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Don't talk, don't feel, don't trust

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Abstract

In the United States there are between seven and fifteen million children under the age of eighteen living with at least one parent addicted to alcohol (Berlin, Davis, & Orenstein, 1988; Knight, Vail-Smith, & Barnes, 1992; Roosa, Gensheimer, Short, Ayers, & Shell, 1989; Webb, 1993; Weddle & Wishon, 1986). Alcoholism is a family disease, and every member of the family is affected. The family organizes itself and revolves around the alcoholic, while the needs of other family members are secondary. Plans, rules and feelings change constantly in an attempt to anticipate and placate the alcoholic's drinking behavior (Campbell, 1988; O'Rourke, 1992).

DON'T TALK, DON'T FEEL, DON'T TRUST

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In the United States there are between seven and fifteen million children under the age of eighteen living with at least one parent addicted to alcohol (Berlin, Davis, & Orenstein, 1988; Knight, Vail-Smith, & Barnes, 1992; Roosa, Gensheimer, Short, Ayers, & Shell, 1989; Webb, 1993; Weddle & Wishon, 1986). Alcoholism is a family disease, and every member of the family is affected. The family organizes itself and revolves around the alcoholic, while the needs of other family members are secondary. Plans, rules and feelings change constantly in an attempt to anticipate and placate the alcoholic's drinking behavior (Campbell, 1988; O'Rourke, 1992).

In order to survive, the family follows a rigid set of rules determined by the alcoholic parent and his or her use of alcohol. The cardinal rules are "don't feel, don't talk, don't trust" (Black, 1981). Although these rules enable children to function in their home environment, they also isolate them, discourage communication, foster mistrust and deceit, and discourage personal growth outside of the home. The lives of the children are characterized by shame, guilt, low self-esteem, confusion, inconsistency, insecurity, resentment and rejection. If there is no intervention or therapy, these problems manifest themselves in adulthood. Forty to sixty percent of children of alcoholics (COAs) become alcoholics (Ackerman, cited in Edwards & Zander, 1985). Children of alcoholics are more likely to marry alcoholics and experience lifelong problems with intimacy and expression of feelings (Woititz, cited in O'Rourke, 1992).

Family alcoholism affects school performance, conduct, and peer and interpersonal relationships (Knight et al., 1992). Children of alcoholics (COAs)

experience more learning problems, higher rates of absenteeism and fighting with peers, and more adjustment problems than children of non-alcoholics (McAndrew, 1985).

There is a need for teachers and counselors to be educated about the effects of alcoholism on children. Teachers and school counselors see children every day and for longer periods of time than any other individuals outside of their families. They are able to observe and identify COAs. They are also an excellent source for providing information on alcohol and other drugs to children and for providing education about alcoholism and the effects on the family. This paper presents information on children of alcoholics and how counselors and educators can assist them.

Alcoholism

Alcoholism is a progressive disease, characterized by an uncontrollable desire to drink. Alcoholics may drink to feel better, to cope with a problem, or to ease a pain of which they do not know the cause (Pitman, 1990). For persons who drink to "feel better" or to solve problems, alcohol becomes the problem (Brooks, 1981). In the beginning, the alcohol helps. It allows alcoholics to believe that they are escaping their problems. It gives them a false sense of security. At some point, they become dependent, either physically or psychologically, on the drug. Alcoholics, believe that they need the drug to stay alive. The drinking may affect work, school, finances, health, family or friends. It may be evident to everyone involved with an alcoholic that there is a problem, yet there is often vehement denial by alcoholics that alcohol is a factor. Alcoholics desperately want to believe that there is nothing wrong with them or their drinking (Brooks, 1981).

Alcohol is a factor in 60% of all reported child abuse cases, 40% of all assaults, 85% of all home violence, 39% of all rapes, 64% of the homicides, 30% of all suicides, 65% of all drownings, and 35-64% of the fatal accidents which involve drivers who have been drinking (Gofen, 1990; Milan & Ketcham, cited in Weddle & Wishon, 1986,). Only one alcoholic in thirty-five gets help (Martin, cited in O'Rourke, 1990). Fewer than five percent of the COAs receive help (NIAAA, cited in O'Rourke, 1990).

Life In A Family Characterized By Alcoholism

For every alcoholic, there are several family members affected by alcoholism (Tomson, 1987). Families of alcoholics are closed, self-regulating and dysfunctional (Pitman, 1990). Alcoholism is the family secret. Family members are not allowed to discuss the drinking with other members of the family, and especially not with an outsider. Life in an alcoholic family is characterized by denial, isolation and lack of trust.

Denial

Quite often the alcoholic and other family members will deny that there is a problem. There is not a problem in the family; there is not a problem with alcohol, and family members are not allowed to discuss or express feelings to the contrary. If something strange or bizarre happens in the family, the family denies, overlooks or ignores it (Woodside, 1986). The family attempts to function as if nothing out of the ordinary is happening.

The shame and stigma of alcoholism, along with the family's denial, make alcoholism seem like a crime to the family (McAndrew, 1985). No one wants to admit that a family member has a problem with alcohol. For many, alcoholism is

perceived as dirty and disgusting. Many people believe that alcoholics are bums who live on the street and sleazy women who hang around bars (Brooks, 1981). This perception makes it easier for alcoholics and their families to deny the problem, because they know their family is not like that. In truth, many alcoholics have families and jobs and are a far cry from this description.

Lack Of Trust

The denial of a problem with alcohol and of the events that occur as a result of alcohol use often lead to a lack of trust. COAs learn not to trust adults because of the denial, broken promises, disappointments and lies (O'Rourke, 1990). Children develop a distorted perception of themselves and others. This interferes with school and their ability to maintain and develop interpersonal relationships (Webb, 1993). They learn that they cannot trust their parents, they cannot trust themselves, and they cannot trust their perceptions. They are unable to trust the accuracy of what they see, feel and hear (Birke, 1993).

The lives of children in alcoholic families are consistently inconsistent (Woodside, 1986). Behavior that is accepted one day is unacceptable the next. Promises are made and broken, and disappointments are a fact of life. When children come home from school, they do not know in what condition they will find the parent. Parents may truly seem repentant about creating a scene, breaking a promise or embarrassing their children. However, no amount of repentance will decrease the embarrassment or erase the hurt.

Isolation

The family of an alcoholic protects itself by isolation from the outside world. Defensiveness and denial are used to keep outsiders out (Pitman, 1990).

Both parents deny there is a problem and discourage the children from talking about the family situation (NIAAA, 1986). The non-drinking parent may be the parent who most strenuously insists upon maintaining the family secret (Campbell, 1988). He or she is often obsessed with preventing the alcoholic from drinking. Denying that alcohol is a problem and maintaining a facade of normalcy becomes the focal point for the parent/child relationship (Campbell, 1988). Alcoholic parents teach their children coping mechanisms which may protect the childen within the family, but which are self-defeating in other environments (Buwick, Martin, & Martin, 1988). Children constantly receives the message, "Don't talk, don't feel, don't trust." These children will protect their parents at all costs (Buwick et al., 1988). Because of the "don't talk" rule, these children become increasingly isolated at school. They cannot bring friends home because of the shame and embarrassment that would result if the family secret should get out (Woodside, 1986). Lack of involvement with adults outside of the family fosters their lack of trust in others as well as themselves (Edwards & Zander, 1985). Often, there are no positive role models in a family in which one of the parents is addicted to alcohol (Buwick et al., 1988). As the children obey the "do not talk" rule, they realize that parents, others and self cannot be trusted. They learn that their feelings must be locked up, because nothing feels good. This results in a "don't feel" coping strategy.

Feelings and Beliefs

The COAs' sense of self becomes tied to their parent's drinking. These children often believe they are responsible for their parent's alcoholism (Berlin et al., 1988; McAndrew, 1985). Frequently children believe that if they are "good"

enough, the parent would not drink. Sometimes alcoholic parents use their children's behavior as an excuse for drinking (Berlin et al., 1988). The children wonder what they are doing wrong, why their parents do not love them enough to stop drinking, (Berlin et al., 1988; McAndrew, 1985).

Besides feeling responsible and inadequate, the children feel anger, confusion and fear. They are angry with the non-alcoholic parent for not fixing everything, for not preventing the alcoholic from getting drunk, for letting the alcoholic break promises, for not defending them, and for not protecting them from the alcoholic's anger. The children are confused by the difference in personality depending upon whether or not the parent is drinking. They are confused when family members ignore or pretend bizarre situations do not occurr. The children fear that the alcoholic parent or other family members will get hurt, sick or die as a result of drinking alcohol (McAndrew, 1985).

These feelings and beliefs further isolate these children because they believe they are the only children who feel this way. They believe that only their family is this way, that no other families have these problems. Since family members are not allowed to communicate feelings, they often fail to recognize that other family members have similar feelings and beliefs.

Roles In An Alcoholic Family

There are roles in all families. One person may be responsible for preparing meals, another for cleaning up. Older children may be expected to watch after younger children and take more responsibility for helping out. These roles provide stability and enable the family to operate more smoothly. In families characterized by alcoholism, adopting roles is a matter of survival.

Relationships in an alcoholic family are with the addiction, not with other family members (Pitman, 1990). Alcoholics are preoccupied with maintaining their alcoholism. Sober parents are often preoccupied with trying to maintain a relationship with the alcoholic while trying to prevent him or her from getting drunk (Pitman, 1990). The lines of authority are arbitrary and inconsistent (Pitman, 1990). Alcoholic parents are often unreliable. Sober parents may be overwhelmed with their responsibilities plus the responsibilities of the drinking parent. The boundaries are unclear (Powell, Gabe & Zahn, 1994). One day the sober parent may confide in the children or request their help and understanding. The next day, the rules may be different. The children, confused by the mixed messages they receive about their responsibilities in the family, assume roles (Pitman, 1990; Powell et al., 1994). These roles not only allow the members to cope with what is occurring in the family, they are an important component of the enabling process. The most commonly accepted roles are those described by Wegscheider (cited in Tomson, 1987; cited in Towers, 1986; cited in Webb, 1993).

Chief Enabler

In an alcoholic family, everyone is an enabler. Family members organize themselves around the alcoholic parent, continually trying to make things right so that the parent will not drink (Birke, 1993). The chief enabler is usually the spouse, but other family members assist and fill in when necessary. The enabler takes over the duties and responsibilities that the alcoholic is unable to fulfill. The enabler provides excuses for the alcoholic and covers up for him or her whenever possible. Enablers hide their feelings of anger, pain and guilt behind a wall of

defenses and powerlessness, manipulation and self-pity (Wegscheider cited in Tomson, 1987; cited in Towers, 1986; cited in Webb, 1993).

The Hero Child

Hero children provide self-worth to the family. These children are often the oldest. They try to make things better at home by being perfect. They excel academically, musically and/or athletically. Hero children believe that if they work hard enough, they can fix the family. These children attend to everyone's needs but their own. Heroes give an impression to the outside world that there is nothing wrong with the family. These children have difficulty being open, trusting, loving and developing relationships with others (Wegscheider cited in Tomson, 1987, cited in Towers, 1986; cited in Webb, 1993).

The Lost Child

Lost children offer relief to the dysfunctional family. They do not cause trouble for themselves or for others. These children may slip through the cracks because they do not draw attention to themselves. Lost children are quiet and shy, but participate just enough not to arouse interest. Lost children lock away feelings of loneliness, hurt, inadequacy and anger behind a wall of quietness, distance and super-independence (Wegscheider cited in Tomson, 1987, cited in Towers, 1986; cited in Webb, 1993).

The Scapegoat

Scapegoats provide a distraction to the family's dysfunction. The acting out behavior of these children take the focus off the alcoholic. The behavior of these children may even provide the alcoholic with an excuse for drinking. Scapegoats are often the second oldest, and their behavior may be a reaction to the

positive attention the Hero receives. Scapegoats try to get attention through failing, drug abuse, unplanned pregnancy, and academic and behavioral problems in school. These children are at a high risk for chemical dependency as adolescents or adults. Scapegoats blame others for thei problems. The behavior problems of these children may lead to identification of the family's problems and eventually to treatment for the alcoholic and/or family (Wegscheider cited in Tomson, 1987; cited in Towers, 1986; cited in Webb, 1993).

The Mascot

Mascots provide fun, humor and relief to the family situation. These children are clowns who will be cute, funny and mischievous in order to draw attention away from a major conflict. Mascots hide their feelings of loneliness, confusion, and insecurity behind a mask of cuteness. Mascots are usually a younger or youngest child in the family (Wegscheider cited in Tomson, 1987; cited in Towers, 1986; cited in Webb, 1993).

COAs may occasionally shift or combine roles. This is most likely to occur when a sibling leaves home, vacating a role. COAs become quite entrenched within their roles and have trouble forming separate identities, because individual development threatens the addicted family system (Powell et al., 1994). Without intervention, COAs continue playing their roles into adulthood (Wegscheider, cited in Tjaden, 1988). Black (1981) also identified similar roles: (a) The Responsible Child, (b) The Adjuster, (c) The Placator, and (d) The Acting Out Child.

Identification of COAs

Alcoholism affects the school performance of children. They experience problems with interpersonal relationships, conduct and academic performance.

Many COAs are identified as a result of their behaviors and performance. However, they are often treated for the behaviors, not the cause (Weddle & Wishon, 1986). Their teachers are interested in fixing the problem, not identifying the underlying cause. Weddle and Wishon (1986) believe that alcoholism may not always be the cause, but it should be considered as a possible factor. The NIAAA (1986) recommended looking past the symptoms and identifying alcoholism as a problem. Pitman (1990) and Powell et al. (1994) suggested that school personnel must learn the difference between adolescents passing through normal stages of development and COAs desperately trying to make sense out of their lives. Early identification and intervention can help prevent alcoholism. Teachers and others who work with students can learn to use behavior, peer relations, appearance, academic perfomance and other sources to assist in the identification of children of alcoholics. With thorough training, all educators and school personnel can provide the quality education and assistance COAs need (Knight et al., 1992).

Behavior of COAs

Identification of COAs may be difficult because some of their coping behaviors appear normal and may even be valued by the teacher (Powers & Zehm, 1991). COAs who assume the Hero Child role are often high achievers. They excel at academics and/or sports. They are approval seekers and have an over-developed sense of responsibility. If teachers are unaware that this might be the dysfunctional behavior of a COA, they may reinforce and enable the behavior (Powers & Zehm, 1991).

Teachers often misinterpret the behaviors of Lost Children. These children attempt to go unnoticed. They do not bring attention to themselves through high

achievement or misbehavior. These children perform well enough to get by, but do not do anything that might draw attention to themselves. These children often slip through the cracks, because they do not display overt behaviors.

Although many COAs exhibit behaviors which teachers appreciate in students, these behaviors are inappropriate. These behaviors,which COAs adopt to survive in a dysfunctional family situation, inhibit rather than help them. They are very anxious to learn the classroom routine because they lack the self-confidence, autonomy, and spontaneity which would allow them to handle change or surprises (Woodside, 1986). They deal much more effectively with rigidity and stability. COAs are afraid of authority figures, angry people and criticism, yet they are very critical of themselves (Weddle & Wishon, 1986). COAs who are quiet and shy may not be able to stand up for themselves or ask questions They never cause any problems in the classroom, but they would probably not ask for help if they needed it.

Not all COAs exhibit behaviors such as those demonstrated by the Hero and Lost Child. Other behavioral symptoms include chronic morning tardiness, frequent requests to see the school nurse, difficulty concentrating, and anxiety about going home or having parents come to school (Campbell, 1988). Buwick et al. (1988) suggested that unprovoked aggression and unusual crying or anger may be early signs of a problem with alcohol at home. McAndrew (1985) stated that COAs have a greater incidence of learning problems, absenteeism, fighting and adjustment problems in school. These behaviors do not necessarily signify that there is a problem with alcohol in the family. If a child exhibits one or more of these behaviors, alcoholism in the family may be a contributing factor.

Alcohol and drug prevention programs often provoke COAs to behave differently than Children of Non-alcoholics (CONAs). COAs often withdraw or misbehave during drug education programs (Campbell, 1988). They display negativity towards alcohol, equate drinking with drunkenness and possess greater knowledge of alcohol than their peers (Edwards & Zander, 1985). These overt behaviors can provide clues to educators that alcohol is a problem for someone in the family.

Rejection By Peers

COAs are often isolated from their peers (Buwick et al., 1988; Edwards & Zander, 1985). The isolation may be self-imposed or dictated by other children. Sometimes they are ashamed of their home lives and isolate themselves to protect the family secret. Sometimes they do not possess the skills to develop relationships with other children or adults. The skills they need to survive at home, inhibit them in different environments.

Appearance

Appearance can also assist in the identification process. COAs may fluctuate in their appearance (Campbell, 1988; Edwards & Zander, 1985). At times their clothes may appear neat and clean, at other times wrinkled and dirty. Their clothes may be inappropriate for the weather. COAs may look and act tired. They also tend to be absent and/or tardy often.

Academic Performance

COAs tend to be inconsistent in their academic performance (Buwick et al., 1988; Campbell, 1988; Edwards & Zander, 1985). This may be attributed to low self-esteem, lack of confidence and motivation, an inability to concentrate or a lack

of time and place to complete homework. COAs live a life filled with inconsistencies. They do not have role models at home to teach them how to maintain consistency in behavior, appearance or academic performance.

Collaborate With Teachers and Counselor

When educators suspect that a student is a COA, they should observe the student over time and in different settings. Teachers should also ask their colleagues about their perceptions and experiences with the student (Powell et al., 1994). It may also be helpful to compare notes with one or more colleagues and get insights from other parties. When educators feel they still have a possible COA, they can present their cases to the school counselor. Counselors can make their own observations and draw conclusions based on information from teachers and themselves. Counselors, because of confidentiality, may not be able to share information with teachers.

Get to Know Student Personally

Powell et al. (1994) suggested that teachers get to know students personally. As teachers develop rapport and build trust with their students, they are in a position to determine whether the behaviors demonstrated by students are normal, developmentally appropriate behaviors or whether they are the behaviors of children adapting home survival skills to school. Teachers should also continue to observe students' behavior, interactions with peers, appearance and academic performance. When teachers' instincts tell them that there might be an addiction problem or dysfunction at home, odds are good that there is one (Pitman, 1990). If teachers are not aware of the difference between normal, developmentally appropriate behaviors and the behaviors of COAs, the counselor can get to know

the student in order to make the determination. Teachers can also consult with the counselor to learn how to recognize the differences.

Meet with the Parents

In order to provide the best assistance to children, it is important to obtain permission and support from the parents. In general, educators tend to believe that parents are totally opposed to any kind of help. Although many of them will not admit that there is a problem with alcohol, they still love their children and want what is best for them. Powell et al. (1994, p. 22-23) offered these hints when speaking with the parents:

1. Keep the focus on the child.
2. Describe specific behaviors of the child.
3. Ask the parents for their help.
4. Avoid criticizing the parents.

If the parents are not placed on the defensive and they believe that the best interests of their child is at stake, they are more likely to be supportive of the school, teacher or counselor.

The Role of School Personnel

School personnel are in a position to help COAs. All children attend school and they spend more time with their teachers than they do with anyone else outside of their families. Teachers have the opportunity to make a tremendous difference in the lives of COAs by offering consistency and a safe environment in the classroom (Morehouse, cited in O'Rourke, 1992).

Recommendations

Powell and Zehm (1991) made several suggestions for teachers and school personnel to help COAs:

1. Examine attitudes, beliefs and misconceptions about alcohol consumption and abuse.
2. Learn about alcoholic home environments.
3. Understand the patterns of denial in COAs.
4. Learn to understand co-dependency and enabling.
5. Learn to recognize when they are enabling a COA by reinforcing dysfunctional behavior.
6. Become aware of identification, assessment, intervention, and prevention strategies for COAs.
7. Learn to distinguish COAs from CONAs and to identify dysfunctional behaviors.
8. Know when and how to refer students to the school counselor or other counseling agencies.
9. Learn appropriate and effective ways to communicate with COAs.

Powell and Zehm (1991) also recommend attending an AA and/or Adult Child of an Alcoholic (ACOA) meeting, visiting an alcoholism and drug treatment center, establishing an Alateen support group in school and having a member or members of the faculty plan and deliver an inservice for teachers about COAs.

There are many strategies which teachers can implement in the classroom to assist COAs. Teachers can help by maintaining a daily schedule, allowing

students to make choices and decisions, providing work time at school for homework, and by being alert to signs of tension and stress (Wilson & Blocher, 1990). These are elements that may be missing from these children's home lives. The classroom atmosphere can be improved for COAs by establishing a trusting relationship through setting limits and maintaining consistency. Teachers should avoid discussing the COAs' problems and behavior during class. They should be reserved for private conversations before or after class. By developing an environment where COAs can establish positive relationships with their peers, COAs will learn to see themselves as worthwhile people (Powell & Garcia, 1991).

School personnel can help prevent COAs from repeating the cycle of compulsive behaviors and alcoholism through education. By learning about the signs and symptoms of chemical dependency, students begin to recognize the effects of alcoholism and make informed decisions about their own use (Fisher, 1989; NIAAA, 1986).

It is important for school personnel to establish good relationships with community agencies and treatment providers (NIAAA, 1986). They are an excellent resource for information on alcohol, drugs and chemical dependency. Counselors from community agencies and treatment programs can help school personnel determine whether a student should be referred to outside counseling. It is also easier to make a referral to an agency and/or treatment program if one is familiar with it.

Counseling Children of Alcoholics

Children of alcoholics experience emotional and behavioral problems because they do not have the skills to cope with the stress of living with an

alcoholic parent (Webb, 1993). Although not all children suffer the same, they all need to learn strategies to cope with their individual situations (Schall, 1986). Many factors contribute to the effects of alcoholism on children. The unreasonable demands, the behaviors they adopt, and the roles they assume affect their ability to build and/or maintain interpersonal relationships and perform academically (Schall, 1986). In order to assist COAs, counselors must develop their trust, listen to them, have an understanding of alcoholism, allow them to communicate feelings and help them build up their self-esteem.

Developing Trust

One of the first things counselors must work on is developing trust with COAs. Even though children may be suffering inwardly, they may not readily reveal the family secret (O'Rourke, 1990). The "don't talk, don't feel, don't trust" rules have been emphasized since the earliest stages of alcoholism. In order to overcome the children's denial, it is important to gain their trust (Brake, 1988). There are several courtesies which the counselors can practice that may help foster trust.

One of these courtesies is that the counselors are on time for appointments (Brake, 1988). Children learn that the counselor can be relied upon to show up when the counselor says he or she will. An underlying message may be, "You are important to me."

Counselors should also show congruence between words and actions (Brake, 1988). Children who are unaccustomed to trusting people may be looking for metacommunications which contradict what the counselor has said. Children

who do not trust people will pick up the nonverbal messages, even the ones the counselor is not aware of sending.

Counselors should avoid sharing even trivial information about students with other school personnel (Fisher, 1989). If the counselor feels that it is absolutely necessary, it is imperative that the counselor obtain the child's permission beforehand (Fisher, 1989; Brake, 1988). Students, in general, do not like it when teachers talk about them. COAs may feel betrayed, and the counselor may not get a second chance.

It is helpful for counselors to use generalities when working with COAs. Questions, especially probing questions, generate the belief that children should have answers. They may feel overwhelmed and threatened (Brake, 1988; McAndrew, 1985). When counselors report what children in similar situations think and feel, the children are not put on the defensive. They also recognize that other children have similar feelings. Vague phrases and generalities address the issues and also show respect for their feelings.

Listen

Children of alcoholics are accustomed to family members denying that there is a problem in the home. No one is willing to discuss it, and no one is willing to listen. When counselors are establishing trust, they should communicate a willingness to listen and discuss the issue (Woodside, 1986). It is important for children to learn that it is acceptable to talk about the family secret and that they will not be thought any less of or condemned because of it. Counselors should attempt to create an environment that is opposite of the home environment (Edwards & Zander, 1985).

It will take time for children to open up and learn to trust. They may expect the counselor to give up. Children are battling denial, lack of trust and isolation. This may be the first time someone has acknowledged a problem in the family and taken the time to listen. Children may believe that if they resist the counselor will give up. Children may also fear having too high of an expectation for the relationship and not know how to respond. It is difficult for children to break out of the patterns of behavior they have needed to survive at home. Patience, flexibility and availability are required for children to realize that all adults do not behave in the same manner (Fisher, 1989).

Understanding Alcoholism

To help overcome the denial of alcoholism, counselors should educate children about alcoholism and how it affects the family (Edwards & Zander, 1985; Reynolds, 1987). It is important to help children realize that alcoholism is a disease and that an alcoholic is someone who cannot control his or her drinking. Alcoholism affects the entire family, and everybody gets hurt (O'Rourke, 1992). Alcoholism does not mean that a parent does not love his or her children, but that the parent has a disease (Berlin et al., 1988). It is very important that children get the message that they are not alone (Berlin et al., 1988; O'Rourke, 1992; Woodside, 1986). Learning that there are other children in similar situations removes some of the stigma and shame attached to living with an alcoholic parent. Children also need to learn that they did not cause the alcoholism. Children are not responsible for their parent's drinking (O'Rourke, 1992; Woodside, 1986). Children also cannot cure or control their parent's drinking (O'Rourke, 1992; Woodside, 1986). Children no longer have to take the blame for their parent's

drinking or feel like they can stop the drinking through behavior. Once children begin to accept these concepts, they can begin to learn new ways to cope with their parent's drinking.

Communicating Feelings

When COAs are ready, the counselor can help them name and identify feelings. This will not be an easy task for COAs, who are accustomed to suppressing and denying their feelings. Identifying feelings is a healing experience and an important step for COAs (Edwards & Zander, 1985; O'Rourke, 1992). When they reach this point, COAs are beginning to accept the reality, but they still need to learn and practice the skills to cope with it.

It is beneficial for children to recognize that feelings are normal. Everyone has them, although not everyone deals with them equally well. There are many different ways to deal with feelings, and some are more effective than others. The counselor's job is to teach children how to communicate their feelings in an appropriate and effective manner. At first it is important for counselors to validate all feelings (O'Rourke, 1990). When children are able to acknowledge their feelings, they will begin the healing process of letting them go.

Self-Esteem

Validating and expressing feelings does not "cure" COAs. They still have to deal with the situation at home and they still need to learn how to adapt to environments outside of the home. COAs need to receive some positive messages about themselves. Counselors should help COAs identify special qualities about themselves and their families (McAndrew, 1985; O'Rourke, 1990). Counselors should validate what the COAs do to deal with alcoholism (McAndrew, 1985).

Viewing children as survivors instead of victims, sends children the message that they are valued (McAndrew, 1985). Counselors can help the COAs identify and refrain from using self-defeating thoughts (Webb, 1993). COAs may believe that they are the cause of the drinking, and that if they were good enough the parent would not drink, or that the parent would not drink if the parent loved them. Counselors and COAs can work together to replace these thoughts with more useful ones such as: Parental drinking is a fact of life; parental drinking is not the children's fault; they are not alone; and they are persons of worth who deserve help (Berlin et al., 1988; Webb, 1993).

In addition to this positive thought replacement, counselors should help implement an element of success in the children's lives (Edwards & Zander, 1985). It is important to provide and encourage children to participate in activities where they can succeed, learn and share ideas (Buwick et al., 1988). Since COAs may not have positive role models at home, the counselor should model the desired behaviors for the children and encourage both guided and individual practice (Webb, 1993). Counselors can take this opportunity to help COAs develop positive relationships with others (Edwards & Zander, 1985). Positive relationships with others help children develop problem solving skills and decreases their feelings of powerlessness (Edwards & Zander, 1985). As COAs begin to feel more positive and confident in themselves, they can try new behaviors which are more appropriate for environments outside of the home. If children can develop an identity which separates them from the alcoholism, the alcoholism will not have a long-lasting affect on their lives (Berlin et al., 1988).

Support Groups

Support groups can be beneficial for COAs. They help discourage social isolation and reinforce the belief that children are not alone (O'Rourke, 1990). Counselors can work with six to eight individuals at various stages of healing in small groups. The COAs have an opportunity to develop more positive peer relations in an atmosphere of comfort, safety and respect. The group members can help each other recognize special qualities and practice new behaviors. There are many types of groups and topics which can be addressed. Members can learn positive coping and decision-making skills, practice stress management techniques and develop personal safety plans. Support groups can address one topic or combine several topics over an extended period of time, depending upon the needs of the group members.

Coping skills. COAs adopt behaviors and roles to help them cope with their situations at home. These behaviors and roles are often ineffective outside of their homes and isolate them from peers and adults. It is important for counselors to teach COAs that there are many positive ways for kids to take care of themselves (O'Rourke, 1992). Group leaders should help members identify support systems outside of the group such as: teachers, counselors, religious group leaders or organizations such as Alateen or Alanon. COAs need to recognize the relationship between cause and effect so they can accept the consequences of their actions. The group members can role-play stressful situations such as refusing to get into a car with a parent who has been drinking, using assertiveness skills like letting others know what their needs are and being responsible for themselves and not the alcoholic. The members can review

personal hygiene and nutrition tips. Looking good and eating right helps people to feel better when they are down.

Decision-making. In decision-making groups, the counselor should emphasize that group members do have a choice in how they behave and that they are responsible for the decisions they make. O'Rourke (1990) suggested teaching members to think before they act; to identify positive outlets for anger; to identify positive people, places and things in their lives; and to identify appropriate ways to avoid arguments and violence. By discussing these issues, group members will be more likely to make a positive choice if the need arises. Counselors can emphasize that the COAs chose not to tell anyone about their family situations, but they also chose to end the denial and accept help.

Managing stress. In stress management groups, the members can practice a variety of stress management techniques. O'Rourke (1990) suggested listening to soft music, doing muscle relaxation exercises, guided imagery, writing, drawing, and providing the opportunity for members to play. Play empowers children to increase their boundaries and challenge their limitations (O'Rourke, 1990). Managing their stress enables the children to employ better coping strategies and enhances their decision-making ability.

Safety plan. Either alone or as a group, COAs need to develop a personal safety plan (Webb, 1993). COAs should identify support systems outside of the group and keep a notebook of important phone numbers (O'Rourke, 1990). They need to know who to call in case of violence, an accident or a fire, if they need a safe place to sleep, or an alternate ride if a driving parent is drinking (Woodside, 1986). They should plan to have money for emergency phone calls such as those

mentioned above. It would be advantageous for them to learn basic first aid skills and safety guidelines for home, neighborhood and possible adverse situations (O'Rourke, 1990). They should also learn the difference between healthy and abusive touching (O'Rourke, 1990). Talking about these possibilities and making a plan can help these children cope more effectively if and when they should encounter a similar situation.

Summary

Not all children are affected the same way by alcoholism, but they are all entitled to help in dealing with it. School counselors are in a position to help. They can begin by exploring their own perceptions about alcoholism. Inservicing faculty and staff about alcoholism, the effects on the family, how it affects the children at home and in school and how to identify COAs is another important step. School counselors should also encourage the development of drug and alcohol prevention and awareness programs to help teach students about alcoholism and its effects. These programs help in the identification of COAs and help COAs recognize themselves. Finally, when working with COAs, counselors need to develop trust, listen, help students identify and express feelings, work on improving self-esteem, teach coping skills, stress management techniques, decision-making skills and help COAs develop personal safety plans. With this kind of assistance, COAs can learn to talk, feel and trust.

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