ADULT CHILDREN OF ALCOHOLICS: A STUDY OF THE PROBLEM AT THE UNIVERSITY LEVEL

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Education Specialist in Counseling

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ABSTRACT OF APPLIED PROJECT

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ADULT CHILDREN OF ALCOHOLICS: A STUDY OF THE PROBLEM AT THE UNIVERSITY LEVEL

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The Children of Alcoholics Screening Test (CAST) was administered to 641 college students to determine the incidence of the problem of students coming from families in which one or both parents were alcoholics. Approximately 22% of the sample were classified as having at least one alcoholic parent. The incidence was higher for females (24.5%) than for males (18.7%). Female ACAs 36 years and older seemed to worry most about their alcoholic parent, 54% of them stated that many of their thoughts revolved around a problem drinking parent. Problems ACAs experience are described and intervention strategies are discussed.

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Chapter 1

INTRODUCTION

It is estimated that there are 9.3 to 10 million alcoholics in the United States (NIAAA, 1980); approximately 2.6 alcoholic men for every alcoholic woman (Hecht, 1973). Alcoholism represents a serious health problem and shortens the life expectancy of its victims approximately 10 to 12 years (Zimering & Domeishel, 1982). Not only does health suffer, but countless hours of work are lost and careers ruined due to the deleterious effects of alcoholism (Woititz, 1983; Zimering & Domeishel, 1982).

For every alcoholic, it is estimated that four or five family members and friends, or some 35 to 45 million persons are directly affected by the disease (VanDoren, 1986). Alcoholism can disrupt marriage life in the family (Wiseman, 1975; 1980), with the alcoholic and spouse becoming embroiled in continual conflict (Sexias, 1977). Poor marital relationships and marital instability have been found in alcoholic families (Chafetz, Blane and Hill, 1977), as well as higher rates of separation and divorce (Whitfield, 1979). No less than their parents, the children in the alcoholic family also suffer the effects.

The Children of Alcoholics Foundation, Inc. (COAF, 1987) reports one out of every eight Americans is the child of an alcoholic, approximately seven million of whom are

under the age of 18. Children of alcoholics (COAs) face a higher than average risk than the general population of becoming alcoholic (Woodside, 1982). Sons of alcoholics are five times more likely to become alcoholic, compared with other sons (Black, 1987). Daughters of alcoholic mothers are three times more likely to become alcoholic, than others (COAF, 1987).

Youngsters growing up in a home where alcoholism becomes a central dynamic in the life of a family, are often subjected to daily tensions and pressure. In fact, life with an alcoholic parent is described as "the most widespread cause of severe stress for school-age children in the United States today" (Schall, 1986, p. 54). Children living in high stress alcoholic environments may be exposed to:

- Family Conflict. In two independent studies, both young and adult children of alcoholics cited parental quarreling and arguing as their chief focus of concern, during childhood. (Cork, 1969; "Many Children of Alcoholics," 1981). Such is the extent of the conflict between their parents, that children worry about their home remaining intact (Hecht, 1973). COAs not only frequently witness violent scenes between their parents but are sometimes "forced to share in them" (Kern, et.al., 1977, p. 208). This tension often generalizes to

other familial relationships, resulting in disharmony and dissension among siblings, as well (Sexias, 1977). Children report being unable to do homework or even eat dinner at home due to the family fighting (NIAAA, 1985).

- Abuse and Neglect. COAs are more apt to be growing up in a home where there is physical abuse and are twice as likely to be victims of incest (Black, 1986). In fact, alcoholism is involved in up to 90 % of all child abuse cases (Naiditch & Lerner, 1987). Children of alcoholics are also frequently victims of child neglect (National Association for Children of Alcoholics, NACOA, 1983; Hindman 1975/76); their basic emotional needs are ignored (Booze-Allen & Hamilton, 1974); their feelings are unacknowledged (Schall, 1986). As Estes and Heinemann (1977) note, "Children living in alcoholic families often feel their own needs are of little importance. The fact that the neglect is not willful does not lessen the devastation these children feel" (p. 72).
- Inconsistent Discipline and Inadequate Structure. The behavior of the alcoholic and often, the nonalcoholic parent is unpredictable; children are erratically disciplined and are provided with "few

concrete limits and guidelines for behavior" (Hindman, 1975/76, p. 3). "There are periods of little or no attention, Black (1984) explains, where children are allowed to do as they please and then there are periods of strict supervision and severe discipline.... Children in these homes are always off balance, never knowing how the parent will behave and what will be expected" (p. 38).

- Disruption of Family Rituals. "Alcoholism is notorious for destroying rituals" (Bennett and Wolin; Cited in Williams, 1984, p. 11). Rituals are family celebrations (i.e. holidays), traditions (i.e. birthdays, summer vacations) and patterned interactions (i.e. eating dinner together). In the alcoholic family, the alcoholic may use such occasions to become intoxicated, creating embarrassing scenes in front of family and friends and uncomfortable tension during family meals (Schmidt, 1984).
- Role Reversal and Parentification. Hecht (1973) writes that "children in the alcoholic family system are forced to play roles and meet parental needs that children in other families do not" (p. 1767). COAs may deny their own needs and prematurely assume as adult role, taking over household duties, (Booze-Allen & Hamilton, 1974),

caring for younger siblings, (Curlee & Salisbury, 1981), and serving as a confidant; listening to the details of a parent's sexual, health and financial problems (NIAAA, 1985), or complaints about the other parent (Estes & Heinemann, 1977).

- Distortion and Denial of Reality. Mislabeling drunken behavior, attributing drunken behavior to someone other than the alcoholic, such as encouraging children to believe they can control a parent's drinking through their behavior (Soyster, 1984), and maintaining the myth that everything is fine, despite a home atmosphere of "hopelessness and depression" (Musello, 1984, p. 9), are some of the denial strategies often employed in alcoholic families. Sexias (1977) writes, "The denial system omnipresent in the alcoholic himself is just as blatant in the alcoholic family, creating an atmosphere of lies in which the child is forced to conspire. As a result, he is cut off from participation in the world of adults and 'normality'. This denial system makes it difficult for him to create boundaries for himself, to determine the parameters of reality and to mature as a person who can give and receive love and who can trust himself and those around him" (p. 157).

. Isolation. The family rules of "Don't talk about the alcoholism", "Don't confront the drinking behavior" and "Protect and shelter the alcoholic so things don't get worse", serve to isolate members of the alcoholic family from one another (Worden, 1984). Shame and embarrassment regarding the alcoholic's behavior coupled with the need to maintain alcoholism as a closely guarded family secret, isolate family members from the community, as well. COAs are often reluctant to bring friends home, (Cork, 1969), avoid activities that involve the alcoholic parent (Morehouse, 1984) and usually don't confide their problems in others (Woodside, 1982). They become, as Stark (1987) suggests, "Co-conspirators in a pact of silence" (p. 58).

These stressful and destructive patterns of familial interaction can continue operating for several years, leaving every member in the alcoholic family "emotionally drained" (Curlee-Salisbury, 1981, p. 32); their personal serenity "lost to worry and fear" (Neikirk, 1984, p. 84). Most families postpone seeking outside assistance for an average of nine years (Bucky, 1978) and even if help is received, if it is limited to the treatment and recovery of the alcoholic parent alone, the problems experienced by children, may continue (Booze-Allen & Hamilton, 1974).

While the nature of the impact of parental alcoholism needs further investigation (El-Guebaly & Offord, 1977; Nardi, 1981; NIAAA, 1985), there is a little doubt "that there are large numbers of children affected by living in alcoholic homes" (Woititz, 1983, p. 2). The suffering of some COAs manifests itself during childhood and adolescence in (a) School and/or behavior problems, characterized by fighting with peers, temper tantrums, disruptive classroom behavior, poor academic performance, truancy, delinquency, and/or abuse of alcohol and other drugs (Chafetz, Blane & Hill, 1977; COAF, 1987; Haberman, 1966; Hindman, 1975/76; Triplett & Arneson, 1978; Wegscheider, 1981; & Werner, 1985); (b) Emotional difficulties, such as anxiety, depression, (Moos-Billings, 1982; Sloboda, 1974), and low self-esteem (Baraga, 1978; Bosma, 1972; Hughes, 1977; Woititz, 1976, Cited in Woititz, 1983), and (c) Physical problems, such as ulcers, obesity, chronic stomachaches (Cork, 1969), and asthma (Black, 1986).

COAs are overrepresented in juvenile justice and mental health facilities, have a higher rate of attempted and completed suicides (O'Gorman, Cited in Perspectives, 1984; NACOA, 1983), and comprise a disproportionate percentage of the annual school drop-out population (Deutsch, 1984). They account for some 20% of all

referrals to child guidance clinics (Kinney and Leaton, 1978) and approximately 40%-90% of caseloads in child and family agencies (Woodside, 1982).

Many COAs, however, do not appear outwardly affected by parental alcoholism until adulthood (Woodside, 1982). As Marks (1986) points out, "children of alcoholics often do learn to cope - superbly - but it is usually at great cost to themselves" (p. 105). These model, seemingly, "well-adjusted" children, have a strong desire to appear "normal" and adopt roles which serve to maintain balance in their family and assist them in surviving the unpredictability of their home environment (Black, 1979, 1981). By learning to repress feelings, rely only on themselves, organize to care for others and engage in activities through which they excel (Black, 1979, 1981; Brown, Cited in Shah & Reese, 1979), their problems remain hidden behind overachieving, caretaking, perfect behavior-coping behaviors which are approval seeking and socially acceptable. Speaking to the concerns of these offspring, Brown (Cited in Shah & Reese, 1979) notes, "We've been missing the boat. There is an entire population of children who grew up looking so good, acting so perfect, achieving so much. Then in their twenties and thirties, things begin to fall apart. My research shows that half of them will turn to alcohol and perpetuate the problem from generation to generation" (p. 82).

Efforts to understand the estimated 21 million adult children of alcoholics (ACAs) in this country, (NIAAA, 1985) are just beginning (Miller and Tuschfield, 1986). However, it appears that for many ACAs, the interwoven behavioral and interactional patterns learned in the alcoholic family of origin, continue into adulthood and adult relationships. The most commonly cited patterns include:

- Denial. It is suggested that nearly 50% of ACAs deny a parental drinking problem (Black, 1984; Cited in Whitfield, 1987). It is further reported that the severity of the trauma in their family of origin, prevents many ACAs from remembering up to 75% of their childhood experiences (Whitfield, 1987). Speaking to this dynamic in ACAs, Wegscheider (Cited in NIAAA, 1984) states, "They deny problems all along because admitting problems involves remembering early experiences, most of which are very painful" (p. 6).
- Excessive Need for Control. Cermak and Brown (1982), reporting on group therapy with ACAs, identified issues of control, as a dominant feature. Cermak (1984) notes that ACAs "remain hypervigilant in order to detect change before it gets out of control and highly value the ability to

maintain a controlled facade, despite whatever turmoil might exist within themselves or the family" (p. 41). Likewise in a study of 59 daughters of alcoholic fathers and 65 daughters of non-alcoholics, ages 21 to 50, Jackson (1985) found daughters of alcoholics were more dominant and had a strong need to control relationships and situations.

Inappropriate Sense of Responsibility. Jackson's investigation also revealed that daughters of alcoholics were more guilt-prone and more inclined to feel responsible for the behavior of others. Similarly, Gravitz and Bowden (1984) indicate many ACAs have an overdeveloped sense of responsibility and "may believe they are the cause of others' emotions" (p. 28). Many not only feel responsible for the feelings and actions of others, but also assume responsibility for catering to the needs of others to the exclusion of acknowledging their own needs (Cermak, Cited in NIAAA, 1984; Cermak, Cited in Observer, 1986). This extreme sense of responsibility seems particularly true in regard to the ACA's relationship with the alcoholic parent. ACAs attending college or living independently from the family may continue to worry about the alcoholic and feel they should be taking care of

the parent, not enjoying a new life with less responsibility (NIAAA, 1985, p. 9).

- Difficulty with Identification and Expression of Feelings. In a study of 400 ACAs and 400 controls, Black (Cited in NIAAA, 1984) found 58% of the ACA respondents to have difficulty identifying their feelings. Sixty-five percent reported an inability to express feelings easily.
- Difficulty Trusting. A majority of ACAs in Black's study (60%) also reported their inability to trust people to present a problem in their lives. In their work with more than 1,500 ACAs in clinical and nonclinical settings, Gravitz and Bowden (1984) report an "all-or-none functioning" among many ACAs such that trust is either maintained to an unrealistic degree or totally absent.
- Discomfort with Intimacy and Difficulty Maintaining Satisfying Relationships. Given the previously mentioned patterns and the lack of healthy role modeling for intimacy in their family of origin, it is not surprising that several authors indicate many ACAs have difficulty with interpersonal, intimate and/or sexual relationships (Black, 1981; Gravitz & Bowden, 1987) Kritsberg, 1987; Norwood, 1985; Rosellini & Worden, 1987; Woititz, Cited in

NIAAA, 1984; Woititz, 1983; 1985; 1986). In a national study with over 1,600 individuals, Ackerman (Cited in Wolkind, 1987) found ACAs to identify as the first and most important area in which they were in need of help, ways to improve their relationships. Likewise, 72% of the ACAs in Black's investigation, (Cited in Black, 1984), viewed intimacy as a major problematic area of adult life. As Woititz (1986) notes, "The bonding necessary for a healthy, intimate relationship, primarily takes place on an emotional level. If the foundation for one's emotional 'training' in the family included alcoholism, that foundation will be shaky" (p. 33).

Compulsive Behavior. The over-achiever syndrome most common among "well-adjusted" COAs (Black & Brown, Cited in Shah & Reese, 1979), has similarly appeared among many grown children of alcoholics, as well. Speaking of the female ACA, Soyster (1984) writes, "Indeed, the adult child of the alcoholic often does succeed remarkably well in the eyes of the world. She is apt to be highly educated, and precocious in her career development" (p. 9). Most ACAs "strive for perfection" (Stamas, 1987, p. 28) and often overcompensate for their discomfort with intimacy and difficulty with

> emotional expressiveness, by seeking positions of high achievement and high performance work situations to 'prove themselves' (Woititz and Wegscheider, Cites in NIAAA, 1984, p. 6). They are at high risk to become workaholics (Woititz, 1987) and often do not allow themselves time to relax in between projects (Black, 1985). "The tough part, Wegscheider (Cited in NIAAA, 1984) writes, is that they are often so successful and look so good that it's hard to identify them and even harder for them to recognize their own problems" (p. 6).

Often, it is when ACAs have begun to lead settled lives that the effects of family alcoholism, hidden for years, begin to emerge. Sudden breakdowns are reported by clinicians working with highly successful professionals (NIAAA, 1985). "By their late twenties and early thirties, many grown children of alcoholics begin to find life flat and unfulfilling" (Woodside, 1982, p. 5). Many ACAs suffer from loneliness, lingering guilt (Black and Brown, Cited in Shah & Reese, 1979; Sexias & Youcha, 1985), stress-related illness (Black, 1987; Kristberg, 1986) unresolved grief and loss (Whitfield, 1987), depression (Black, 1981; Goglia, 1986; Norwood, 1985), and feelings of failure and shame despite their ostensible success (Soyster, 1984). ACAs,

previously nondrinkers, may become alcoholics and/or choose alcoholic mates, thereby recreating the alcoholic life patterns of parents and grandparents (NIAAA, 1985). It is estimated that 40 to 60 percent of COAs will become alcoholics and 30 percent will marry alcoholics (Black, 1981). Indeed, as Meg Woodside (1982) writes, "although there is a wide range in the chronological age that individuals experience the effects, it is certain no one can avoid the problems which come from being the child of an alcoholic" (p. 37).

In recent years, there has been increasing evidence to suggest that many students in elementary, secondary, college, and graduate classrooms across the country, have at least one alcoholic parent. It is estimated that 25% of all public school children are COAs (Naiditch & Lerner, 1987). While the prevalence among students of higher education is less clear, a recent study on the campuses of Hobart and William Smith Colleges in New York, found one in five college students to be the child of an alcoholic or alcohol abuser (Observer, 1986).

Educational settings have been targeted as appropriate locations for identifying and assisting these students (Edwards & Zander, 1985; Newlon & Furrow, 1986; Sexias, 1977; Ackerman, 1987), yet resources have been sorely limited (McAndrew, 1985). Needed, are concentrated efforts to examine the prevalence of students from

alcoholic homes, utilizing reliable screening instruments for identification. Historically, most attempts to identify and assist COAs have been initiated after a child displays behavior problems or a parent comes to the attention of professionals (Hindman, 1975/76). Considering that many sons and daughters of alcoholics do not display outward symptoms and "only fifteen percent of alcoholics ever receive treatment" (Stark, 1987, p. 62), an accurate picture of the prevalence of students in need of assistance, has been difficult to achieve.

Also needed, are efforts to further enlighten and sensitize school and university personnel to the distress incurred as a result of growing up in an alcoholic family. Teachers and counselors who could serve as potential caregivers to this population, are often "unaware of the severe effect alcoholism can have on the entire family" (Newlon & Furrow, 1986, p. 288). In turn, the lack of information available to the professional community has often resulted in sons and daughters of alcoholics being misunderstood and misdiagnosed (Naiditch & Lerner, 1987; Kritsberg, 1986). As Naiditch & Lerner (1987) write, "We must remember that children of alcoholics are not 'sick'. They are experiencing normal reactions to what are often abnormal circumstances" (p. 37).

In response to these needs, the present study

sought to assess the incidence of parental alcoholism among a collegiate population through the identification of students who could be classified as adult children of alcoholics. In addition, students' perception of and responses to, a parent's drinking, as well as students' desire for help, were examined.

Chapter 2

METHOD

Participants and Procedures:

The sample consisted of 363 female and 278 male, undergraduate and graduate students, enrolled in classes at a mid-sized university. Students ranged in age from 18 years to 53 years, with a mean age of 24.5 years for the total student population screened.

The Children of Alcoholics Screening Test (C.A.S.T.) was administered to volunteer participants in regional and on-campus classroom settings, during day and evening classes and to members of Greek sororities and fraternities, during regularly scheduled business meetings. Classes were selected from course offerings in all three colleges of the university.

Instrument:

The Children of Alcoholics Screening Test is a 30-item inventory developed from published case studies and personal experiences reported by clinically diagnosed children of alcoholics (Jones, 1981, Cited in Pilat and Jones, 1984/85). Used to identify latency-age, adolescent and adult children of alcoholics in a confidential manner, the C.A.S.T. measures one's perceptions, feelings and experiences related to a parent's drinking.

Jones (1982, Cited in Jones, 1987) administered the

C.A.S.T. to children of clinically diagnosed alcoholics, self-reported COAs and randomly selected control group children and found that a cutoff score of six or more reliably identified children of alcoholics. The clinically diagnosed COAs were from a home where a parent was diagnosed alcoholic by a psychiatrist, psychologist and a certified alcoholism counselor, based upon diagnostic criteria of the American Psychiatric Association and National Council on Alcoholism. A Spearman-Brown split-half (odd vs. even) reliability coefficient of .98 was computed with these samples and also with a random sample of 81 adults.

In the present study, the total number of YES answers on each completed C.A.S.T. were tabulated to yield a final score and the C.A.S.T. standards (Pilat and Jones, 1984/85), were applied as follows: 0-1 YES answers, Adults of nonalcoholics; 2-5 YES answers, adults of problem-drinkers, and 6 or above, adult children of alcoholics.

Chapter 3

RESULTS

Incidence of Parental Alcoholism:

Of the total college sample (N = 641), one hundred forty-one students (21.9%), were classified as having at least one alcoholic parent. The incidence of parental alcoholism varied with the sex of the student screened. Of the 363 female students completing the C.A.S.T., eighty-nine students (24.5%), tested in the category of ACAs. Of the male students screened (N = 278), fifty-two students (18.7%), scored 6 or more on the C.A.S.T. and were classified as adult children of alcoholics. The responses of students identified as adult children of alcoholics were examined to determine the student's perception of a parental drinking problem, student's responses to a parent's drinking and the student's desire to help.

Perception of Parental Problem Drinking and Parental Alcoholism:

The vast majority of these students (89.3%), reported perceiving at least one of their parents as having a drinking problem. Approximately 90% of the males and 70% of the females also reported perceiving at least one of their parents as an alcoholic. Of these students (N = 109), 79% reported perceiving their father as an alcoholic, 14% perceived their mother as alcoholic, and 7% reported

perceiving both parents as alcoholics.

Responses to a Parent's Drinking:

Fear, worry, resentment, and control, seemed to be characteristic responses of students to a parent's drinking, a parent's inability to stop drinking, and/or to alcohol-related problems in the family. Many students reported having:

- Resented a parent's drinking (86.5%)
- Worried about a parent's health because of his/her alcohol use (78.7%)
- Felt alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking (70.2%)
- Lost sleep because of a parent's drinking (70.2%)
- Felt like hiding or emptying a parent's bottle of liquor (60.2%)
- Felt sick, cried, or had "knot" in their stomach after worrying about a parent's drinking (59.5%).
- Feared their parents would divorce due to alcohol misuse (58.5%)
- Felt caught in the middle of an argument or fight between a problem drinking parent and their other parent (52.4%)
- Protected another family member from a parent who was drinking (43.9%)

Most students not only desired a parent to stop

drinking (95%), but also reported having encouraged a parent to quit drinking (73.7). Such was the alcohol-related distress in their family that 62.4% reported having wished their home could be more like the homes of their friends who did not have a problem-drinking parent.

Perhaps, the most notable finding, was the large percentage of female students, 35+ years, whose thoughts seemed to be largely centered around an alcoholic parent. Roughly, 30.4% of the ACA student sample reported many of their thoughts to revolve around a problem-drinking parent or difficulties that arise because of his/her drinking (C.A.S.T. question 11). However, 54.5% of the female ACAs, 35 years of age and older (N = 22), answered YES to this C.A.S.T. question.

Desire for Help:

Of students testing in the category of ACAs, sixty-two (44%) reported a desire, now or in the past, to talk to someone who could understand and help the alcohol-related problems in their family (C.A.S.T. question 26). Despite similar average C.A.S.T. scores of male students (14.0) and female students (15.3), approximately 33% of the males compared to 50.5% of the females, answered YES to this C.A.S.T. question. Of the female students thirty years of age and older (N = 31), fifty-eight percent reported having desired help.

Chapter 4

DISCUSSION

The present study differed from many previous investigations due to the utilization of an instrument which identified students who are presently residing or have lived with, an alcoholic parent. Of the total college sample, roughly, 22%, or 1 in 5 students screened, tested in the category of adult children of alcoholics. A majority of these students also perceived a parent as alcoholic. For many of these students, exposure to drinking-related arguments and fights, parental conflict, as well as worry, resentment, fear, and loss of sleep engendered by a parent's drinking and a parent's inability to stop drinking, are a part of their history as the child of an alcoholic.

Most females wished they could talk to someone who could understand and help such problems in their family. Of special concern, are the many non-traditional age female students who appear preoccupied with an alcoholic parent or difficulties that develop from a parent's drinking. Given the high percentage of women in this age range classified as ACAs (37.8%), as well as the percentage having desired help (58%), this subgroup, appears in particular need of further investigation and assistance.

Chapter 5

SUMMARY

In general, the data obtained from this study, in concert with existing research, signal the need for school and university personnel to engage actively in efforts to identify and assist this population.

In recent years, articles have emerged in the literature, which suggest ways of helping young and grown children from alcoholic families (Bingham & Bargar, 1985; Brooks, 1981; Donovan, 1981; Downing & Walker, 1987; DiCicco, et. al., 1984; Edwards & Zander, 1985; Hawley & Brown, 1981; Hecht, 1977; Manning & Manning, 1984; Schall, 1986; Weddle & Wishon, 1981). While many students can benefit from groups specially designed for the sons and daughters of alcoholic parents (Donovan, 1981; and Downing & Walker, 1987), expanding the academic curriculum to include the subject of family alcoholism can also be of assistance. As DiCicco and her colleagues (1984) point out, "the norms of secrecy about alcoholism in the family are so well entrenched that many children of alcoholics are willing to be served only in integrated settings" (p. 22).

Efforts to reach adult children of alcoholics also need to reflect a sensitivity to the difficulties inherent in expecting ACAs to self-identify. As Bratton (1987) writes, "When we ask the ACOA to come into treatment and

talk about his/her feelings and trust us, we are asking him/her to violate the modus operandi of a lifetime. That is something she/he cannot or will not do. It is unrealistic to expect the vast majority of ACAs to simply call and make an appointment for counseling for themselves" (p. 11). Even if they enter counseling, most adult children do not present with complaints that they are ACAs (Weiss and Weiss, 1987), or seek counseling to deal with the effect parental alcoholism has had on their lives (VanDoren, 1986).

Perhaps, most important, is the need for the educational community to improve their understanding of the unique problems and special needs of this population. Addressing this issue, Brown (Cited in Perspectives, 1984), states, "Teaching and training about children of alcoholics belongs in curriculums of school teachers, psychologists, psychiatrists, and all helping professionals" (p. 32). Beals (Cited in Stark, 1987), found that teachers, coaches, and counselors who can "talk with and advise children from alcoholic homes, can make a real difference to a child" (p. 61). In regard to adult children, Cermak (Cited in NIAAA, 1984) states, "Just knowing there is a reason they feel bad, is enough to help some people explain and understand their feelings" (p. 6). School and university personnel, who are aware of and sensitive to, the prevalence of students from alcoholic families and the distress many of

these students experience, can provide the assistance many sons and daughters of alcoholic parents need and desire.

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