

## Comments

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In her report, Dr. Bowman documents her attempts to provide domestic violence counseling to American Indian women living on a plains reservation. Although not successful in her efforts, she recognizes the existence of this problem through informal discussions with women on the reservation and through participation in an Al-Anon group, where some of the women were victims of wife-beating. This author's experience highlights the need for domestic violence interventions in these communities, and also illustrates the challenges of developing successful programs for battered American Indian women.

In 1977 the White Buffalo Calf Women's Society opened the first shelter for battered women on the Rosebud reservation (DeBruyn, Wilkins, & Artichoker, 1990). Subsequently, many American Indian communities have developed shelter and victim assistance programs. Dr. Bowman argues that battered women did not utilize her services because of fear; the success of domestic violence programs in their respective American Indian communities is evidence to contradict this theory. Fear may be a factor for some women, but many women will seek informal and formal sources of help to end the violence. Although there is no literature on help-seeking among battered American Indian women, a significant percentage of battered women in the general population utilize services (Bowker, 1983; Gelles, & Straus, 1988). In the study by Gelles and Straus, human services were used by 38% of the women who were beaten by their partners.

Non-Indian professionals are faced with the task of establishing themselves as a provider who is trustworthy and able to help the community. Dr. Bowman reports she was assigned to the reservation for a seven month practicum. Establishing these relationships occurs over time, and this process would be hampered by the knowledge that her practicum was time-limited. Concerns about confidentiality and the revelation of highly personal and sensitive material would inhibit women from seeking assistance from an unknown non-Indian professional. The abuses and oppression that American Indians have endured from Whites is another important barrier in this regard.

These barriers can be overcome, but the professional therapist must expand beyond the office or clinic based approach, and instead be willing to provide outreach to battered women. An American Indian program director of a domestic violence program provided shelter for a battered woman in her home. Although providing shelter for women in one's home may be beyond the abilities of most counselors, caregivers in

American Indian communities who are active in meeting their clients needs will be more effective.

Dr. Bowman mentions providing dinner, child care, transportation, and meeting in private homes as potential strategies in planning domestic violence interventions. I have found that home visits facilitated establishing an alliance with many battered American Indian women in an urban setting, who were then receptive to individual and group counseling. Additionally, sharing meals in our domestic violence group created an informal atmosphere for sharing experiences. Importantly, counselors should obtain the woman's permission prior to initiating a home visit, because home visits may be dangerous for the woman if the partner is at home (Norton & Manson, in press).

There is presently scant literature regarding domestic violence intervention in American Indian communities, and Dr. Bowman's paper adds to this literature by illustrating the potential problems that arise in program implementation. There is also a tremendous need for information describing successful domestic violence programs, to guide program directors who are interested in starting new programs. Dr. Bowman mentions that alcohol abuse may be a risk factor for domestic violence among American Indians; there is also little information on risk or protective factors for domestic violence in this special population. These are important areas for further study as well as documentation of existing efforts.

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