




THE WAR ON CRACK

RESTORING THE SOUL OF THE FAMILY

A THERAPIST IS CONDUCTING A SESSION WITH A 63-YEAR-OLD black grandmother, Louise, and three of her grandchildren, Janet, 14, Derek, 12, and Krista, two and a half. This is only the family's third session in six weeks; they have cancelled or failed to show up for three other appointments. Derek is the identified patient, although everyone in the room could easily carry that honor. A sullen, angry boy, Derek has already been held back once in school and appears to be failing again. His teachers are fed up with his mouthy attitude and clownish horseplay, and his counselor has already talked with Louise several times. Louise quietly listened to the standard discipline-begins-at-home lecture, not even bothering to voice her real feeling that, "when he's in school, he's your problem." Derek's mother, Sheila, is a crack addict and his father is in jail for drug dealing.

Two years ago, Derek and his sisters were living with Sheila in an increasingly common urban horror story.

**BY BRUCE BUCHANAN
AND JAY LAPPIN**



*Grandparent-
headed
families fight
the odds
against
survival*



Diane Werner lives off welfare and is raising her emotionally scarred grandson, Seth, because her crack-addict daughter will not stay off drugs. Werner was fired from her \$42,000-a-year job after missing too much

work because of the constant crises with her daughter. This sudden change in lifestyle and circumstances has made Werner an outspoken advocate on behalf of grandparents who face the same lack of financial and social sup-

port in their new parenting role. She helped form a support group in her county, and was recently awarded the "Spirit of the American Woman" award by J.C. Penney and Channel 29-Philadelphia.

Sheila had ceased functioning as a mother, letting her children look after themselves, even selling the family's food to support her habit. Janet and Derek were truant from school for most of the year. Janet, starved for any affection and human warmth, had become sexually active and acquired a sexually transmitted disease by her 12th birthday. Graced with a cheerful spirit and strong capacity for survival, Janet learned to bend to her mother's exaggerated mood swings to avoid being beaten. Derek wasn't so lucky. When Sheila craved the pipe, which was most of the time, she became desperate and violent. Merely a sideways glance or barely audible mutter from Derek would earn him another scar from a fist, belt buckle, or ironing cord. Eventually, Derek simply ran, and began sleeping in abandoned cars.

During that time, Louise, who didn't realize just how bad things were, tried to help out, though in mostly unhelpful ways. She would yell at the kids to mind their mom, and give Sheila a few extra dollars in return for another iron-clad guarantee that the money would be well-spent. Finally, the birth of Sheila's crack

THESE GRANDPARENTS MUST CHOOSE BETWEEN STRUGGLING THROUGH A FORCED SECOND PARENT-HOOD OR SALVAGING SOME REMNANT OF THEIR OWN LIVES BY ABANDONING THEIR GRANDCHILDREN.

addicted and neurologically impaired baby, Krista, made reality undentable. Louise, the hospital, and Child Protective Services intervened, and Grandmom reluctantly became a full-time mother again.

TODAY, THE THERAPIST, EILEEN, A young woman in her mid 20s, listens to Louise, battle-worn and angry, attack Derek and the therapy team as well. "I've had it. This ain't helping. He's not getting any better—he's getting worse. This kid, you can't crack him. He doesn't do anything I tell him. He just sasses me and gives me that look of his. I'm telling you—he's evil and I've had it. He needs to be put away in a home or something. I'm

not dealing with him no more!" Derek turns away and silently looks down at his Nikea. Janet, as if to agree with her grandmother, shakes her head and takes Krista on her lap to stop her crying.

Eileen unconsciously pulls her chair a half-step away from Louise and toward Derek. She takes a deep breath and thinks to herself, "No wonder this kid runs away," and tries to lower the tension in the room while simultaneously coming to Derek's rescue. Eileen turns to Louise and says, "I can tell that you're really upset and I understand your anger, but I don't think that what you are doing is helpful. There's no way that Derek will be able to change if he only hears criticism. As for us not helping—well, Louise, therapy is a slow process and you have missed a lot of sessions." Louise simply glares at Eileen in disgust and says, "You don't get it. I didn't ask for this—he's the problem. The boy is bad, and I'm not dealing no more—you keep him!"

The intercom buzzes with a message from the supervisor to Eileen, asking her to take a break and consult with the team behind the mirror. Once out of the room, Eileen pours out her frustration to her colleagues and supervisor. Just as Louise has had it with Derek, Eileen would like to be rid of Louise. The training group is demoralized; this is the third time in a week they've heard a custodial grandmother push vigorously for placement of one or more of her grandchildren. This is also the third time that the therapist has been drawn in by the pain of a child, almost to the point of excluding the adult, who then feels abandoned in the therapeutic relationship.

The team encourages Eileen to vent her distress, but then asks what she thinks Louise's experience must be. Quickly, she is able to take a more systemic stance. The decision is made that if the goal is to keep the family together, Eileen must convince Louise that she is in her corner 100 percent. Again, for the third time this week, the team will practice and observe a major sequence of interventions that we have loosely termed "You're stuck with me."

Children of addicts carry heavy emotional baggage, terrified of being abandoned again. Setb gets stomach aches at school every day because he misses his grandmother. "These kids need special school programs—you can't just put them in day care," says Werner, who spends most of her welfare money to send Setb to a kindergarten for kids with special emotional needs.



THE DEPTH OF THE CRACK CRISIS really hit home for us this past year, when we found that among the 60 families seen by the training group we direct and supervise, we repeatedly encountered grandparent-headed families caught in the same struggles as Louise and her family. For therapists working with poor, urban families in which both parents are impaired by drugs, willing grandparents are often the last hope before one or more of the children must be placed in the custody of the Department of Human Services.

As we tried to find ways to help these families, we realized that we had to rewrite the book of structural family therapy. We found that our families were not the same ones Salvador Minuchin talked about in *Families of the Slums* or *Families and Family Therapy*. The grandmother-headed households in today's crack-devastated neighborhoods are making a crazy stew of standard organizational patterns, blending ingredients from step, extended, and foster families, liberally sprinkled with gerontologic and addiction issues as well. We no longer had the luxury of simply restoring hierarchies, creating boundaries, and breaking through enmeshment patterns. The families we saw were so dramatically disconnected, so chaotic, that they barely hung together at all; they had been robbed of the very soul of their identities as families.

WHEN EILEEN RECONVENES THE session, Louise has her overcoat on and her purse in her lap, making all too clear her intentions. Derek continues to look down, refusing to let his sadness or anxiety show. Eileen pulls her chair closer to Louise and says, "Louise, I think I owe you an apology. I didn't realize before how much Derek was pushing you to the wall. Even in here he's doing it, muttering under his breath and disrespecting you. I don't think he has any idea of what you've done for him and his sisters. You saved their lives! They could have been dead in another week, but you refused to let it happen. You have sacrificed a period of your life when you should be able to put up your feet and watch the world go by in order to give these kids a family and a future. And this is the thanks you get. You keep giving and giving and Derek's just taking and taking and you're not getting anything back. I think it stinks. And I can certainly see that if Derek doesn't begin to change soon, placement may be the only alternative." Louise looks down, her eyes filling up with tears, and says, "I'm just so



tired. I just don't know how much more I can take."

Eileen then says, "Louise, I would like to have another member of the team meet with Derek in a separate room, to try and find out what's making him tick and how to help him, while you and I meet so that I have more of a chance to understand what Derek is like at home. Would that be all right with you?" Much of Louise's rage has drained away, and now, looking spent and tired, she just nods "Okay." Eileen has accomplished the first goal agreed upon behind the mirror. Louise is able to see that she is no longer quite so isolated, so unsupported. And, perhaps even more importantly, Eileen has acknowledged Louise's sacrifice for her grandchildren.

Last year Lola Anderson got a call from her son's mother-in-law telling Lola that her three granddaughters were going to be placed in foster homes because their parents were both drug addicts. Anderson took them in, and is raising them on her own, support-

ing them by working full-time as a store cashier. She finds time to take the girls, ages nine, seven and three, to the playground and on outings after church on Sundays. When the girls ask about their parents, she is honest: "I say I haven't heard from them."

At the emotional heart of the grandparent-headed family is the experience of ambivalence, in itself nothing new to therapists, but showing up here with a ferocity that demands far more from the therapist than mere technical expertise. These grandparents—primarily grandmothers—must choose between accepting and struggling through a forced second parenthood under harrowing conditions, or salvaging some remnants of their own lives by abandoning their grandchildren. But despite the immensity of this decision, how these women feel at any moment of any day typically rides upon scores of small interactions. If she receives a hug or smile from a grandchild, or a real sign of support from a friend, teacher, or neighbor, it may be enough to anchor her in the sense that “this is my family—it’s hard, but it’s worth it.” Alternatively, the turmoil of dealing with an unappreciative, hostile kid who refuses to do his homework, an unexpected visit from an addicted and disruptive daughter, or a delay in a public assistance check can make her give up—“These aren’t my kids; I shouldn’t have to be doing this for the second time around.”

Therapists must be capable of the kind of empathy that allows them to understand both sides of a grandparent’s dilemma. In the clinic, we see the ambivalence acted out dramatically during crisis periods. The rapid shift from expressions of complete loyalty to the grandchildren to bitter denunciation of them during a session—often within seconds—can be unsettling to a therapist, who must develop a tolerance for these instantaneous flips and a sensitivity to what triggers them. We must be sounding boards for both sides of the ambivalence, and, even more, tenacious advocates for

THE THERAPEUTIC STRATEGY IS TO CREATE BETWEEN CLINICIAN AND GRANDMOTHER A KIND OF MODEL FOR THE RELATIONSHIP BETWEEN GRANDMOTHER AND GRANDCHILD.

the full and open expression of it. If a grandmother cuts herself off from her own internal dialogue, she is likely to vacillate wildly between guilty over-involvement with her grandchildren and resentful desires to abandon them.

Often we introduce the grandmother to her own ambivalence by voicing for her the half she is unable to admit. A number of common themes turn up, including her resentment, the feeling that she has been cheated out of a deserved retirement, and the defeated sense that she has failed her first go-round of childrearing. The emergence of these “gypsy truths” often releases a wellspring of emotion that dissipates the anger, blame, and punishment the grandmother usually directs at the child.

Though our goal is to keep families intact when possible, we don’t try to talk a grandmother out of her conviction that her grandchildren should go into placement. Trying to argue her into family preservation only creates an escalating sequence of attack and defense, and leaves her feeling that nobody is listening to her. Instead, we discuss placement as a real option, though not a very desirable one. When we make plain to the grandmother the realities of placement—the paucity of decent facilities for poor children, and the loss of control that the family will

experience—she usually rethinks her decision to have the child “put away” somewhere. Simply discussing placement as a concrete possibility, however, helps the grandmother regard the therapist as an ally rather than a child saver, and makes her more likely to accept therapeutic challenges farther down the road.

AS EILEEN LISTENS TO LOUISE—closely, without trying to persuade her of anything—she is able to appreciate the oppressive sense of isolation that dominates her life, and her disappointment at Derek’s rejection of her attempts to help him. The two discuss placement as a choice and Louise begins to equivocate. Meanwhile, another therapist meets with Derek. A typical crack kid, robbed of his childhood, he has lived his life taking care of adults. Throughout the meeting, his own ambivalence emerges, toward both his mother and grandmother. He worries about his mom, afraid that she will overdose or get killed. He feels guilty about not being with her, not watching out for her. At the same time he remembers the beatings but dismisses them, preferring to idealize his mother. He doesn’t like living with his grandmother. “All she wants me to do is rest,” he complains. “I can’t go outside like a normal kid. I think she thinks I’m a rest

machine.” But, finally, he admits that as much as he doesn’t like living with his grandmother and listening to her yelling, he is also frightened that he might not have a home in the near future—that Grandmom will die because he will give her a nervous breakdown or a heart attack, or that she’ll simply kick him out. Derek gives the okay for the therapist to let his grandmother know about his fears.

The stage is set, and Louise, Eileen, and Derek’s therapist meet together. Louise is now more relaxed; she feels she’s been heard and the severity



Anderson and therapist Michelle Cufford applaud when 3-year-old Jane eats. This crack child weighed only 15 pounds last year, and is now up to 24. Jane is in a Failure to Thrive program, and is encouraged to eat by Anderson singing and playing with her.



of Derek's behavior is not being dismissed. She can absorb the report that Derek is hurting badly, and that his fear of becoming a "hot potato" actually contributes to his bad behavior.

We now present a new challenge to Louise. She must decide up front whether she wants the team to help her deal with Derek in the family or if the goal should be family separation and placement. Either way, Eileen explains, the team is committed to her and Derek, to see them through the entire process, no matter what it takes or however difficult. What won't work, however, is to leave Derek's

place in the family continually threatened and contingent upon his good behavior—"If you're good, you can stay. One wrong move, and out you go." We give no guarantees that Derek's behavior will improve if Louise tells him that she's not placing him, only that it cannot improve if he doesn't develop the security that comes with having a home where he belongs. We predict that he may become temporarily even more obnoxious if he hears he's staying with Louise; he will need to put her decision to the test.

Louise hears and understands. Supported by the therapist, within the cooling distance provided by her separate work with Eileen, she can allow herself to be touched by Derek's misery. She wants to keep Derek in the family as long as she knows she can count on getting help. Again we challenge her. "Are you sure? Let's really think this through. You don't want to promise to contend with his next school suspension or temper tantrum, only to feel you can't stand it and have to change your mind in a week or so. We all know Derek pretty well. As you said, Louise, he's tough to crack"—an intentional modification of Louise's earlier statement that "you can't crack him." Louise insists that she's ready. After Eileen and Louise talk some more, Derek and the girls are brought back into the room.

Louise talks to Derek, who looks more anxious than before. "Derek, listen to me—I've been talking with Eileen about your behavior. I don't like it, and we're gonna keep coming here so it can get better. And Eileen is going to visit the school with me to discuss with Miss

Johnson and Mr. Matthews how to help you there. But there's somethin' else I want you to know—you ain't gonna go in no home or hospital. You're gonna stay with me and Janet and Krista. But you're gonna change. You're stuck with me, you hear?"

Derek looks down and doesn't answer.

Eileen interjects, "Get him to answer you, Louise—you deserve an answer."

Louise sharpens her voice. "Look at me, Derek. Don't look down at your shoes. I asked you a question—you hear me?"

Derek looks up and says, "Yeah."

Louise says, "You better say 'Yeah' because from now on the buck stops here."

Finally, to seal the matter and to further convince Louise that the team is with her, she is asked to give Derek a consequence for his actions before and during the session.

IN THE DAYS AND WEEKS TO FOLLOW, Eileen will deal with the best and worst of Louise and Derek. Louise will change her mind a few more times and, as predicted, Derek will give Louise ample reason to reconsider placement. These first weeks are typically a period of maximum therapist involvement, when the time spent on case management often equals the hours in actual family contact. At this point, the therapist calls and visits the home and school, and works with other community resources to ease some of the grandmother's burden.

"They are beautiful children and bring me a lot of joy," says Anderson. "I feel like God has blessed me with a second chance, and I can raise them a little better than I raised their father."

To an outsider, our therapists at this stage can appear overinvested in their clients or hyperresponsible. But we believe that if clinicians dealing with such vast and complex problems take their jobs seriously, they will have to leave the sanctuary of their offices. Just to make use of the available resources, they will have to become as proficient at working different city bureaucracies

as old-style ward heelers.

Furthermore, we believe that unless therapists are wholeheartedly committed to keeping families together, they will find themselves quickly swept along by the grandmother's urgency to drop her burdensome grandchild in somebody else's lap. Or, the therapists' own disapproval and dislike of the grandmother will undermine their resolution to preserve the family and they both will be parties to an unspoken agreement in favor of placement.

The therapeutic strategy is to create between clinician and grandmother a kind of model for the relationship between grandmother and grandchild. Just as Louise has been coached to tell Derek that he's stuck with her—she won't let him go—so Eileen shows Louise that she won't be easy to shake off either; she will hang in even when Louise is at her infuriating worst. Granted, this dogged pursuit of family solidarity requires a certain degree of therapeutic heroism, but a therapist-warrior who won't be easily daunted also gives a grandmother

like Louise the courage to continue struggling on behalf of her family. Nonetheless, there is a big difference between heroics and martyrdom, which therapists and grandmothers both need to understand in order to avoid burnout. Eileen, therefore, will not take over for Louise, but she will work aggressively with her to expand her own network of resources in the family, the church, the neighborhood, and the social services system.

Once we are sure the family is reasonably stable—once we don't hear at every session demands or heartfelt pleas to remove the child from the home—we can work on increasing the mutual pleasure that is the real glue holding families together. During this time, we assign tasks and rituals designed to further increase the grandparent's effectiveness, promote the health of the family, and counter discouragement and exhaustion. Many of these tasks are designed to help the grandmother to "steal back her grandparenthood"—time-limited tasks that break through the daily drudgery of reparenting. At these times, we assign activities such as having the grandmother share old photo albums and pass on the oral history of the family through stories to the kids, or giving a tour of old neighborhoods and homes where family members have lived. It not only develops a healthier heritage for the family, but it also creates an empowering teacher-student bond between the grandparent and grandkids.

When we assign tasks designed to allow grandmoms time off from parenting, we make sure that another adult is on hand as a parental surrogate to keep the kids in line. The grandmother isn't permitted to discipline during these times—she can only play, indulge, or pass on those parts of family culture that only she can know. Younger kids love it, and while adolescents put up initial resistance to it, their hunger for health usually wins out and they too end up sitting in wonder, though with a teenager's veil of cynicism. These tasks create a special atmosphere of mutual appreciation and giving, a time in which the family's memory banks, already overstocked with painful episodes and crises, can be resupplied with pleasant, or at least ordinary, nontraumatic aspects of family history.

"I'm afraid to tell you how much I love bringing up Seth," says Werner, who admits that while she has complicated her life more than she ever imagined, she never regrets her decision to raise him.



This is our *modus operandi*. Would that it were all so simple and neat. Though we have helped most of the grandparents and grandchildren who have come to the clinic stay together as a family, a few kids have been placed. In those cases we have held true to our original promise of guiding the family through the separation process as smoothly as possible. In a couple of cases, we have pushed for placement against the wishes of the grandmother. Even with our bias toward family preservation, and an eye to the unheralded strengths of the family, we do not minimize severe dysfunction; the safety of the child always comes first.

Sometimes a grandmother simply isn't able to provide the type of home or parental guidance that a child needs, but pride and shame won't allow her to realize it. Such was the case of 14-year-old Charlene. A chronic runaway, when she was not with her grandmother, Charlene hung out in crack houses, using coke and contracting venereal infections. She was in real danger of acquiring AIDS. Her grandmother, in spite of all our efforts, simply refused to see what was happening to the girl, never confronted her, and fought any notion of placement. Unfortunately, even after an inpatient hospitalization, and many attempts to get her placed, some involv-

ing the Child Protective Services, Charlene is still on the streets—one of those children who fall between the cracks of an overwhelmed and somewhat calloused social services system. At last report, she had been gang-raped, but the only one pressing charges, besides us, was a pimp who was lining her up for his business. Still, the therapist continues to try, and hopefully she'll still be alive when we finally find a place for her.

Fortunately, we see more Louises and Dereks than Charlenes. Otherwise, we would all lose hope. As it is, hope, commitment, and faith are what pull us and the grandmothers through. The grandmothers continually speak of the support they get from their religion and the church for getting through the day-to-day struggle. Their most fervent prayers are for their children to stop taking drugs; sometimes, when their prayers are answered, it is because their children have adopted their own spirituality as a first step toward recovery. Even when their sons and daughters don't get well, the grandmothers still hold on to their faith and find their rewards in seeing their grandchildren become young again. As Mary, one of the grandmothers, said, "I see him getting there—the street stuff is not getting in the house anymore. I can see a little light. He's alive again." ■

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Bruce Buchanan, M.A., M.S., is Director, Post-Masters Certificate Program in Family Therapy, University of Pennsylvania—Philadelphia Child Guidance Clinic. He is also in private practice, Professional Services Group, Philadelphia, PA. Address: PCCG, 34th and Civic Center Blvd., Philadelphia, PA 19104.

Jay Lappin, M.S.W., A.C.S.W., is Associate Director, Post-Masters Certificate Program in Family Therapy, University of Pennsylvania Philadelphia Child Guidance Clinic. He is also in private practice in W. Collingswood, NJ. Address: 1106 Newton Ave., W. Collingswood, NJ 08107.

