
The Assumption of Caregiving: Grandmothers Raising the Children of the Crack Cocaine Epidemic

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In this article, selected findings are presented from a study of the experiences of 71 African American women who have become the sole caregivers for at least one grandchild or great-grandchild as a result of the involvement of the parent in use of crack cocaine. Despite the unique circumstances of each situation, three patterns of the assumption of caregiving emerged from analysis of the intensive interviews and participant observation: sudden assumption, negotiated assumption, and inevitable assumption of the permanent caregiver role. Each pattern is described along six dimensions: forewarning, initiation, the trigger event, the caregiver's goal, her assumed trajectory of the caregiving period, and her perceived influence on her own destiny. These accounts provide important information for those who work with women, children, and families, as well as unique insight into the consequences of the crack cocaine epidemic.

More than 3 million American children of all ethnic and racial groups currently live with their grandparents or other relatives, almost a 40% increase over the past decade (U.S. Bureau of the Census, 1991). Close to a third of these children live in homes in which neither parent is present and in which the grandparent has assumed the role of sole or primary caregiver.

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The increase in grandparent caregiving is particularly pronounced in African American families. The 1990 census estimated that more than 12% of Black children lived with their grandparents, compared to 5.8% of Hispanic and 3.6% of White children (U.S. Bureau of the Census, 1991). Local estimates from many low-income African American communities, devastated by drugs, violence, and AIDS, suggest that up to half of the children there may be in the care of their grandparents (Gross, 1992; Minkler & Roe, 1993).

The relatively high proportion of Black children living with grandparents reflects, in part, a continuing pattern of co-residence and shared caregiving within the African American extended family (Stack, 1974; Wilson 1986). The crack epidemic, however, is one of the central forces driving the dramatic increase in the prevalence of such caregiving since the mid-1980s (Feig, 1990). More often than not, when a parent's life is ravaged or ended by involvement with crack cocaine, caregiving for the children is assumed by the grandmother.

The assumption of full-time, permanent caregiving is both a moment and a process of profound significance in the lives of women, many of whom had assumed that their caregiving days were behind them. This moment is particularly significant when crack is involved, for the children left to be cared for are often very young and very vulnerable. They also may be suffering from the effects of crack on their environments, their homes, their parents, and their own physical and/or emotional health.

The experience of assuming caregiving for young grandchildren as a result of the crack-related problems of an adult child is the focus of this article. Although the assumption of caregiving is merely a moment in a much longer relationship between the grandmother, her grandchildren, her adult child, and the rest of her social world, it is a pivotal moment in each woman's life story. The findings presented in this article provide a look at the process through which women assume caregiving and some of the life changes it precipitates. Qualitative research methods provided a way in which these women's voices could be brought forward to contribute to our collective under-

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standing of the changing experiences of American families as they are lived in the intersection of individual biography and complex social forces.

BACKGROUND

This article presents selected findings from the Grandparent Caregiver Study, a multidimensional exploration of the experiences of African American grandmothers raising grandchildren in Oakland, California. This research was undertaken with a purposefully open conceptual framework because of the recency of the phenomenon studied and our deep conviction that our most important role as researchers of this issue at this time was that of bridge between the private world of personal troubles and the broader domain of public issues (Mills, 1959). We wanted to explore, understand, and then communicate the experiences of the women we would meet with words and concepts that they would feel were resonant with their lived experience.

No research is undertaken without some conceptual frame of reference. The Grandparent Caregiver Study was crafted around several guiding, or sensitizing, concepts. We were certain that the experiences of the women in our study would demonstrate both individual differences and broad commonalities. We assumed that much of what the stories would have in common would be rooted in the social and cultural contexts within which caregiving occurs. We agreed with Baines, Evans, and Neysmith (1991, p. 29) that "the relative invisibility of women's caring, the implicit assumption that it is natural for women to care, the lack of attention paid to the complexities involved in caring, and the contradictions caring poses for women" all needed to be considered in order to bring forward the individual and common experiences of this new group of caregivers. We suspected that the conflicting social attitudes that simultaneously sentimentalize and devalue mothers and caregivers for the old (Abel, 1991) might similarly operate with respect to the caregivers we would meet. We were also aware of the historic kinkeeping role of African American grandmothers (McAdoo, 1982) and agreed with Burton and Dilworth-Anderson (1991) that the contemporary role of Black grandmothers must be understood in the context of the dramatically altered demographic and sociocultural conditions within which they now live. We assumed that all of these contextual dynamics would pro-

foundly influence the experience of grandmothers raising young children.

We also carried assumptions and sensitizing concepts to our exploration of the psychosocial experience of individual caregivers. We assumed that grandmothers raising grandchildren might be, like other female family caregivers, women caught in the middle (Brody, 1981) of competing role demands, competing generations, and competing emotions. We were aware that changes in the web of interpersonal relationships bear an important relationship to health and well-being (Cohen & Syme, 1985) and that other types of caregiving have been associated with periods of grief, despair, helplessness, and hopelessness (Schulz, Vistainer, & Williamson, 1990). We were interested in exploring the range of individual reactions to the challenges of caregiving, particularly coping processes (Folkman & Lazarus, 1991). We were particularly sensitive to the often hidden dynamics of "emotion work" (Hochschild, 1983), the very private way in which people intervene with their feelings in order to shape them and to maintain the integrity of the interpersonal sphere. As a shared frame of reference, these concepts alerted us to the emergence of grandparent caregiving and informed the way in which we approached our work.

METHODS

The Grandparent Caregiver Study combined qualitative and quantitative research methods to explore the experience of grandmothers serving as primary caregivers for infants and young children within the context of the crack cocaine epidemic. The heart of the data collection was two in-depth interviews with each of 71 grandmother caregivers. Responses related to the assumption of caregiving are the focus of this article. Data from other parts of the study have been published elsewhere (Minkler & Roe, 1993; Minkler, Roe, & Price, 1992).

Study Design

The overall study design was exploratory, descriptive, and interactive. We were committed to an approach that would honor the integrity of women's experience (Klein, 1983) and foster empowerment

of the participants (Marti-Costa & Serrano-Garcia, 1983). The co-investigators worked closely with four research assistants, a community liaison, and a community advisory group made up of 14 local health and social service professionals, community organizers, and individuals working with grandparents of young children in Oakland. The study was designed to be flexible enough to involve the research team in community activities, to maximize respondent benefit from the experience of participating in research, and to encourage shared ownership of the data and its interpretations among researchers, respondents, and the advisory committee.

Sampling. The study used a theoretical sample in order to identify, investigate, and describe as many different caregiving experiences as possible (Glaser & Strauss, 1967). The community advisory group played a central role in the construction of a rich and varied sample.

Initial sampling identified differences in caregiving experience based on age, number of dependent grandchildren, sources of financial support, marital status, and social support. Later sampling enabled comparisons based on factors such as employment, health status, and additional caregiving responsibilities.

Potential respondents were identified through health and social service providers, a dense network of community contacts, an invitational flyer, and snowball referrals from study participants. The latter two strategies were particularly effective in finding women who were without telephones, were not well connected to health and social services, and were in other ways likely to be overlooked by more traditional sampling methods.

To be included in the sample, potential respondents had to have assumed full caregiving responsibility for at least one youngster under the age of 5 as a result of the crack involvement of the child's parents. In order to develop a picture of caregiving within a situated context, sampling was restricted to African American women living in or near the borders of Oakland, California. We used a broad definition of the term grandmother, including great-grandmothers, great-aunts, and biological grandmothers. Of the more than 100 caregivers expressing interest in participating, 71 met the study criteria and were included in the study sample.

The final 71 participants ranged in age from 41 to 79; approximately half were under 55. Twenty of the women were married with the husband present in the household; another eight reported a steady

relationship with a male partner. Education ranged from third grade to master's degrees. One third were employed, with most of these women working 40 hours a week or more.

Most respondents had assumed responsibility for one (25%), two (37%), or three (23%) children under the age of 5. One grandmother had seven grandchildren under her care, and one couple was caring for 10 of their grandchildren, 3 of whom were 3 years old. Ten respondents were caring for at least one great-grandchild; five were caring for the young children of nieces or nephews.

Half the respondents had at least one of their own children still living at home; the others had been living without children in the household, often for a number of years, when they assumed primary caregiving. Respondents had been in this new role from 6 months to 5 years at the time of interview. At least nine of the respondents had raised other youngsters, usually other grandchildren.

Data Collection and Analysis. Each participant was interviewed twice, with the interviews usually 1 week apart, at a time and place of her choosing. Most interviews were conducted in the women's homes, but we did meet women at the mall, in restaurants, and even after-hours at a beauty salon as requested. The first interview, which usually lasted 3 to 4 hours, was conducted by one of the two investigators and a research assistant. The second interview, typically somewhat shorter, was conducted by only one researcher, usually the research assistant. Each participant received compensation of \$50 for her participation in the study, a packet of resource materials, and a handmade gift from the researchers.

The interviews followed a format designed specifically for this study. The data presented in this article were offered in response to open questions regarding how the grandmother came to assume primary responsibility for the children in her care, how she felt about it then, and how she coped with the immediate consequences of taking on this new role. Additional data came from the open discussions, "conversations with a purpose" (Kahn & Cannell, 1957) that surrounded more focused questioning.

Data were collected and analyzed in an ongoing and reflexive process during 10 months of interviewing in 1990 and 1991. The audiotaped interviews were transcribed and reviewed by both investigators and a research assistant. The data collected during interviews was enriched by the addition of a growing body of data collected during participant observation.

As interviews were conducted, core themes were identified, case study accounts developed, and further sampling needs were determined. First-level coding was done independently by both researchers. Second-level coding—analysis of patterns, characteristics, and central themes—was done by one and verified by the other. Our ongoing analysis of the interview and observational data was designed to be interactive, fostering dialogue among the research team, the advisory group, study participants, and members of the broader community. Our overriding purpose in handling the data was to preserve its integrity and contextual roots as offered by the grandmothers, and then to re-present their individual accounts from the perspective of shared experience.

Validity Concerns. The research team was committed to a process that would bring forward valid findings, which we defined as full descriptions of the nature, essences, characteristics, and meanings of the subject matter (Leininger, 1992)—in this case, caregiving within the context of the crack cocaine epidemic. We were particularly concerned with our ability to elicit valid data given the complexities of the crack epidemic, the personal nature of the experience we were exploring, and the fact that the investigators were White women and the respondents were African American. We also hoped that our analysis would yield representations that would resonate with respondents and provide insight and encouragement for the challenges they face. To that end, we developed a research process that continually checked and rechecked the validity of assumptions, data, and interpretations.

Our initial assumptions were analyzed through extensive conversations with a variety of women we knew who were themselves caring for their grandchildren or who knew others that were. We also had extensive conversations with people involved with relative caregiving from the legal, social welfare, and health care perspectives. Most important were the frequent, frank, and enlightening discussions with our community advisory group that continued throughout the study.

To deal with the validity issues that often arise in cross-cultural research, we selected an interviewing strategy that involved a team interview first, conducted by one of the White co-investigators and one of the African American research assistants, followed by a shorter interview, most often by the research assistant alone. We anticipated that study respondents might be more comfortable, and therefore more candid, at the second interview. Although this may have been

true in some cases, researchers and respondents alike were moved and somewhat surprised by the level of sharing that occurred in the first interview. Once both interviews had been completed, the relevant team members discussed the responses, checking for consistency (when important) and any noticeable patterns of revelation or withholding of information. When important inconsistencies were discovered or crucial data were found to be missing, a team member contacted the respondent by telephone or short visit to round out the account as needed. In only two cases did it appear that anything significant had been avoided or even discounted in the first interview but later revealed at follow-up.

Although the researchers knew the people they interviewed by name, the interviews were the only time when real names were used. Pseudonyms were developed for each respondent early on and were used throughout all subsequent analysis and presentation of findings, including this article. We found that using names, albeit assigned ones, helped our data reflect the personal intimacies that had been shared and the respect with which we received what was offered, while maintaining confidentiality of responses.

Participants helped us examine our assumptions and our data in several ways. At the end of each interview, respondents were asked if there were additional areas that we should explore with other grandparent caregivers. Their recommendations were invaluable in helping us identify assumptions we had made or important data we had misunderstood. Participants also provided valuable suggestions for ways that we might better probe responses that were vague or incomplete.

As we began to identify core themes, we actively took those back to women we had interviewed before or to new interviewees, presenting what we were hearing and what we made of it, then eliciting their assessments of the validity of both our data and our interpretations. Throughout this period of data collection and preliminary analysis, we were fortunate to have numerous occasions on which we could informally explore our initial concepts with individuals not directly involved in the study. Telephone requests for information or assistance from other grandmother caregivers, informal social gatherings, fortuitous conversations, and our growing network of contacts in the field provided opportunities to clarify what we were learning and to measure its resonance against the experiences of others. Our first formal presentation of findings was made to the group of study participants at a gala luncheon celebration at the close of data collection.

Following that presentation, we responded to many requests to share the findings with community groups, health care providers, and policy-makers. These varied and interactive activities gave us increasing confidence in the integrity and validity of our data and interpretations.

FINDINGS

Assuming the Caregiver Role

Despite the unique circumstances of each family situation, three distinct patterns of the assumption of caregiving emerged from our analysis: sudden assumption, negotiated assumption, and inevitable assumption. Each of the three patterns can be described across at least six critical dimensions: the nature and length of forewarning, the individual responsible for initiation of the new role, the circumstances and emotions related to the trigger event, the new caregiver's goal in assuming the caregiving role, her assumed trajectory or vision of the length of time for which she would be the primary caregiver, and her perceived influence on her own destiny (Figure 1).

Sudden Assumption of Caregiving. The first pattern, the sudden assumption of caregiving, reflects the experience of women for whom becoming a full-time caregiver happened quickly and without warning. Lucy Thomas (an assigned name) provides a case in point. Although her daughter Kasandra had been involved with crack at one time, Mrs. Thomas was convinced that the young woman had straightened out; she was, after all, attending church regularly once again and appeared to be caring for her four children, ages 3 through 12. Mrs. Thomas thought nothing was out of the ordinary when Kasandra dropped the kids off "for a couple of hours" one afternoon, asking that grandma baby-sit. Two hours stretched into 2 months before she realized that Kasandra was never coming back. For 59-year-old Mrs. Thomas, like many others, assuming permanent caregiving was completely unanticipated, initiated by her daughter, with no forewarning whatsoever.

For Ronda Leeds, the catalyst to becoming an instant and permanent caregiver occurred when her 2-year-old granddaughter was removed from her mother's home by child welfare workers who had evidence that the young woman's male partner had molested the child. Like other grandmothers confronted with acute family crises,

Patterns of Assuming the Caregiver Role

Sudden assumption
Negotiated assumption
Inevitable assumption

Critical Dimensions of Each Pattern

Forewarning
Initiation
Trigger event
Caregiver's goal
Assumed trajectory
Sense of control

FIGURE 1. Patterns and Critical Dimensions of the Assumption of Caregiving

Mrs. Leeds stepped in quickly to help out and "keep the family together." She assumed that she was offering a short-term solution to an emergency situation that, despite the involvement of crack cocaine, would resolve itself shortly. Although she felt as though her life was suddenly "out of control," she also was certain that she could make it through until "things straightened out." Things never did straighten out for the young parents, and the little girl now lives permanently with Mrs. Leeds.

For several of the women we interviewed, the sudden assumption of caregiving began when a hospital called to say that a daughter or niece who had just given birth had left the facility and abandoned the infant in the process. Mary Byrnes was at work when such a call came. She was completely unprepared for the news about her daughter, much less the hospital's request that she come to pick up the baby. Things happened so quickly that she did not have time to think about the long-term implications of bringing the child home. "I didn't want to quit work," she said. "I didn't know the baby was drug-exposed at first, so I just took a leave of absence." Mrs. Byrnes assumed that she would be back to work rather quickly but found that caring for a drug-exposed infant changed her life completely. Eventually, she was forced to quit her job because of the overwhelming demands of caring for the baby completely on her own.

The accounts of Lucy Thomas, Ronda Leeds, and Mary Byrnes are characteristic of the stories of others who experienced a sudden assumption of permanent caregiving. For each, the new demand was completely unanticipated and was initiated by someone else. The

trigger event was the sudden absence of the child's parent for any number of reasons, including abandonment, incarceration, or sudden death, often leaving the grandmother devastated over the tragedy. In each case, the grandmother felt compelled to help out in what she perceived as an acute crisis that she was certain would resolve itself in time. In all cases, the sudden assumption of caregiving left the grandmother feeling that the events and circumstances of her own life were suddenly and definitively beyond her control.

Negotiated Assumption of Caregiving. A second and more frequent pattern of assumption of caregiving involves informal negotiation with a crack-involved child or grandchild. In these cases, the grandmother, great-grandmother, or great-aunt arranged to have the children come and stay while the substance-abusing individual went into treatment or "took some time to straighten out." Grandmothers reported that their adult children, grandchildren, or nieces were relieved when they suggested the arrangement, feeling that it was clearly in the best interests of the children. Gayle Street's daughter felt this way and, as Mrs. Street put it, "I took them so she could get herself well."

When caregiving is negotiated, there is often continuing contact between a grandmother and her adult child or other relative, with the latter typically living with the grandmother or maintaining frequent contact while making a genuine effort to "get clean." Laura Shipley was among the grandmothers who reported letting a drug-involved daughter or niece live with her and her grandchild "on a trial basis" while the young woman tried to stay off cocaine. Mrs. Shipley offered to care for her niece and her 9-month-old baby when the two became homeless 4 years ago. For a while, her niece was able to stay away from drugs. When her efforts failed repeatedly, however, and she refused to get professional help, Mrs. Shipley insisted that she move out but leave the baby there until she could care for it herself. There has been little contact between the young woman and her aunt or child since.

The majority of grandmothers who assumed caregiving through informal negotiation reported that money was never an issue. It was assumed by all parties that any financial support for the children, such as Aid to Families with Dependent Children (AFDC), would now be handled by the grandmother. In a few cases, however, a financial arrangement was a difficult part of the informal negotiation that

allowed the grandmother to assume the caregiving role. In such cases, the grandmother agreed to allow the drug-involved parent to continue to receive the children's entitlement check. In exchange, the parent permitted the grandmother to take the grandchildren into her care.

Sarah Thompson assumed caregiving by negotiating such an arrangement with her daughter. The 54-year-old grandmother had to stretch a small monthly paycheck of \$650, her only source of income, in order to meet expenses now compounded by raising her 4-year-old granddaughter. The girl had serious learning disabilities and a host of physical and emotional problems when Mrs. Thompson brought her back from her daughter's home in Nevada. Although things were very tight financially, giving up access to the child's AFDC support seemed to Mrs. Thompson a small price to pay for the chance to "catch the girl up on her learning" and help her get a decent start in life. Characteristic of these negotiated arrangements, Mrs. Thompson perceived a positive opportunity for change and initiated what she thought would be a temporary, constructive period of full-time caregiving. Negotiating the finances was uncomfortable but less of a concern than being able to "make a difference in this child's life."

Although this type of informal financial negotiation was relatively rare among participants in our study, it was reported often enough to illuminate the complexity of the negotiated assumption of caregiving and the range of feelings it evokes. Caregivers in this situation were almost always uncomfortable with the arrangement, expressing concern about enabling their child's continued crack use or the diversion of already scarce resources to the wrong person. Many were angry at the parent's demands. Some, such as Alice Clark, felt that they were doing something wrong by allowing their child to receive money meant for the grandchildren:

I worked every day of my life for over 45 years and I never cheated the government or anybody else. I know this isn't right—she's out smokin' up the money somebody thinks is going for the babies—but I can hold my head up because it was the only way to get the babies out of that situation. If I had left them there, they'd be dead or even worse by now.

Miss Clark, like many other caregivers who informally negotiate their assumption of caregiving, began with an internal sense of control, even if bothered by some of the specifics of the arrangement.

The experiences of Gayle Street, Laura Shipley, Sarah Thompson, and Alice Clark reflect the pattern of negotiated assumption of care-

giving. Each had some forewarning and actually initiated the new relationship, although each felt that it was only for a short, and often very specific, amount of time. The trigger event was the grandmother's perception of a positive opportunity for change in a deteriorating family situation. The overall goal was to assist in the transformation of the children's circumstances, with family reunification assumed. Because they initiated full-time but not permanent caregiving, and because there was an end in sight, these women at least initially felt a positive sense of influence over their own destiny and efficacy in their own lives.

Inevitable Assumption of Caregiving. The third and by far most prevalent pattern, inevitable assumption of caregiving, typically begins with a woman's growing awareness of and concern over the extent of an adult child's drug involvement and the toll it is taking on the grandchildren. Assumption of permanent caregiving often comes after a difficult and sometimes protracted period of trying in vain to help the crack-abusing relative to conquer the drug habit, "checking up" on the grandchildren, and providing more and increasingly lengthy informal care to ensure their well-being. This situation usually comes to a head when the grandmother feels forced either to take the children or to call the police or child welfare authorities to have them removed from the parents' home.

Some of the grandmothers in our study told of how the discovery of an adult child's drug habit (or the worsening of that habit) began a long process of taking increasing amounts of responsibility for the grandchildren. Vera Mullholland, a food service worker in her mid-40s, talked of going to her daughter's apartment on her lunch break and on the way home from work each day to be sure that her young grandchildren had food to eat and clean diapers and clothes to wear. Her forewarning of what was to come was her growing realization of how hopeless her daughter's situation was becoming.

Evelyn Cross watched weekend respite for her 3- and 4-year-old grandchildren stretch to weeks at a time, increasingly unannounced and open-ended. Each time they came, the children seemed more vulnerable and her daughter seemed more disoriented. For Dorothy Scott, it was hard to remember "how it happened. [It] just seems like they used to live with their mother and then they lived with me."

When the assumption of caregiving is inevitable, sooner or later the adult child "crosses the line," engaging in behavior or creating a

situation of such hopelessness or danger that the grandmother takes drastic action to save the children.

For Sandra Young, the trigger came when she went to see her infant grandniece and found her having a severe asthma attack and in need of hospitalization. The gas and electricity had been shut off, and Mrs. Young's niece, high on alcohol and crack, vigorously resisted her aunt's attempts to take the baby to the emergency room. The infant, who was also badly undernourished, nearly died on that occasion, and Mrs. Young realized she had no choice but to intervene and try to get custody. The trigger event for 58-year-old Sharon Lane was almost too painful to recount. With tears in her eyes, she told of driving down a large street in downtown Oakland and being stunned to see her 1- and 2-year-old grandsons, dirty, disoriented, and only partially clothed, alone on the sidewalk while their mother was inside with a crack dealer.

For several of the grandmothers, the trigger event telling them that they had to step in occurred when the parents of infant or young grandchildren took the babies to crack houses or left them unattended for hours, and in some cases days, at a time. Shelley Henderson told of how her granddaughter, evicted from her apartment after using the rent money for drugs, had left her baby unattended for long periods. "She was taking the baby to crack houses . . . leaving the baby at this one's house and that one's house—leaving him with no food, no diapers." At this point, 63-year-old Miss Henderson, who had been gradually assuming more responsibility for the baby's care, knew that full-time permanent caregiving was inevitable.

Some women spoke of their shame, anger, or incredulity on learning that a drug-abusing child had sold food stamps, diapers, or even baby formula for crack. When the grandmothers confronted such realities, however, and took the painful step of reporting the children's parents to the authorities, their nightmare often simply took a turn for the worse. Indeed, one of the hardest parts of the assumption of caregiving, according to many of the women we interviewed, was getting the authorities to take their concerns and warnings seriously.

Sally Fairlane, who now has custody of her 3- and 5-year-old great-grandchildren, recounted her anger and frustration at trying in vain to get social services to intervene when she discovered just how badly the youngsters were being neglected by their crack-involved mother:

I was talking to social workers, trying to get them to do something for these children. I told the social worker how she was selling the food

stamps to buy drugs. He told me there was nothing he could do, that all he was supposed to do was give her the food stamps. I had to sit here and watch her get the money and walk out the door, down the street, and when she comes back she has no money, no diapers, no food stamps, nothing! . . . I had to let them go down to where [the social workers] had to step in, and the little baby almost died.

Wanda Kehoe told a similar story:

The parents had no place to live, both were on drugs. I'd bring them Pampers and baby food and they'd sell them for drugs. The little boy was nearly starved when I got him. I asked [the Department of Social Services] "do you have to wait until there's a death?" They said, "Basically, yes." I finally just went and took them. The baby was nearly starved to death by then.

This third and most commonly described pattern of assumption of caregiving often entailed a lengthy process of growing disillusionment on two fronts. These grandmothers became disillusioned first with a crack-involved child who appeared unwilling or unable to care for his or her own children. At least as disillusioning for many were their interactions with the social services bureaucracy. With plenty of forewarning, the change finally came as the result of a dangerous and disastrous incident. In these cases, the grandmother's only goal was to save the children. Stunned by external events but feeling empowered by their ability to do something about them, most of these women assumed full-time caregiving knowing that it would most likely be for the rest of their lives.

The patterns of assumption of caregiving, and their characteristic dimensions, are summarized in Figure 2. Each pattern has different implications for the physical, emotional, and social health of the grandmothers during and after the process through which they assume the primary caregiver role.

Life Changes with the Assumption of Caregiving

The assumption of permanent caregiving inevitably causes a major and sometimes abrupt disruption of mid- or later-life activities. It can also irrevocably alter plans and hopes for the future as well as altering a wide range of relationships.

Although the women we interviewed were at different stages of the life cycle and faced varied life circumstances, the assumption of caregiving represented for each a significant transition, causing major changes in the ways they lived their lives and in what they anticipated

<i>Dimensions</i>	<i>Patterns</i>		
	<i>Sudden Assumption</i>	<i>Negotiated Assumption</i>	<i>Inevitable Assumption</i>
Forewarning	Unanticipated	Growing realization	Growing responsibility
Initiation	Initiated by another	Initiated by caregiver	Initiated by disaster
Trigger event	Sudden absence of parent	Perceived opportunity for positive change	Disaster or danger
Caregiver's goal	Acute crisis resolution	Transformation of the children's circumstances	Save the grandchildren
Assumed trajectory	Short term, open ended	Variable with definite end	For the rest of her life
Influence on destiny	No influence	Positive influence	Empowering influence

FIGURE 2. Summary of the Assumption of Caregiving

would lie ahead. Just as there were different patterns of assumption of caregiving, the immediate life changes experienced by grandmother caregivers can be organized around five central themes: losing freedom, feeling cheated, moving backwards, making a little more room, and renewing a relationship. Although these life changes were often overlapping, we present them as discrete entities for analytical purposes.

Losing Freedom. Many women told us of the sudden loss of their freedom and their current inability to "do what I want to do." A 41-year-old grandmother raising three preschoolers lamented:

I got a taste of freedom a year ago. I was just finished raising my children. I'd go around everywhere, get up whenever I wanted to. I didn't have any more babies to tend. Now when I go out, they come too.

Many women felt uncomfortable losing the freedom of their long-standing routines or household schedules. An older grandmother compared her brief period of freedom from childbearing to her situation now that grandchildren were there on a permanent basis:

Once the house was clean, it stayed clean. There was no extra cooking or cleaning or washing. [Since the grandchildren came] everything is stress for me now because I can't relax or do what I want to do.

Unmarried grandmothers frequently brought up the loss of time to travel and to live the kind of life they had anticipated for their later years. One 58-year-old grandmother caring for three of her daughter's five little girls, all less than 5 years old, spoke wistfully of "that restless feeling a woman gets when she turns 50—that get up and go feeling." She added that she had planned to live with her suitcase "half packed and always waiting by the door" once her youngest child was grown. Taking on the responsibility of the grandchildren changed that forever.

When asked to describe their life since the assumption of caregiving, many women spoke of having lost a life of their own: "I put my life on hold since I got the kids," "My life is at a standstill," "I have no life of my own now."

Feeling Cheated. Another life change after the assumption of caregiving was the feeling of being cheated. For 48-year-old Gwen Eaker, raising five of her grandchildren:

[My child's] responsibility has become my headache. I feel I've been cheated. I'm not ready for the rocking chair, but if I want to go out with friends, I can't. I feel like something has been stolen from me.

Grandmothers in our study frequently reported feeling cheated by their adult children ("I raised my kids, why can't they raise theirs?" or "I'm supposed to be their grandmother, not their mama!"). As one great-grandmother put it:

I'd just like to be on the sidelines and if needed, to be able to help out not because I have to but because I want to. . . . When you do things because you want to, you can appreciate them more. But when you're doing things because you have to, you get some pretty bad thoughts sometimes.

The failure of other family members to shoulder part of the responsibility for caregiving also led some to feel that they had been taken advantage of. Paternal grandmothers raising their sons' children sometimes complained that the maternal grandparents should be playing more of a role. Several women who were raising their great-grandchildren reported feeling cheated because the responsibility to provide care really should have fallen to the younger grandmothers.

For many of the women who were married or in relationships with male partners, the assumption of caregiving led to feeling cheated out of long-anticipated private time and leisure activities with the men in

their lives. Comments like Wanda Kehoe's were frequently expressed: "We used to travel a lot. Now we can't, we feel tied down." For two women in our study, assumption of caregiving robbed them of the marriage itself, serving as the last straw in an already troubled relationship and culminating in separation or divorce.

Moving Backwards. Many women who had quit work to be full-time caregivers reported that they felt as though they were moving in reverse. "I feel like I'm going backwards," one grandmother explained. Like many others, the job that had given her income, dignity, and a chance at a decent retirement had been permanently relinquished when she took in two of her grandchildren. A grandmother who had recently had to declare bankruptcy and another who could no longer afford the expense of a car and was back to riding buses were among others for whom "going backwards" was a frequent and unwelcome sensation. Similarly, diaper washing, midnight feedings, ear infections, and colicky winters were offered as examples of "something wrong in the life of a woman my age."

Making a Little More Room. Although most of the women we interviewed described the assumption of caregiving as having profound effects on their current activities and life plans, there was a smaller group for whom the new caregiving role fit relatively easily within a life that had always revolved around caregiving. Nine of the women we interviewed had already engaged in "second time around parenting" when they became caregivers for grandchildren, great-grandchildren, or grandnieces or -nephews as a consequence of the crack epidemic.

For most of these grandmothers, a lifetime of caregiving had been the norm, made easier in part by a large and well-functioning extended family. Claire Shawcross provides full-time care for two grandchildren and regular part-time respite and baby-sitting for at least five others:

There's always kids here—always has been. I don't treat these two any different than the others and I don't want them to feel any different. They're all family, no matter how they got here or how long they'll be staying. They really aren't a problem—if it wasn't these two, it would be two others!

Although the women in our study were all, by definition, sole or primary caregivers for at least one grandchild, some clearly experi-

enced the new role not as a radical life change but rather as a new variation on a familiar life theme.

Renewing a Relationship. Among some women we interviewed, the assumption of caregiving, although tragic in what it stood for in terms of an adult child's life story, was nevertheless a positive life change. This was evident in the accounts of several great-grandmothers, for whom an infant or young child in the home meant companionship and sometimes a new lease on life. Lena Johnson, 76 years old, spoke about the positive change that caregiving for her 9-month-old great-grandson had made in her own life. Although her initial reaction was one of anger and despair, she quickly saw caregiving as providing an important new sense of purpose:

I've changed my way of thinking. Sitting down eating a lot of greasy food like you did at those senior centers, that isn't getting you anywhere. I like [raising my great-grandson] because I can educate him, make available numbers and things.

For Sarah Thompson, whose own children "didn't turn out very well," raising a young granddaughter and being able to help her overcome the emotional scars of early abuse and neglect provided an important sense of pride and accomplishment. Some found that having a small child in the house again had surprisingly positive effects on their marriages or relationships by necessitating improved communication between the women and their husbands or partners. Sometimes raising a grandchild became a joint project, renewing relationships that had been abandoned long ago.

Even among grandmothers for whom the assumption of caregiving represented a positive life change, the long-term consequences of taking this step were often hard to think about. As one grandmother put it, looking down at the giggling 3-year-old in her care, "I can't imagine my life without her now. But I can't imagine life with her as a teenager!"

DISCUSSION

In their examination of the African American extended family, Martin and Martin (1978) described several alternate routes by which grandparents and other relatives most typically become the primary caregivers to young children. Predating the devastation of the crack

cocaine epidemic, they found assumption of caregiving to occur "mainly out of economic necessity," when the children's parents lacked adequate resources because of age, unemployment, or family size. They found informal adoption often to be desired by grandparents or other relatives because of the status and respect it brought within the family. Grandparents often assumed caregiving responsibilities out of a felt obligation to their children in need or because, as children themselves, they had been taken in by relatives. Caregiving in later life provided a "second chance" at parenting and often was the only means available to prevent a child from being put up for adoption (Martin & Martin, 1978).

The crack cocaine epidemic has added elements of danger and desperation to the life circumstances of the people caught within its side effects. These new dynamics are reflected in the contemporary variations on Martin and Martin's findings that emerged from our interviews more than a decade later.

Our study found three distinct patterns of assumption of caregiving, each indelibly shaped and tempered by the painful intersection of private family problems and the much larger social tragedy that is the crack epidemic. Violent death, overdose, AIDS, suicide, incarceration, abandonment of a newborn, or removal of a child from the home as a result of neglect or endangerment were among the reasons why the women in our study had to assume caregiving responsibilities for their own children's children. In contrast to the conferred status of caregivers under other circumstances, these grandmothers often felt cheated out of something they had looked forward to, whether it be the joy of grandparenting or their long-awaited privacy or leisure time. Rather than seeing a gain, most were acutely aware of the psychological losses that the tragedy within their family had caused: loss of family, loss of the expected intergenerational relationships, loss of self-determination. This sense of loss is echoed in the ways in which grandparents "shoulder the burden" of the new caregiving (Poe, 1992) or cope, over the long haul, with the more tangible losses, such as financial resources, space, and significant adult relationships (Minkler & Roe, 1993).

There are other important ways in which assuming caregiving now may be different from how it was even a decade ago. Caregiving within the context of the crack epidemic sometimes must be hidden from others who might force a woman and her newly expanded family from their apartment (Generations United, 1991) or might pose

a threat to the tenuously negotiated caregiving arrangement. In stark contrast to other times and circumstances, caregiving within the context of the crack epidemic frequently involves assuming responsibility for children who experienced early, and often persistent, neglect or abuse, and who may have been exposed to drugs and be suffering related health or emotional problems (Coles, 1991), in neighborhoods with increasing drug activity and danger, and in a society that casually refers to the children as "crack babies" and wonders what will happen when they "invade" the schools or reach their teenage years (Jackson, 1990).

Implications for Practice

The specific patterns of caregiving assumption that emerged from our data call attention to the lived experiences of an increasing number of women who are, often very privately, becoming parents again in mid- or later life. These data have particular relevance to health and social service workers who encounter grandparent caregivers or their extended families. Given the pressing needs of children, the overwhelming demands, and frequent frustrations with the social service bureaucracy, grandparents assuming the caregiving role may well be "hidden patients" of the crack epidemic. We must be aware of their presence, even when they do not identify themselves, and sensitive to their concerns. Their accounts alert us to the complexity of their situations, the range and depth of their emotions, and the seriousness of the situations they are trying to resolve.

The stories of grandparent caregivers also have particular importance for those involved in the full spectrum of social policy and for those who document the history of our time and our response as a society. In sharing their experiences, the 71 women in our study helped shine much-needed light on some of the more subterranean dynamics of modern family experience and round out our understanding of the nature of the crack epidemic. Looking through a mother's eyes, social relations are understood in a unique and important way (Ruddick, 1989; Gregory & Longman, 1992). Qualitative research is particularly well suited to do this. Only qualitative methods could have brought forward such detail on a moment in time as private as the assumption of full-time, permanent care for a young grandchild. The subsequent accounts reveal patterns of loyalty and responsibility, love and loss, and entrapment and empowerment that

must be honored and understood if we are to develop the urgently needed policies and programs that will support grandparents raising the children of the crack cocaine epidemic.

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