the, blood, semen, vaginal discharge, breast milk, and saliva. Hepatitis B is not spread through food or water, or by casual contact. Infection can result in chronic liver disease, cirrhosis, liver cancer and death. Preventive vaccines are available.

Hepatitis C is an infection caused by the hepatitis C virus (HCV), which is spread by contact with the blood of an infected person. Most people infected with HCV have no symptoms. In fact, most people infected with the hepatitis C don't know they have the infection until liver damage shows up, decades later, during routine medical testing.

Incorporating Complementary Medicine Toward Healing
by Sandee Conroy and Arcadia Asa Reyes Caraballo

There were two separate workshops – both devoted to hands-on demonstrations of the ways that singing bowls and yoga could be powerful tools for relaxation and healing.

Ms. Conroy played relaxing music to greet participants. She instructed everyone to make themselves comfortable, offering blankets to sit on the floor and lay down if preferred. As Ms. Conroy played the musical bowls, which released relaxing/soothing vibrations throughout the room, she gave a spoken meditation with a series of monotonous and hypnotic words. She informed participants that the vibrations will "go inside of you" and that everyone should feel relaxed. She then began making the vibrations louder. It was a great relaxing experience. Toward the end of the session, Ms. Conroy guided participants in a meditation to come out of the "trance." Slowly the audience awoke and Ms. Conroy gave a sample of a poem that she wrote in memory of her late daughter.

In the yoga workshop, Ms. Reyes Caraballo led participants through a set of simple yoga exercises that can easily be performed anywhere, including at work. These exercises left generally participants with more energy and a feeling of well-being.

Summary of CAPC Forum Evaluation Responses

A total of 66 out of 100 attendees returned evaluation forms, a response rate of 66%. Evaluations of all three plenary presentations were very positive – the vast majority (84%, 94%, and 94%, respectively) gave overall "excellent" ratings, with lesser numbers (16%, 6%, and 6%) deeming them "good," and none "poor." The spoken word performance got similarly high ratings: 89% "excellent," 7% "good," and only 4% "poor." The panel discussion received somewhat lower ratings: 66% gave "excellent" ratings, and 34% deemed it "good."

For the ratings of overall program quality – which included opportunity for discussion, usefulness of information, clarity of information and overall panel quality and expertise – 70-74% gave "excellent" ratings, 22-28% "good," and only 2%-4% "poor."

As to the four workshops, ratings were generally high. The one on *Trauma and Domestic Violence* received overall marks of 67% "excellent," 30% "good," and 4% "poor." For *New Challenges to Perinatal HIV Prevention*, the numbers were 36% "excellent," 57% "good," and 7% "poor." For *Hepatitis*, the ratings were 67% "excellent" and 33% "good." For the *Complementary Medicine* workshop, the ratings were 80% "excellent" and 20% "good." Note, however, that 24% of respondents did not fill out the part of the form concerning their evaluation of the workshop they attended.

The overall positive assessment of the Forum can be seen in the many highly favorable comments: Several participants wrote words like "Great conference." One person wrote, "Very useful clinically. Very beautifully presented." Another wrote, "I appreciate this training - it opened my eyes to a lot of things I overlook because I am not directly affected by them." The main concerns expressed were inadequately amplified sound.

CAPC Forum Evaluation Data
Plenary Session

Bronx CAPC Updates ***Nancy Genova, MPA***	**Poor**	**Good**	**Excellent**
Presenter's knowledge of the subject		**9%**	**91%**
Usefulness of information		**14%**	**86%**
Overall presentation quality		**16%**	**84%**

The Real Housewives of the South Bronx ***Rodney Wright, MD***	**Poor**	**Good**	**Excellent**
Presenter's knowledge of the subject		**8%**	**92%**
Usefulness of information		**8%**	**92%**
Overall presentation quality		**6%**	**94%**

Keynote Speaker ***Marsha Woodland***	**Poor**	**Good**	**Excellent**
Presenter's knowledge of the subject		**1%**	**99%**
Usefulness of information		**6%**	**94%**
Overall presentation quality		**6%**	**94%**

Panel Discussion	**Poor**	**Good**	**Excellent**
Presenter's knowledge of the subject		**31%**	**69%**
Usefulness of information		**34%**	**66%**
Overall presentation quality		**34%**	**66%**

Special Performance *Cardidad De La Luz 'La Bruja'*	Poor	Good	Excellent
Overall presentation quality	**4%**	**7%**	**89%**

Workshops

(Note: 24% of respondents did not rate their workshop at all.)

Trauma and Domestic Violence	Poor	Good	Excellent
Presenter's knowledge of the subject		**29%**	**71%**
Usefulness of information		**33%**	**67%**
Overall presentation quality	**4%**	**29%**	**67%**

New Challenges to Perinatal HIV Prevention	Poor	Good	Excellent
Presenter's knowledge of the subject		**29%**	**71%**
Usefulness of information	**7%**	**43%**	**50%**
Overall presentation quality	**7%**	**57%**	**36%**

Hepatitis	Poor	Good	Excellent
Presenter's knowledge of the subject		**33%**	**67%**
Usefulness of information		**33%**	**67%**
Overall presentation quality		**33%**	**67%**

Incorporating Complementary Medicine Towards Wellness	*Poor*	*Good*	*Excellent*
Presenter's knowledge of the subject		**80%**	**20%**
Usefulness of information		**80%**	**20%**
Overall presentation quality		**80%**	**20%**

Overall Program

	Poor	**Good**	**Excellent**
Opportunity for discussion	**2%**	**28%**	**70%**
Usefulness of information	**4%**	**22%**	**74%**
Clarity of information presented	**3%**	**26%**	**71%**
Overall panel quality and expertise	**3%**	**26%**	**71%**

2012 CAPC Conference
Comments on Evaluation Forms

Overall conference:

- **Great presentation**
- **Very useful clinically. Very beautifully presented. Thank you**
- **This was a great conference and what our community need**
- **I appreciate this training - it opened my eyes to a lot of things I overlook because I am not directly affected by them**
- **Great conference, would recommend to others. Very informative**
- **Great conference, important issues hopefully good solutions can be made**
- **No microphone made it difficult to hear**

Workshop on perinatal HIV infection:

- **I know that the presenter is an epidemiologist and although there were some case studies there was too much statistical info. DATA OVERDOSE. Had hoped for ideas to engage perinatal-infected youth into care. Discovery of barriers, etc. There was no microphone – she had a quiet, low voice.**

Workshop on complementary medicine:

- **The humming bowls were loud and distracting. At times unable to hear speaker because of outside noise**
- **Need microphone for breakout – hard to hear over singing bowls**
- **This was an excellent workshop and I will use information with empowering those I assist**

Suggestions:

- **More talk about solutions to community issues. More council member involvement.**
- **Focus on the abuser more for the next forum. Where can we find the tools to work with the men in our community?**
- **Next year have panel of consumers to present:**
    - **Their journeys to healing/quality care (or not)**
    - **Key role of consumers in program planning and advice**
    - **More detailed presentations on programs that work**

Biographies of Presenters

Plenary Speakers

Magdy Mikhail, MD

Magdy Mikhail, MD, is Professor and Chairman of Obstetrics and Gynecology, Bronx-Lebanon Hospital Center, Albert Einstein College of Medicine and Director, Residency Program, Department of Obstetrics and Gynecology, Bronx-Lebanon Hospital Center. Dr. Mikhail is also Director, Urogynecology Division, at the Albert Einstein College of Medicine. Dr. Mikhail is Principal Investigator of the AIDS Institute Service Grant entitled "Family-Centered Health Care" and Co-Investigator of "Prevention Services for Women." He has researched issues related to cervical dysplasia and HPV and has authored various publications from these investigations.

Dr. Mikhail is a member of many professional organizations including the American College of Obstetricians and Gynecologists, the Urogynecology Society, the American Medical Association, the Bronx Obstetrical and Gynecological Society and the New York State Perinatal Society. He is also a Fellow of the American College of Surgeons.

Rodney Wright, MD

Rodney L. Wright, MD, MS, is currently the Director of HIV Programs in the Department of Obstetrics and Gynecology and Women's Health at the Montefiore Medical Center and an Assistant Professor of Obstetrics and Gynecology and Women's Health at the Albert Einstein College of Medicine in Bronx, NY. He also is Co-director of Women's HIV Services at Bronx-Lebanon Hospital. Dr. Wright is a graduate of the University of Pennsylvania School of Medicine, completed his residency in obstetrics and gynecology at the University of California – Irvine, and completed a fellowship in Maternal Fetal Medicine at the Albert Einstein College of Medicine. Dr. Wright also obtained a Master of Science Degree in Clinical Research Methods in 2007. He is a member of the Society of Maternal Fetal Medicine, the HIV Medicine Association, and is a fellow of the American College of Obstetricians and Gynecologists. Dr. Wright presently serves as chair of the Board of Directors of the AIDS Healthcare Foundation, one of the largest providers of HIV care in the U.S. with over 150,000 patients in 23 different countries.

Maria Teresa Timoney, CNM

Maria Teresa Timoney, CNM, is currently the Director of Women's HIV Services for the Department of Obstetrics and Gynecology at Bronx-Lebanon Hospital Center, where she has been providing prenatal and gynecological care for HIV-infected women since 2001. She graduated from the Columbia University School of Nursing and Barnard College.

Before becoming a midwife, Ms. Timoney worked for many years as an artist and curator in New York City. She is deeply inspired by and grateful to the women she has met and cared for in her practice at Bronx-Lebanon.

Nancy Genova, MPA

Nancy Genova is currently the Program Director of the Bronx Community Action for Prenatal Care Initiative (CAPC) for the Department of OB/GYN, Women's HIV Services. She has been in the field of HIV/AIDS since 1993. Ms. Genova holds a Master's in Public Administration with a concentration in Health Care Administration from Long Island University and a B.A. in Social Work and Fine Arts from Lehman College.

Nancy Genova oversees and maintains a coalition of 600 participants and establishes, negotiates and monitors contracts with collaborating agencies. She is also responsible for the continued funding of the CAPC program by writing proposals and fundraising. She has developed a program promotion DVD and other social marketing materials for the programs she manages. In addition, she is responsible for the yearly multidisciplinary Bronx CAPC forum. She is considered a social activist by her peers, and acknowledged in a report issued by the NYS AIDS Advisory Council, *Women In Peril HIV & AIDS The Rising Toll On Women of Color.* She has been called to testify before the NYC Council Chambers to the Women's Committee on the impact HIV/AIDS has had on women in the Bronx and gave similar testimony to NYC's Medical Delegation.

Ms. Genova serves on the board of The Bronx Health Link, T.O.U.C.H., and 100 Hispanic Women. She was appointed to the Human Rights Commission of Rockland County in April 2008 by County Executive Scott Vanderhoof. Ms. Genova was awarded the Manager of the Year Award in 2009 by the Association of Hispanic Health Care Executives and the Community Service Award by the New York League of Puerto Rican Women in 2011. The play that she authored, "The Death of a Dream," had its off-Broadway debut in October 2009 at Roy Arias Theater and received considerable media coverage. The show is now on a college tour throughout the United States.

Marsha Woodland

Marsha Woodland is a Criminal Justice major in her junior year at the University of Maryland, University College in College Park, Maryland. Her major accomplishments include publishing her first book, *Doomed to be Nothing; Destined to be Something*, becoming a trauma-informed consumer-turned-advocate, and establishing the Building Bridges Foundation, a non-profit organization serving female ex-offenders. Her foundation will offer second chances to her clients, with the hope of reducing the recidivism rate and improving the quality of life for them and their families.

Ms. Woodland is a former three-year employee of a local police department, which inspired her educational and career goals. She has enormous experience volunteering at the Center for Addiction and Pregnancy (CAP) mentoring women suffering from substance abuse, domestic violence, and other traumatic incidents. She volunteered for several years at the Family Emergency Shelter, and presently at the Just for Us Foundation in Prince Georges County, Maryland. She has been in leadership for three years at a religious organization, participating in street outreach and crisis intervention.

Ms. Woodland brings almost 14 years of experience in dealing with the disease of addiction, trauma from the past, and 12 years of experience in active addiction. At 17 years old, she was introduced to cocaine by her biological mother. Shortly after her introduction to cocaine, she was introduced to the streets of Washington, DC, due to her mother's death as a direct result of her addiction. In April 1997, Ms. Woodland went into a treatment program and has been abstinent since that time. She is committed to providing help, healing, and hope to victims of trauma. Ms. Woodland is extremely grateful for the opportunity to make a difference, to serve others, and embrace her purpose as Voice of the Victim with passion and enthusiasm. She believes that offering help, healing, and hope are her reasonable duty.

Workshop Speakers

Trauma and Domestic Violence

Dita Dobroshi, LMSW

Dita Dobroshi, LMSW, is a social worker at Steinway Child and Family Services's Courtlandt Avenue Clinic, a graduate of the NYU School of Social Work, and a member and candidate for psychoanalytic psychotherapy at the New York School for Psychoanalytic Psychotherapy and Psychoanalysis. She has a focused interest in resolving trauma.

Sabra Jackson

Sabra Jackson is the founding coordinator of The Child Welfare Organizing Project's (CWOP) Parent Advocate Network (PAN). PAN is a professional network of parent advocates throughout child welfare and the intersecting systems. Ms. Jackson has a long history in the social services profession on the direct staff and supervisory level. She has guest lectured at numerous universities and conferences, including the National Advocates for Pregnant Women's conference on drugs, pregnancy, parenting in Beirut Lebanon. Ms. Jackson is the only parent advocate that is a member of New York State Court Improvement Project. She is a member of the ACS Commissioner's Parent Advisory Work Group. Ms. Jackson is a proud parent of Sabra Inez (14 years old) and Peyton Ulysses (7 years old) and is a supervisory of domestic violence.

Tanya McLeod

Tanya McLeod is a domestic violence survivor and advocate. She is the Senior Campaign Organizer at the Voices of Women Organizing Project (VOW,) where she is overseeing and coordinating VOW's three main campaigns that focus on improving family court, stopping false and malicious child abuse reports by abusers, and ensuring that victims of domestic violence and their children receive safe and affordable housing. In addition, Ms. McLeod coordinates VOW's public speaking training and presentations. Ms. McLeod shared her story of animal abuse and domestic violence in a documentary titled, "Tanya's Story" through CONNECT and the Alliance for the Safety of Animals and People (ASAP) which is being used as a teaching tool nationally. Ms. McLeod is an accomplished speaker and has spoken at rallies, conferences, on the radio and on television. She is featured on the recording of VOW's song, "Take a Walk in my Shoes". It is her goal to turn her pain into power and to put an end to domestic violence.

New Challenges to Perinatal HIV Prevention:
Working With Perinatally Infected Youth and Pregnant Women

Vicki Peters, MD

Vicki Peters, MD, is an Infectious Diseases Pediatrician who specializes in perinatal and pediatric HIV infection. She has been the Director of the Pediatric HIV Surveillance Unit at the New York City Department of Health and Mental Hygiene since 1999. Prior to joining the Health Department, she was the Director of the Pediatric HIV Clinic at the Mount Sinai School of Medicine from 1990-1998. She is a member of NYS Department of Health's Task Force for the Prevention of Perinatal HIV Transmission (since 2000), a member of the Working Group on Antiretroviral Therapy and Medical Management of HIV-infected Children (since 2005), a consultant for the CDC-sponsored Longitudinal Epidemiologic Study to Gain Insight into HIV/AIDS in Children and Youth (LEGACY) (since 2005), and a member of NYS's AIDS Institute Committee for the Care of Children and Adolescents with HIV Infection (since 2007 and from 1996-2002). She has co-authored pediatric HIV clinical care guidelines for NYS AIDS Institute and has authored 25 manuscripts and presented findings at national and international meetings on pediatric HIV infection.

Hepatitis

Helen Adams, PA

Born, raised and still residing in the Bronx, Helen Adams is a graduate of Herbert H. Lehman H.S., Herbert H. Lehman College/CUNY division and then Bronx-Lebanon Hospital PA Program in 1996. Prior to becoming a Physician Assistant, she taught high school at James Monroe H.S., also in the Bronx. As a Physician Assistant she has spent

her career treating HIV+ and Hepatitis C+ patients at many Bronx facilities including: VIP Community Services, Hunts Point Multiservice Center, and Bronx Lebanon Hospital, where she worked as the Coordinator of HIV/HCV Care in the Infectious Disease Department. She later went on to work with the Liver Transplant Department at Mount Sinai Medical Center in NYC. Currently Ms. Adams works for Vertex Pharmaceuticals, where she serves as a Treatment Educator in their Hepatitis C Division.

Incorporating Complementary Medicine Toward Healing

Sandee Conroy

'Singing' Bowls entered Ms. Conroy's life about 11 years ago. Through personal study and time, she has developed a powerful method of sound meditation. Ms. Conroy has studied T'ai-chi Ch'uan and acupressure, and is honored to have had two personal teachers of 'the Work' in her life. She brings a unique blend of wit and wisdom to every session. Ms. Conroy has produced two CDs: *The Art of Balance –Singing Bowl Chakra Clearing*, released in 2010; and, just released, *The Portal - Music & Vibrations of Crystal Bowls*, co-created with Peter Olsen. Her venues have included the United Nations Church Center, Yankee Stadium Legends Club, Steeplechase Cancer Center, Rutgers University, as well as various regional Hospitals, Health & Yoga Centers. For more information: www.MyEnergyWorks.net.

Arcadia Asa Reyes Caraballo

Arcadia Asa Reyes Caraballo is a certified Hatha Yoga instructor who has spent over a decade studying movement healing and dance techniques. A native New Yorker who is fully bilingual (English-Spanish), Ms. Reyes Carabello views yoga as a constantly evolving path to self-discovery and works within the principles of Hatha Yoga to assist individuals in discovering their full potential. Ms. Reyes Carabello's instruction is inspired and informed by a multitude of diverse sources. She is also trained in Chair Yoga (for individuals with restricted movement) and is certified in both Prenatal and Postpartum Yoga. She has also worked with individuals with HIV and communities such as the Queens Women's Health Center, 100 Hispanic Women, Bronx Community Action for Prenatal Care Initiative, and the De Alma's Women's Collective.

In 2004, Ms. Reyes Carabello received the Kripalu Yoga Teacher's Association Award, "Teaching for Diversity," funded by the Ritter Foundation, in recognition of her work with underserved communities. She currently teaches yoga at Bronx Community College, where she is an adjunct professor and provides private instruction for individuals and organizations. The Integral Yoga Institute, Castle Hill YMCA, Lehman College, Hostos Community College, and Ta-Yoga House in Harlem are among the many institutions that are included in her client base.

Trauma and Domestic Violence (Excerpts from Presentation)
By Dita Dobroshi, LMSW

The following are testimonies presented by Ms. Dobroshi about three of her clients:

The Child

The first girl is the youngest of four. She has a step-brother. So there is about five. There are older brothers, a sister, and a stepbrother. From the ages of 6 to 8, she was sexually abused by her brother. Her brother, giving him a history as well -- since, of course, the abuser also has a history -- he, before my client was born, was in a foster care system. He was raped repeatedly. As he grew older, he started to sexually abuse the child, the girl. And he would penetrate her with a broomstick, with his fingers. He would give her change for different sexual acts. And this is something she endured for two years. She would say that she was holding through. She had to deal with it until one day she was at school and the school counselors had a meeting on education about sexual abuse. And they described what sexual abuse was. And, of course, at the end of the meeting they said, "If this rings true for anyone, please talk to me at once." So my client went to the counselor and says that she had actually felt that she understood the stories the counselor was talking about, how she too had been sexually abused.

So the counselor, of course, talked to her and called ACS right away. And so ACS went to the house. It turned out that the mother knew about the sexual abuse all along. The mother had actually walked in on the child and the brother humping each other – those were her own words – and she wanted this to stay within the family. She thought that she would be able to find ways to deal with it herself. She had the oldest daughter stay with my client, the girl, at night, and she had the oldest son stay with the stepchild to protect him at night. Needless to say my client's mother was arrested for child endangerment and my client was in the home and saw her mom handcuffed and taken away to the police station and she felt it was her fault. And she thought it was something that she did that broke up the family. And she had the chance to visit her mom still handcuffed. And my client felt deep guilt, deep shame, that she had put her mom in that position.

Her mom of course had to stop working. She had a charge, so she was unemployed for a while. And she eventually found a job as a maintenance worker at nighttime. And my client, seeing her mom handcuffed and separated from her mom, she couldn't sleep, she couldn't eat, she couldn't concentrate at school. So she came for therapy to me. I had seen her for about three years. She would come and let me know how her feelings are and what is going on with her, and how she couldn't eat and couldn't sleep.

We brought the mom in the room and the girl explained to the mom how guilty she feels and how sad she feels. And the mom was able to reassure her that it wasn't her fault.

"You know, this is something that happened. And the family is trying to heal and grieve it out."

In the meantime, the older brother, who was the abuser, he was sent to Children's Village, an agency here. And he didn't get much treatment, according to her mom. When he was eighteen, he was ready to come home. So my client had to deal with seeing her brother after two years. On one side, she wanted her brother to come home. On the other side, she had deep fear and anxiety, he's going to come and what would he do to her then with the anger, after all the history that they had.

My client started to have hallucinations at night, as part of the symptoms of her anger and anxiety. And she created this man named Toby. And Toby had a friend named Mary. And Mary had two children. Toby also had a bulldog with blood on it. All these people would come to her at night and keep her safe. That's how her mind defended from the trauma she endured and the threat of her brother coming and the threat of her family being separated again. So we talked about Toby and Mary, and she was able to draw pictures of Toby and Mary. And we talked about these hallucinations, called her imaginary friends. Of course, you're trained that if somebody sees things they're schizophrenic. I didn't go that route with her. They have been healing for her. They were just an extension of her emotions. So for six months, we would talk about her imaginary friends. And, with time, sometimes the imaginary friends would be in the room with us. We talked together, sometimes all four of us in the room.

She would be able to express it, honestly and openly without judgment. So we just matter-of-factly explained what it all meant. A few months ago, she stopped seeing these hallucinations. She stopped seeing these imaginary friends. She said,"You know Dita, I don't need them anymore." So through talk and being able to sit with the horror and emotion of her pain and trauma, she was able to have some healing and relief of her symptoms.

The Teenager

The second story was of a teenager who sought therapy at the age of 16. Her mother would constantly take her to the hospital. Her dad was not around. He was in jail. For all of her life, she remembers seeing him only three days in all of life. She would act out and not go to school and be angry. Her mom seemed to use 911 as a parenting tool. If her mom called 911, off she would go. And she came to me and said, "Look, I don't want to go to the psych ward anymore." Then I said OK, then let's try to master what's going on. Let's try to figure out what is causing all this pain and angry outbursts.

So she started coming to me twice a week and she was talking about her family and her mom. She had a boyfriend at that time. But at 16, she fell in love. It was her first love. During this time I was seeing her. We would talk about the boyfriend and he was a drug

user. She didn't like that very much because her dad was a drug user. And she decided that she was going to move in with him when she turned 18. So when she turned 18 she moved in. Shortly afterwards, she became pregnant and her boyfriend said for her to have an abortion. Now she didn't want an abortion and she told her family that she was pregnant and they wanted her to keep the baby. But he said, "No way, we're not having a baby. You have to abort." So he promised that he would take her to the clinic. But that morning he didn't take her to the clinic. He said, "Go by yourself and just do it." So she took her grandmother to the clinic and had an abortion.

And several months later, she had this feeling of immense loss and immense grief. And she decided she was going to get pregnant again. This time it was to replace what she had lost because ultimately what she really wanted was a baby.

So she ended up having twins and her boyfriend decided that he was very angry with her. So she was in the apartment and he choked her so severely, she had bruises around her neck. And he beat her and tasered her. And because it was so loud, neighbors called the police and the police were able to intervene. The police, of course, were charging attempted murder on him and she decided to drop the charges. She didn't want to raise babies without a father like she had been without a father. So, she dropped the charges and she went back home to him.

Shortly after, because of the abuse, because of the beatings she had, she miscarried. And she remembers going to the bathroom and bleeding heavily and having intense pain and just sitting on the toilet and having her babies come out. And she remembers just kind of looking at them and just flushing the toilet. Now, that is something that she carries still today and it is still very difficult for her to even have the words to talk about what had happened and the grief, the sadness, and the pain.

So her boyfriend also makes her use drugs now, but she refuses to do that. We talk about him being an abusive boyfriend. We talk about her trying to get away, but she's not there yet. She can't do it. After all that, she says she still loves him. She can't leave him. But as kind of a memorial to her three babies that she lost, she decided she was going to change her life completely around.

She is now at night school. In the morning she has two internships. She is making up credit. She is in an advanced credit school. She has been on the honor roll lately. So this pain that she had she is able to kind of tuck away and live a kind of productive life. She knows that she does not want to have a baby now, especially in her teens, or have a baby in her twenties. She says that she wants to be established and have a baby in her thirties. And I allow for that. Maybe it won't happen, but this is her wish. So this is where she is now, with her being able to listen to herself, being able to tap into her strengths, her education, her personality, her ability to have friends and relationships. So she was able to heal from the trauma she had with the pregnancies she had.

The Adult

The third story was that of an older Latina woman who sought therapy in her late thirties. She experienced abuse all of her life, including at the hands of her mother, who one day crushed her face onto the ground with a shoe. She remembers the next morning, waking up with shoe marks on her face. She had to go to school like that.

At the age of 16, she had a boyfriend who was her first love. She became pregnant by him. He was a drug addict and belonged to a gang, but she loved him and wished to stay with him. Her boyfriend wanted her to use drugs and beat her. When she was about 16, she became pregnant. She had her first baby boy at 17, while her husband was using drugs and beating her. He wanted her to use drugs. One day, she threw a bag containing drugs in the toilet. Her boyfriend, furious at her, then took her by the head and forced her to pick up the bag from the toilet with her teeth. She said she thought she was going to die. Hearing the commotion, a neighbor came and saved her.

Her boyfriend eventually stopped beating her. She became pregnant three times after that, in her late teens and early 20s. And she describes that her boyfriend at the time did not want to share her with children. He didn't know what it was like to have a son. When he had the son, now it is ok. But he was not happy having other children. He didn't like to share her so he proceeded to beat the babies out of her every time she became pregnant. She would constantly miscarry after being beaten every time. She was another woman who was unable to leave her boyfriend. She felt powerless. The highs were high and the lows were low. And she thought that was what love is.

But then he actually went to jail. He went to jail for about 20 years. And that is when she was able to have freedom from him. It wasn't her separation; it was him separating from her. So she was able to live her life free of abuse for a number of years. And she met her husband now. And she still has her baby boy.

She would beat her baby boy because that's what she knew to do. And when the boy was about 5 years old, she beat him so much, and after being so angry at him, she took him and threw him against the closet door. The door broke and she did that with his 5-year-old body. Her husband took her by the shoulder and said, "Never again. Never do that again." Something inside of her just clicked and she was not able to then beat him any more.