SPECIAL COMMENTARY

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As a component of the doctoral program in clinical psychology at the University of North Dakota, I spent seven months in residence on a plains Indian reservation. This portion of my graduate experience was designed to enhance my understanding of both rural and American Indian cultures. The practicum included teaching psychology classes at the tribal college, providing individual and community psychological services and the possibility of pursuing my research interests.

During the first several months on the reservation, I focused on meeting community members and trying to understand how rural and/or Native culture differed from my own experiences. I am of Scottish, Irish, English, and Dutch descent and have lived primarily in more urban communities.

Native women were warm and welcoming to me and helped me understand some of the intricacies of reservation life. They helped me find the best buys at the grocery store, told me which was the best cafe in town, taught me to make fry-bread, showed me how to quilt, invited me to sweat with them, and taught me about traditional healing methods. In addition, they helped me understand that one of the most valued things in this community was the recovery from addiction. They also began to let me see glimpses of their intimate relationships that suggested that domestic violence was as common here as in my own culture.

In regard to domestic violence, the use of alcohol by the victim, the offender, or both is common. For example, Silverman and Mukherjee (1987) found that in 54 of their investigated relationships (87%) alcohol had been consumed by one or both parties. Only 8 relationships (13%) were alcohol free. Although alcohol use is certainly not limited to American Indians (Edwards, 1992), and there is great variability among American Indian communities in the prevalence of alcohol use (Jessor, Grave, Hanson, & Jessor, 1969; Levy & Kunitz, 1974; Longclaws, Barnes, Grieve, & Dumoff, 1980; Whittaker, 1962), it has been suggested that the rate of heavy alcohol use is "common among American Indians, perhaps more so than in other populations" (Helzer & Canino, 1992). Given the relationship suggested between alcohol use and domestic violence plus the prevalence of alcohol use among Native populations, one might expect Native women to be a high risk group for experiencing violence in their homes.

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My first attempt to reach this population was through a support group that had been formed for battered women by a Caucasian, female graduate student. She had been a provider of clinical services and had taught at the tribal college for four months before I arrived. Her practicum over, she had left the area. She had told me that the group met at the Indian Health Service (IHS). Upon arrival at IHS on the appointed evening, I found the emergency room door locked. It was necessary for me to press a buzzer and wait outside for the emergency personnel to open the door. I felt exposed to the observation of others while waiting and wondered if members of the group had similar feelings. Once allowed into IHS, I waited for some time, and no group (in fact no individual) arrived. After the third week of a similar attendance record, I questioned the emergency room nurse about how effective the group seemed to be. She told me that no one ever came.

My second attempt to reach this population involved a relocation of the support group. I chose the Catholic church which was often used for other social functions. The door was not locked, so one did not have to stand outside waiting for admission. I distributed flyers throughout the community to announce the change, using care not to identify the group as one for "battered women" but for discussing women's issues. The end result was a replication of my first attempt. No one came.

My third attempt involved the cooperation of the ALERT (formerly the Battered Women's Task Force) from a neighboring (off reservation), predominately Caucasian community. After discussions with their staff, we decided to hold an informal "fact-finding" meeting and invite women of the community to come in and visit about what needs they might like to see addressed in their community. This information was passed by word of mouth rather than by flyers. The social workers at IHS, the priests, medicine women, and other service providers were informed of the place and time for the meeting. It was stressed that any needs of women would be heard. I felt that if battering were defined as a problem within this community, the women might be willing to discuss it after trust had developed within the group while addressing less intense issues. The result of this attempt was the same as the previous two. The only women who attended the meeting were myself, the staff from ALERT, and a nun.

There may be many reasons why these attempts failed. Possibilities include, but are not limited to (a) battering was not defined as a problem by this population, (b) the tribal council did not support an effort to identify battering as a problem, (c) child care difficulties, (d) transportation difficulties, (e) my ethnic background and lack of integration into the community or lack of cultural understanding, and (f) men may have been reluctant to allow women to attend a support group focused on women's issues.

Karen Horney (in Monte, 1977) has suggested that neurotic coping mechanisms include compliance, aggression, and withdrawal. Similarly,

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Walker (1979) found that the survival skills women develop to cope with violence in their homes are most often passive and include those designed to please the batterer (e.g., having supper ready on time, not talking with other men, dressing modestly). None of these passive strategies decreased the violence within the home. The women in Walker's (1979) study were afraid of expressing their anger overtly for fear of intensifying the battering incidents and therefore used more passive aggressive strategies.

Although these coping strategies were not effective in reducing violence and are often not seen as maladaptive in more normal situations, it should not be assumed that something was "wrong" with these women. Their responses were an attempt to survive, both physically and emotionally, in a possibly lethal situation. Those who study the psychological impact of the holocaust have suggested that people cope differently under extreme circumstances than when in a more normal environment (Gampel, 1979; Kestenberg, 1982).

Walker (1983) found that most battered women perceive the dangerousness of their batterer, with 86% believing that he could or would kill them. Given Walker's findings, one reason women did not attend these support groups may have been fear.

There is, as noted previously, a very active recovery movement in place upon this particular reservation. Groups that were addressing the recovery of members of this community included Alcoholics Anonymous (AA), Al-Anon (support group for family and friends of alcoholics), Narcotics Anonymous (NA), and Co-Dependents Anonymous (CODA). These meetings were well attended and helped form part of a social network that was acceptable to the tribe. The social activities included open meetings once a month which involved two speakers (AA and Al-Anon), and sobriety birthday celebrations. Dances were also held on holidays such as Halloween and New Years Eve.

I was an active member of Al-Anon both prior to and during my practicum due to circumstances in my private life. I began to wonder whether or not I might use the group process already in place, and my membership in it, to broaden the scope of the support provided to Native women. As an Al-Anon member, I was less of an "outsider" having had a common experience with other women in the group. Anonymity, or confidentiality, was already a valued component of the group, the group process was already well established, and would remain so after I left the reservation. I decided to teach a "Big Book Study" (BBS), a review of the AA "Big Book" (*Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*, 1976) with an Al-Anon focus. I hoped to be able to teach adaptive coping strategies to the women who attended this study.

The BBS was designed to be held for 16 weeks in the hour and a half prior to the regular Al-Anon meeting. Women did attend, and five women completed the course. Because of the reading limitations of some of the students, the course was expanded to 20 weeks.

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The course was designed to complete chapters 1–12 in the Big Book. In addition, the students completed the 12 steps of Al-Anon (see Appendix). Each chapter was read by the instructor and the students followed along. At the completion of the reading, we returned to the beginning of the chapter and used underlining and note-taking to enhance the salient principles of each chapter.

Within the first section, "The Doctor's Opinion," we discussed the disease concept of alcoholism that is the basic concept of Alcoholics Anonymous.

Those who live with an alcoholic often adopt both cognitions and behavior patterns that are maladaptive. Horney (in Monte, 1977) would probably consider these behavior patterns to be neurotic. As is traditional in Al-Anon Big Book Studies, the women were instructed to substitute "thinking" for "drinking" through the Big Book to increase the emphasis on self rather than another and to engender a more self-centered focus.

Chapter one, "Bill's Story," was an overview of the history of the founding of AA and Al-Anon. It noted the progression of Bill's alcoholism and reinforced the disease concept. It also gave a brief explanation of each of the twelve steps.

Chapter two, "There is a solution," held hope that there was a way out. For members of AA, this is a way out of alcoholism. For members of Al-Anon it is a way out of maladaptive behaviors, obsessive thoughts, and feelings of low self-worth.

Chapter three, "More About Alcoholism," was the point at which the group completed step one. Step one involved the acceptance of the disease concept of alcoholism. For Al-Anon women, we discussed some ways in which women had tried to deal with their alcoholic friend or family member in the past. Neither passively placating the alcoholic nor expressing rage overtly seemed to have worked for members of our group. Again, focus was directed to self. Freud might see this as contact with reality (or a strong ego), the most central aspect to effective coping (Coan, 1983).

Refocusing away from obsessive thoughts about the alcoholic and his behavior and toward oneself was seen as cognitive restructuring. Refocusing is facilitated by repeating Al-Anon slogans to oneself (see Appendix). As noted in Al-Anon literature, this refocusing helps lead to ". . . the idea we could take charge of ourselves." (Al-Anon, 1990). Psychological literature as well supports both cognitive restructuring and positive self-talk as methods of developing self-control (Meichenbaum & Goodman, 1971).

Chapter four, "We Agnostics," addressed the necessity that one accept the reality of a "higher power." That power might be God as He is understood in our society, the support of others in the group, or the individual's private and idiosyncratic conceptualization. Many appeared to feel less alone as they began to share their common experiences around the table.

As noted from Walker's (1979, 1983) studies, abused women attempt to control their batterer through ineffective means. Beginning to

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study the twelve steps seemed to help women talk about their common experiences with alcoholic loved ones which often included past futile attempts to cope. Additionally, seeing the "problem" differently (focus on self rather than other), the freedom to share with others, an acceptance of the lack of control one has over another's behaviors (step 1) and the knowledge that there is help available (step 2) seemed to engender a sense of hope that life could be better.

Chapter five, "How It Works," reassured the women that following the 12 steps would lead to an improvement in their situation. There was a qualification "those who do not recover are people who cannot or will not completely give themselves to this simple program. . ." (p. 58). Within this chapter, steps 2, 3, and 4 were taken (see Appendix).

Briefly, these steps included the preparation for and completion of a moral inventory of self. This led to a recognition of both strengths and weaknesses within the self. This recognition fostered the ability to choose more rationally how to cope with a difficult situation. Rogers (1961) suggested that the "self" is an internal locus of evaluation. Movement toward a more rational internal evaluation (rather than listening to the evaluation of self by the alcoholic) was facilitated by steps 2, 3, and 4.

Chapter six, "Into Action," addressed steps 5, 6, and 7 (see Appendix). Briefly, these steps involved the sharing of a personal moral inventory with a trusted other and privately asking a higher power to remove defects of character. These steps engendered self-acceptance as the trusted other accepted the individual's worst secrets. The private act of asking for removal of the self-defeating aspects of oneself cleared the slate for more adaptive strategies.

This chapter (six) also addressed steps 8 and 9 (see Appendix). These steps involved making a list of people one had harmed and making "amends" to them. Where possible, these "amends" took the form of an apology, or a change in behavior toward the injured party. These two steps helped bring the individual back into harmony with her society.

Chapter six also addressed steps 10 and 11 (see Appendix). Step 10 involved continuing to observe one's behavior toward others and attempting to correct those behaviors before they became maladaptive. Step 11 helped one to remain in contact with self and a high power through prayer, meditation, or simply taking time out to think.

Chapter seven, "Working With Others," addressed step 12 (see Appendix). This step allowed the women to become more socially involved. They now possessed knowledge to pass on to others and could, if they wished, teach a BBS themselves. Speaking at open meetings would be another example of service work suggested by step 12.

Chapter eight, "To Wives," is seen by many Al-Anon groups as outdated information that could be construed as reinforcing negative coping strategies (e.g., ". . .never be angry. . ." [p.111], ". . .often you must carry the burden of avoiding [family dissensions] or keeping them under control. . ." [p. 117], ". . .be careful not to disagree in a resentful or critical

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spirit. . ." [p. 117]). The chapter was reviewed, however, and gave good impetus to the discussion of maladaptive strategies such as problem avoidance, wishful thinking, self-criticism, social withdrawal, and the hesitancy to express one's emotions. These were contrasted with the more adaptive coping mechanisms of problem solving, reality testing, cognitive restructuring, emotional expressiveness, and social contact.

The remaining chapters addressed reintegrating oneself into family, work, and society after the recovery process has begun. Those chapters included 9, "The Family Afterward," chapter 10, "To Employers," and chapter 11, "A Vision For You."

In summary, an attempt was made through the already existing avenue of the Al-Anon support group to teach effective coping strategies to women who might be at high risk for domestic violence. In brief, the students were guided through the 12 step process of Al-Anon while attending a study of the AA "Big Book." Although I did not approach domestic violence in an overt manner, the discussions during the BBS allowed women to share experiences that included incidents I would classify as abusive. Rather than focusing upon the violent nature of the incidents, we focused upon constructive ways of reducing such experiences in the future.

Relevant suggestions from interested others for future work in this area have included using private homes as meeting places to facilitate group cohesion and trust, providing dinner, child care, and transportation for the women.

It should be noted that the women who completed the BBS felt a great deal of pride. They held a graduation dinner to which I was invited and bestowed gold-colored pins that we could all wear in recognition of our accomplishment. As previously noted, there was already a well-functioning Al-Anon group in existence; the support of peers with anonymity was available for the women after I left the reservation.

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Appendix

Twelve Steps of Al-Anon

1. We admit we were powerless over alcohol — that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly ask him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to others, and to practice these principles in all our affairs.

Al-Anon Slogans

Let Go and Let God	Easy Does It	Live and Let live
First Things First	Think	One Day at a Time
Keep it Simple	Listen, and Learn	How Important is it?
Simple, Not Easy		

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Twelve Rewards to the Twelve Steps

1. Hope instead of desperation.
2. Faith instead of despair
3. Courage instead of fear.
4. Peace of mind instead of confusion.
5. Self respect instead of contempt.
6. Self confidence instead of helplessness.
7. The respect of others instead of pity and contempt.
8. A clean conscience instead of a sense of guilt.
9. Real friendship instead of loneliness.
10. A clean pattern of life instead of a purposeless existence.
11. The love and understanding of our families instead of their doubts and fears.
12. The freedom of a happy life instead of the bondage of an obsession.

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