

There's No Place Like Home: Preparing Children for Geographical and Relational Attachment Disruptions Following Parental Death to Cancer

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Abstract The death of a parent precipitates a number of profound losses and transitions for children, disrupting their sense of safety and security. Children who have lost both parents or who, due to divorce, are relocating across great distances following the death of their custodial parent incur a number of profound secondary losses, including place attachment disruptions. Work with this population should aim to create a holding environment for children to normalize and validate their experiences while keeping them on track academically, socially, and psychologically. The paper will present two case studies and will offer family-, developmental-, and attachment-based interventions to help prepare children for these inevitable transitions. The paper will suggest a unique role for clinicians when working with this population.

Keywords Attachment · Human development · Children · Place attachment · Grief · Divorce

Introduction

The death of a parent precipitates a number of profound losses and transitions for children, disrupting their sense of safety and security and violating their assumptions about

the world (Christ 2000; Compas et al. 1996; Silverman 2000; Webb 2002). When the deceased parent was the sole caregiver, as in the case of earlier parental death, divorce, or separation, severed attachments are compounded by the need for children to transition into a new living environment. These children may lose access to their social and relational worlds, including important teachers, community leaders, friends, and neighbors. These relationships provided continuity and support during the parent's illness as well as a link back to their life with their parent. These connections would have otherwise supported them after their parent's death. Grief is further complicated by the loss of familiar spaces, such as their home, school, place of worship and even therapeutic environments. Frequently, extended family groups absorb these children. While these arrangements may represent the best possible placements, they present a host of challenges to grieving children's adaptation. This paper will discuss the significant, and often hidden, losses children experience after a sole or custodial parent dies of cancer. We will demonstrate these issues with two recent clinical cases. Case analysis and implications for clinical practice will be grounded in family-, developmental-, and attachment-based frameworks.

Prevalence of Parental Death to Cancer

National databases do not collect statistics on the number of children under age 18 who are exposed to a parent's cancer, however, data extrapolated from Census (Fields 2003) and SEER data (Ries et al. 2007) suggest over 375,000 children may experience such a trauma. While fewer people are dying of cancer than a generation ago, a younger age at diagnosis (i.e., under 45) suggests a poorer long-term prognosis (Ries et al. 2007). Adults under the age of 45 are a demographic group likely to have children

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under the age of 18 living at home. This suggests that a significant number of these children will experience a parent's relapse and early death. Further, with the national divorce rate reaching upwards of 50%, a considerable number of these children are likely to have experienced the dissolution of their parents' marriage. Some of these children may not have memories of their parents or their home life before cancer or conflict. For children who have experienced more than one divorce, the death of a custodial parent may mean separation from step- and half-siblings as they transition to different extended family homes.

Literature Review

The Loss of Home

The emotional and physical geography of "home" provides children with anchors (Brown and Perkins 1992), orienting them to the physical and social world. These anchors promote stability and continuity and provide a foundation to build individual and group identity and a sense of self (Marris 1991). Secure attachments in these environments allow children to explore the world knowing they can return to a space where they will be welcomed, nourished, and celebrated (Ainsworth 1991; Bowlby 1988). Children's attachment to the unique constellation of individuals and places in their lives strengthens over time as a result of meaningful life events. These events cannot be reproduced in new environments (Brown and Perkins 1992). While attachments develop over long periods of time, they can be quickly disrupted, as in the case of floods, school shootings, or parental divorce, illness, and death. To navigate uncertain terrain, children seek out important others for guidance, reassurance, and comfort (Bowlby 1980). When the availability of primary attachment figures is compromised, children may be left without an emotional compass.

Place attachment refers to our connections to our physical world and our perceptions of that world as meaningful (Gustafson 2001). These meanings are encoded in representational models. Generally, place attachments operate out of conscious awareness (Brown and Perkins 1992), yet when children are severed from the comfort and security of familiar environments, these connections become more clearly evident. This is manifested as homesickness, or longing for a place that no longer exists, either physically or existentially. Place attachment disruptions are amplified if children do not have adequate information (Bowlby 1988), prior connections to people and places are stronger, the loss of space is not socially acknowledged, resources are scarcer afterwards, and the resulting changes are more pervasive (Brown and Perkins 1992). Loss of place must be grieved like more visibly and

socially acknowledged losses (Doka 2008; Werner-Lin and Moro 2004). Further, children who believe that they are responsible for the traumas that lead to their relocation (i.e., for their parents' divorce or a parent's terminal illness) will encounter greater difficulty in making significant changes (Fogerty 2000; Goldman 2002), such as transitioning out of their old space and into their new living environments.

Living with Revised Histories

Cancer is, now more than ever, a chronic illness that requires families to cope for longer and more uncertain periods of time. As a chronic progression transforms into a terminal diagnosis, families may experience painful anticipatory loss, shifts in family dynamics and a lack of adequate social support. The time between diagnosis and death allows families and clinicians to prepare children for these changes (Rolland 1994). These losses are not limited to cancer, or to illness more generally; they may include the extended absence or death of a parent in the military, in prison, or any other significant separation during early childhood and adolescence. Collectively, the authors have treated over 600 children aged 3–21 who have a family member, most commonly a parent, with cancer. Since our expertise is in oncology, we use parental death to cancer as a model.

Children coming of age in households living in the shadow of a cancer diagnosis may not remember life before cancer. When children have lost both parents, they have lost a connection with their own history (Rando 1995). For parentally bereaved children, this history includes clues to the person their parent was before they were ill, and frequently before they were a parent. Children may look to family friends, distant relatives, and environments that hold those memories to fill in the blanks for themselves. Otherwise, as parentally bereaved children transition to new homes, custodial relatives with their own perspectives and agendas rewrite the family history, especially for the young child. Children's memories of life before cancer and their parent's death may be discounted, invalidated, and lost in the tide of powerful and reinforced stories from their caregivers. The facts become distorted, and children live with a revised history that meets the needs of caregivers rather than their own (Nickman et al. 1998). The psychological presence of a deceased parent (Boss 2000) gradually disintegrates, disconnecting children from any lingering representational models. Finding threads of authentic representation and validation is easier when custodians were more intimately involved with the illness experience or when siblings transition together.

The literature on kinship foster care and divorce identify the challenges for children living with revised family

histories. Similar to kinship foster care and divorce, children who have experienced the loss of their only parent experience (1) severed attachment, (2) a specific trauma leading up to the separation, and (3) the need to adjust to a new physical and social environment. When children are younger at the time of a kinship foster care placement, they experience more difficulty remembering and making meaning of the events that lead to their placement. They operate without their own memories of these traumas. As a result, they become particularly susceptible to the stories and meanings of their foster caregivers. These stories may remain brief and factual (Messing 2006), or may contain disdain and disappointment in parents for their choices and behaviors. Reconstructed histories are also common for children who were very young at the time of their parents' divorce. These children may retain "memory fragments" of painful or poignant scenes from the separation that remain with them into adulthood (Wallerstein and Lewis 2004), yet they lack a composite picture.

Young children are still working to build and consolidate an identity. Disruptions in place and relationship attachments, thus, interrupt a process in motion. Children may become developmentally "stuck," failing to build mastery over normative developmental tasks or circumventing developmental stages out of necessity to cope and adapt to highly stressful and novel environments. Children who have not yet achieved formal thought and cannot make sense of the loss may look to magical explanations to answer their questions (Fogerty 2000). These explanations may become entrenched as caretakers in their lives, due to their own grief, fail to provide honest and developmentally appropriate answers. This leaves children without cognitive foundations to place their parent, the experience, or themselves to build on into the future.

Integrating Bereaved Children into New Family Environments

Following profound and traumatic loss, the quality of care children receive has a significant impact on their long-term mental health outcomes (Brown and Harris 1986; Fazel and Stein 2002; Harris and Bifulco 1991). For example, when children are placed in kinship foster care, they remain in settings that preserve family culture, tradition and knowledge, and they have continued access to relatives and familiar environments (Heger 1999). These children are more likely to have their emotional, spiritual, and social needs met by family members who have known and loved them since birth, and with whom they have some enduring attachment. Yet, when children transition into new homes they must learn a new family culture and dynamic.

Children are subsumed into extended family contexts where custodial adults have pre-existing lives, agendas, and priorities into which the new children must fit.

New custodial relatives are frequently mourning the loss of the children's parent as well, potentially leaving limited emotional energy to attend to the bereavement and adjustment needs of new children in the household. Everyone is grieving multiple losses, of which the deceased parent is only one. Other losses include the children's loss of place and the new custodial adult's loss of lifestyle. Whereas in the home of biological parents the children's needs were likely to take priority, the needs of bereaved children are likely to compete with the needs of other adults and children already residing in the household. The unconditional love children often experience from parents is replaced with family dialogue about whom will "take" them. Children have limited control over maintaining connections to their old lives and worlds and remain dependent on caretakers to support these bonds. Children may experience pervasive loneliness, even if surrounded by family, or may spend long periods of time alone and run the risk of depression (Harris and Bifulco 1991) and self-medication with illicit substances (DeWit 1998). These children must learn new coping skills and develop strengths to navigate novel social, physical, emotional, and structural environments. In search of these pathways, they may become chameleons, looking for clues and models of behavior in their new environments to make and sustain connections. In the process, they may struggle to develop a coherent sense of self.

Death of a Custodial Parent Following Divorce

Children's Adjustment Following Parental Divorce

Divorce, like a cancer diagnosis, presents a significant loss for children. Two nationally renowned, longitudinal investigations tracked the experiences of children and families following divorce (Hetherington and Kelly 2003; Wallerstein and Lewis 2004). Hetherington and Kelly (2003) collected data from a large sample of divorced families across the United States and tracked child and parental experiences and outcomes. They found that following divorce, a full quarter of children see their fathers once a year or less and a full quarter of ex-spouses are still embroiled in significant conflict 6 years out (Hetherington and Kelly 2003). Hetherington and Kelly (2003) notes that while nearly 80% of children of divorce develop into mature, resilient, responsible young adults, the remaining 20% experience pervasive social and psychological distress resulting from the divorce and its aftermath. Wallerstein and Lewis (2004) detailed the experiences of children

struggling against the cumulative impact of their parents' divorce. Of particular relevance here is Wallerstein's (2004) conclusion that following divorce, children may be "confronted with seriously diminished parenting just at the time when they needed their parents' help to make sense of what was happening and to support their efforts to adjust to the major changes within and outside the family" (p. 259). The ramifications of these compounded losses were more profound for younger children who had not yet developed coping skills. Half of the boys and girls she followed were using and abusing substances earlier in their lives than their peers, and the girls were more likely to engage in early and risky sexual activity.

Death of Custodial Parent to Cancer

For children who experienced their parents' divorce, representational models for family life may include provisions for separation, attachment disruption, and loss (Hetherington and Kelly 2003; Wallerstein and Lewis 2004). When a custodial parent dies and children must relocate to a new primary residence, the continued attachment and relational trauma of divorce may shape the integration of that child into family life. These children may already have fears about commitment and vulnerability in relationships. The death of their remaining, primary anchor to the world can further damage their sense of security in relationships. While they may appear to be functioning well on the outside, they may remain emotionally isolated and alone with their grief. This loneliness may follow them into adult relationships, inhibiting their ability to firmly connect to important others.

Non-custodial parents may not be as distressed as children following the death of their former spouse, opening the possibility for relational instability, disconnect and resentment. This may inhibit children's comfort in making bids for emotional support and erect a major barrier to establishing roots in the new environment. In the case of lingering resentments and conflict between ex-spouses, the non-custodial parent may be cut off from the deceased parent's extended family and social networks, further isolating children from important sources of continuity and care.

When children do not blame themselves for their parent's separation, they may blame the offending and non-custodial parent for the separation. They may believe the stress of the divorce caused their custodial parent's cancer and blame their noncustodial parent for the illness and death. They are then transplanted into the house of the adult they believe is responsible for the multiple attachments traumas. In these situations, children may have no one to process feelings with because they perceive themselves to be living in hostile territory, or at the least in a

space where the adults are not grieving in the same way as they are. The need to belong to a family group may incite a deep desire to re-ignite the love that they missed from the non-custodial parent, and these children may only be disappointed again that their parent cannot provide this support.

Grounding Children after Severed Attachments

The clinical work described here was conducted in the context of a non-profit, community based organization that provides a host of psychosocial services at no cost to individuals, families, and communities affected by cancer. Programs provided educational, psychosocial, and supportive interventions in family, group and individual modalities. These programs were built on the conceptual pillars of family systems, developmental, and attachment theories. We worked from the basic assumption that under stress, representational models may erode (Bowlby 1988) and family life and organization are restructured (Nichols and Schwartz 2007). The primary therapeutic tasks were to provide a safe place for children and families to explore these changes while integrating illness information with novel understandings of themselves and the world around them. These goals were predicated on the therapists' ability to provide a secure base and to assist the client in these explorations (Bowlby 1988).

A family systems focus informed interventions to normalize and validate the challenges of parental illness and to recognize the pervasive impact of serious and terminal illness on family structure and organization. This approach directed the clinician to "join" family life and reshape the family system to maximize resources and build on areas of vulnerability (Nichols and Schwartz 2007). A developmental perspective informed our aim to balance energy directed towards illness management with the need to keep children on track developmentally, socially, and academically. When planning interventions, clinicians attended to the range in cognitive, emotional, and moral development of young participants as they struggled to integrate novel information about illness, death and family change.

The focus on attachment theory addressed new limits illness imposed on parents' responsiveness and availability to children, and the anticipation of death or separation as a threat to attachment. For securely attached children, separation from a parent is unthinkable. As attachment figures become increasingly unavailable, children may develop representations of themselves as unworthy of care. Children's adaptation to these separations is impacted by whether they are given enough information about what is happening, and whether they can access a safe space to

process the loss, and express anger and sorrow. Thus, individual, group, and family work aimed to build self-esteem and improve family communication (Johnson-Schroetlin 2000), clarify misconceptions about illness and death (Taylor-Brown et al. 1993), address magical thinking, and build a strong support network.

Clinicians integrated theoretical concepts from these distinct perspectives to create a holistic, eclectic treatment program for children and families. The clinical team frequently saw all members of a given family across a variety of programmatic offerings. Standard treatment employed a combination of relational and structural family therapy techniques (Biank 2002; Werner-Lin and Biank 2009). With children, clinicians used a combination of directive and non-directive techniques (Landreth 2002), drawing on expressive art, dramatic play, music, health education, and group discussion to build emotional intelligence and comfort in emotional expression. With parents, clinicians combined relational and structural techniques (Nichols and Schwartz 2007) with coaching (McGoldrick and Carter 2007) to cope with anticipatory loss and grief while shoring up parental functioning.

Working from a dynamic perspective, clinicians created a holding environment (Winnicott 1965) for children and families that allowed for the family to slowly adapt and transition together. In the therapeutic space, illness was accepted as a common denominator, as a normal, shared part of family life. While attachments to primary caregivers were in crisis and as family life changed irrevocably, the basic structure and chemistry of the therapeutic environment remained unaltered. Connections with the homelike space, clinicians, and group members provided supplementary attachments to shore up children emotionally as their parents approached death. The clinical team sponsored holiday events and other typical family events, such as movie nights and cookie bakes to capture aspects of pre-illness family life. Thus, the clinicians took an active role in family life, parallel to that of the “good enough mother” (Winnicott 1953); they were available as needed and adapted interventions to the unique developmental and systemic needs of each family. In doing so, during the chaotic upheaval of terminal illness, the social workers provided centrifugal force, anchoring family energy to address the dual demands of the terminal illness and child development.

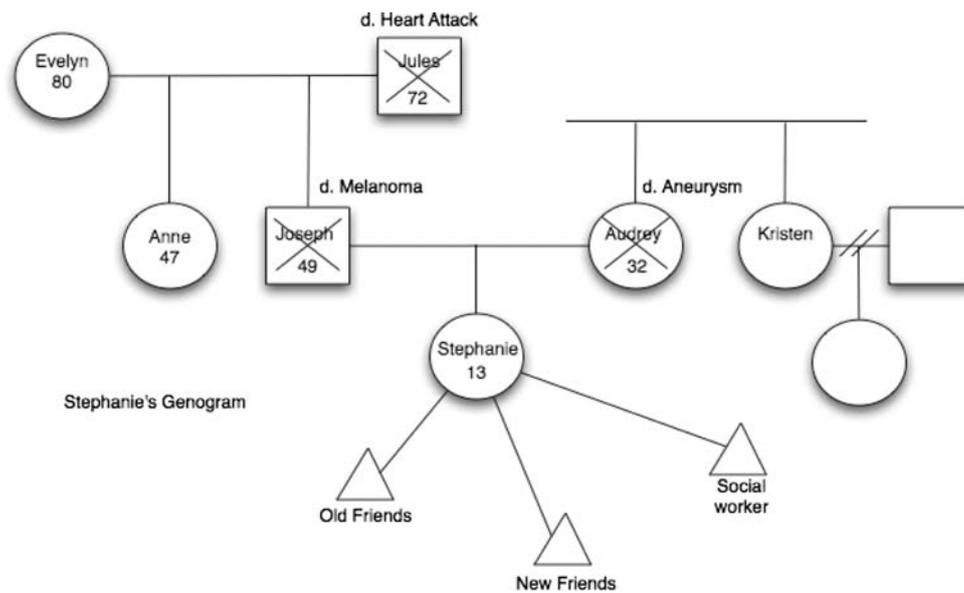
Children feel nurtured and protected in home and therapeutic environments with consistency and structure (Davies 2004; Landreth 2002). Family structure refers to the organization of family life and includes hierarchies, subsystems and alliances that regulate family interactions (Minuchin 1974). This structure is frequently dismantled

by the pragmatic and emotional demands of serious and terminal illness. Thus, the team worked with families to build a new structure with parental figures at the helm and children supported and nurtured. This enabled families to address ongoing crises and to provide a safe foundation for children to experience profound loss and reorganization. For children and adolescents transitioning to new living environments, the clinicians collaborated with custodians and new caregivers to create this structure to anchor and raise the grieving child. This collaboration with clinicians relieved dying parents and extrafamilial caregivers from the burden of “doing everything right” during a critical and taxing time.

The following two cases will demonstrate the clinical issues faced by these children and the treatment of their families. The case of Stephanie demonstrates the clinical presentation of an orphaned adolescent transitioning from her childhood home to live with extended family. The clinical team worked with her father before his death and with her paternal aunt afterwards to identify hidden attachment disruptions (to her home, school, etc.) and to preserve continuity throughout the loss. This case demonstrates the ability of the clinician to remain a solid and stable presence (a transitional object) through a period of intense instability and reorganization in family life. This case also identifies target interventions throughout the family system, addressing the dynamic needs of Stephanie, her father, and her paternal aunt.

The Case of Stephanie

Stephanie was 6 years old when her mother died suddenly of a brain aneurism. Eight years later, her father Joseph, was diagnosed with melanoma and died only 3 months later during Stephanie’s first year of high school. Joseph brought Stephanie for treatment shortly after his diagnosis, allowing the social worker access to Stephanie, Joseph, and his sister Anne, age 47, who was single, did not have children of her own, and who would become Stephanie’s custodian. Treatment of Stephanie’s family included a combination of support and bereavement group work for Stephanie, individual counseling with each family member, and family therapy. The goals of these interventions aimed to keep Stephanie in school while helping her adjust to her father’s impending death. Clinical work focused on (1) anticipating and planning for the changes so that everyone could move slowly and without chaos and (2) establishing a structure for Anne and Stephanie in their new life together.



During the initial meeting with Stephanie and her family, Stephanie was very clear that her peer relationships sustained her far more than her familial relationships. She was quickly enrolled in a weekly support group for adolescents with sick and dying parents. Not surprisingly, Stephanie connected easily with members of the support group. This facilitated her attachment to the space and allowed the clinicians to establish a safe holding environment; the physical space and therapeutic relationships with the clinician and her support group peers provided a consistent and stable anchor for her as everything else around her changed.

As Joseph approached death, the clinician encouraged an ongoing dialogue between father and daughter to prepare them both for the separation. During weekly sessions in the month before Joseph's death, the social worker challenged Joseph and Stephanie to confront the reality of his death and to discuss the changes that would ensue after he died. To support emotional communication between father and daughter and to prevent Stephanie from feeling guilt or responsibility for her father's death, it was important that Joseph tell her directly about his prognosis and his plans for her following his death.

The clinicians conducted a single, extensive family meeting with Joseph and Anne to establish a plan for Stephanie that would honor her wishes, her connection to her father, her peer networks, and her developmental needs. In the days before Joseph's death, Anne was given custody of Stephanie. Anne's home was in a suburb near where Stephanie was attending her freshman year of high school, and, with the social worker's help, arranged for Stephanie to remain at her school and with her friends in the months following his death. Stephanie was relieved to live with a

supportive family, including many cousins and grandparents. This plan attended to her need to remain firmly anchored in familiar social, academic and familial contexts during the traumatic changes.

Leaving her father's home was traumatic for Stephanie, largely because it represented a solid and remaining connection to her parents, pushing her to confront her new status as an orphan. Even though she was given a bedroom and freedom to decorate the space, she would often walk by her old house when she was visiting her friends. Anne painted and re-carpeted the house prior to putting the house up for sale. Stephanie experienced these changes as a further assault on her connection to the space. In additional weekly sessions starting before Joseph's death and continuing through the first year afterwards, the social worker helped Stephanie understand her level of attachment to her home and how it held the place for all of Stephanie's losses. They made a timeline of all of the things that happened while she was living in the house—from starting school, to making friends, to losing her mother, to living alone with her dad, to transitioning to her Aunt's home. This helped Stephanie understand the meaning of the house as the last stronghold of her former life and to see a trajectory oriented towards the future.

Anne met with the social worker monthly during the first year after Joseph's death to help her parent a grieving adolescent. With guidance from the social worker, Anne recognized how angry she was with her brother for dying and leaving her with the responsibility and financial burden of raising Stephanie. Stephanie spent as much time as possible out of her aunt's house. Anne allowed this, partially because she felt sorry for Stephanie and had difficulty

setting limits for her, and partly because it allowed her to frame herself as a single person with a child at home, not as a single mother raising a daughter. Anne also felt a pervasive loss of her lifestyle; while she welcomed Stephanie into her home and loved her deeply, she had never intended to become a parent. To cope, she sought to preserve her private time by supporting Stephanie's attachment to and time with her friends. Yet, Anne left Stephanie without house rules to bound her time with friends. The social workers helped Anne to develop a parental voice, which involved establishing a daily routine, providing boundaries around family and social time, and developing rudimentary discipline. Rather than resent these new rules, as Anne anticipated, Stephanie reinforced that this structure helped her feel like she was a legitimate part of Anne's household.

As Stephanie settled into life with Anne, she had many questions about her mother's life and death, and with Anne's support and the social workers encouragement, sought out her mother's family. Stephanie was only six when her mother died and she had limited memory of her. At thirteen, with the help of Anne, she reconnected with her maternal aunt, Kristen. Stephanie learned about her mother's childhood and was given some of her mother's belongings. These connections placed her mother and her own childhood years in the broader context of family life and confirmed her mother's love for her. She watched home movies to learn more about her mother, but was frustrated listening to family stories because she recognized these were not *her* memories.

Stephanie is now settling into her new life, but she is just beginning to grieve the loss of her parents. Clinical work at this point is focused on preserving her memories of her parents through storytelling, journaling, and pictures to place these parts of her history and integrate them into who she wants to be as an adult. After the first anniversary of Joseph's death, sessions became more intermittent. Yet Stephanie and Anne continue to return for periodic consultations when they identify challenges. The separation from the clinical environment and the safety Stephanie feels in her new physical and emotional environment permits her to grieve the loss of her father more deeply. She is now working to integrate his loss into her life story and to prepare for the next phase of her life.

Case Analysis

After losing her mother as a child, and her father in adolescence, Stephanie is forced to leave her home, the only place she feels connected to her parents. The house symbolized her attachment to her parents, and losing the physical structure was an additional assault on her sense of

self and continuity. Leaving the space meant severing additional ties to security and deepening the grief over her father's death. The profound nature of this move out was invisible as clinicians prepared for her to transition into a new family dynamic. Stephanie pleaded with her father, her aunt, and the social workers to remain in her home by herself and, after moving out, fantasized about buying the home with friends and living there as an adult. Her memories and stories about family life were embedded in the structure of the house.

As Stephanie moved further away from her connection to her parents, she became frustrated that her memories were not pure. She was jealous of family members and friends who had enough time with each of her parents to develop their own solid memories. Together with the social worker, and with family photos and videos, Stephanie began to construct a family history that attended to her own vision of her early family life. The social worker guided her to construct family albums with treasured photos, stories, recipes, even pieces of wall paper from the old house to preserve a sense of continuity in family life.

These connections helped Stephanie to settle into her new family life with Anne. The social worker acted as a liaison between Anne and Stephanie, facilitating conversations together and separately about the losses and gains in their new living arrangement. Anne was deeply grieving the loss of her brother and her lifestyle when Stephanie became a big part of her life. Stephanie represented these losses to Anne, which complicated Anne's attempts to provide parental guidance and structure. Processing this grief with the social worker allowed Anne to create a new relationship with Stephanie that attended to Stephanie's dual need for security and growing independence. As Stephanie and Anne established this structural frame, they began to separate from the transitional object (the clinician) in the same way a teenager establishes independence from a parental figure.

The next case presents a more extreme set of attachment disruptions. After Toby's parents divorced, he had limited contact with his father. He experienced a series of relational and place attachment disruptions before moving from the Pacific Northwest to Chicago with his mother and connecting to a new family structure and environment. When his mother was diagnosed with an aggressive, and ultimately lethal, form of breast cancer, Toby faced the loss of his remaining anchors to the world. He moved to Japan in the hopes of being reunited with his estranged father. In this case, the social workers had access to Toby's maternal family before his mother's death, but had no contact with Toby's father. Thus, the clinical work required shoring up Toby's emotional reserves to grieve and integrate into a new life with limited support, contact or continuity.

The Case of Toby

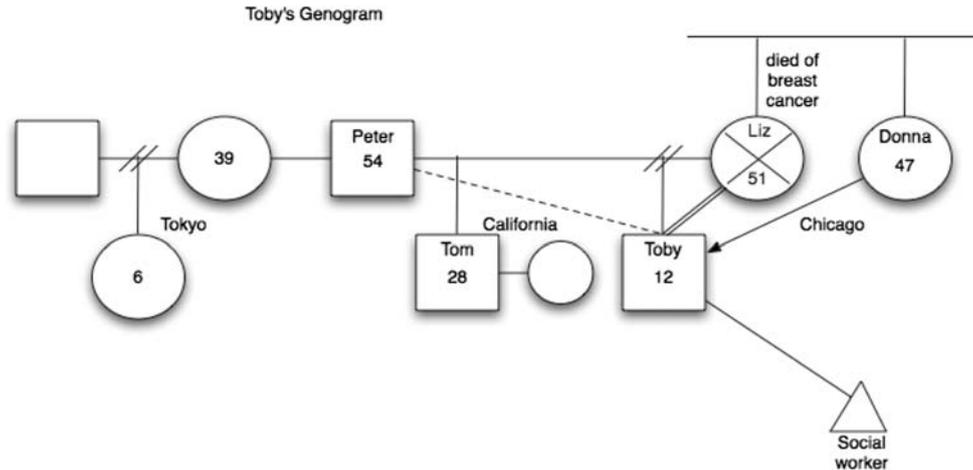
Toby grew up in the Pacific Northwest with his parents, Liz and Peter, and his brother, Tom, 16 years his elder. As Toby entered middle school, Peter’s attempts to control Liz’s behavior lead to constant bickering. They divorced 2 weeks before Toby’s eleventh birthday. Liz was awarded sole custody of Toby. Tom, now in his late twenties, was engaged to be married and living out of state.

Following the divorce, Peter frequently failed to show up for scheduled visits and eventually stopped sending child support. After Peter’s failed attempts at co-parenting, Liz and Toby moved to Chicago to be near Liz’s sister, Donna. Toby changed schools, leaving close friends and familiar teachers. Eventually Toby settled into life in Chicago. With the help of a favorite aunt Donna and several cousins, he began to connect with local children and community groups. He started to feel at home. Liz and Peter worked out an arrangement for Toby to visit Peter during school holidays. However, Liz was concerned that much of Toby’s time with his father was unsupervised or spent with inappropriate video games and movies. Six months after the divorce, Peter was relocated to Tokyo, where he met and married a Japanese woman with a daughter of her own. After Peter’s move and remarriage, Peter and Toby had limited contact.

what he imagined cancer to look like. While Toby’s drawings were quite explicit, they were entirely monochromatic. He used only a pencil to express his perceptions of how cancer had destroyed his mother’s body and his hopes for family life. His art provided a medium to communicate with the group about his life.

Over a short period of time, Toby experienced a number of significant losses during crucial developmental stages that made it hard for him to sustain attachments and pushed him to shut down emotionally. He had no consistent relationship to build a healthy and adaptive representational model. He felt threatened by closeness, and tended to retreat into his art. The circumstances of Toby’s move and his prior losses made it a challenge for the social worker to establish herself as a transitional object for Toby; it was clear to him that people he loved were only temporary in his life. Yet Toby did connect with the social worker. She provided consistency and stability for him in weekly group sessions. She was able to join with him in his artistic expression, and noted that the absence of color in his work mirrored the lack of affect and connection in his life. He felt safe with her, and was eventually able to verbally express his fears about losing his mother and wishes about being reunited with his father.

Treatment options for Liz were pursued aggressively but none were successful. As her health deteriorated, Toby had



One year after the move to Chicago, Liz was diagnosed with an aggressive breast cancer. She brought Toby to meet with a social worker who enrolled him in a support group for children who have a parent with cancer. During weekly support group sessions, Toby was quiet, choosing to express himself with art. He always carried a sketchbook and a pencil. He drew elaborate and skilled pictures about his experience of having a mother with cancer and about how he missed his life and his friends in Oregon. He drew fierce objects attacking his mother’s body, demonstrating

trouble in school and in maintaining friendships. He withdrew, exhibiting signs of depression. He refused to leave his mother’s side, turning down the chance to visit his brother in California during the summer. Liz spoke with family about creating a plan for Toby in the event of her death. While Toby wanted to live with his father in Oregon, he knew this was not an option, and saw living with his father in Tokyo as the next best possibility, and fantasized about the relationship that might develop between them. Although the divorce remained contentious, Liz conceded

that since Peter was Toby's father he should have custody of his son. This deeply upset Liz's family members because Peter had only minimal contact with Toby during the course of Liz's illness and death, and Donna worried about how Peter would parent Toby in the wake of this impending and devastating loss.

When it became evident that Liz's death was imminent, Toby began coming in for weekly individual support. Sessions focused on preparing Toby for his mother's death, for saying goodbye to her and to his social networks in Chicago, and the future changes in his life. Although Liz made plans for Toby to join his father in Tokyo, Donna, who had provided significant instrumental and emotional support to Liz and Toby during Liz's illness, asked Peter for custody of Toby. Toby and Donna had built a strong bond and were experiencing the impending loss of Liz together. This connection would have provided a foundation for Toby to experience support, continuity, and to gather momentum as he developed into a young man. While Peter refused to take calls and did not return emails from Donna or the social worker, he did not want to give up custody. At this point, Liz was too weak to take her husband to court to challenge the custody arrangement and allow Toby to stay in Chicago with Donna. In August, Liz died in home hospice.

Shortly after Toby began his school year, Peter informed Donna that Toby would move to Japan as soon as he received his passport. Although Donna asked for more details to help Toby prepare for the move, Peter gave no information about the neighborhood he would be living in or the school he would attend. He declined requests to speak with Donna or the social worker to help Toby transition into this new life. Toby discussed mixed feelings about moving to Japan. He did not speak the language, he would start in a new school with new classmates, he had never met his father's wife or her daughter and he was not able to communicate with either of them. Despite these uncertainties, Toby wanted to be with his father, a wish the social worker hoped would facilitate his transition. Toby fantasized about reconnecting with his father and moving back to the Pacific Northwest. This reflected his desire to recreate his past. His only connection to this new place was through his father, who had coped with a messy divorce by severing all connections to previous family life. Peter was now invested in his new family, and he took Toby as the trophy from a failed marriage.

Clinical work in the final weeks before Toby's departure was designed to solidify his representations of his attachment to his mother and to build on the coping skills he had learned in the group. Since his attachment figures (his mother, his aunt, his social worker) would not travel with him, clinical work focused on shoring up his internal working model of these healthy attachment to sustain him

across time and space. The social worker framed the sketchbook as his new transitional object, and encouraged his continued self-expression through art.

A ticket arrived in the mail mid September. Toby had 2 weeks to say goodbye to his Aunt, friends, school, therapeutic relationships and his life in Chicago. Although Toby was scheduled to meet with his social worker one final time the week before he left, he told Donna the day of the appointment that he did not want to come but agreed to talk to her on the phone. Donna thought it was too hard for him to have to say goodbye to more people in his life because he has done this so many times. Toby and the social worker spoke briefly. Knowing that he was not going to have a strong support system in Japan, she reminded him of the coping mechanisms he had developed, namely drawing and writing. She also discussed his strengths and ways he could remember and stay connected to the memory of his mother. The social worker acknowledged that the clinical work contained fragile yet resilient links to his mother, and saying goodbye to the clinician meant leaving his memory of his mother. His connection to the social worker was evident in his inability to say goodbye to her, facing another painful and significant loss in his life.

In early October, Toby flew to California to spend a week with his brother. At the end of the week, Tom drove 13 year-old Toby to the airport, where he boarded a plane to Tokyo by himself. Four months later, Toby was not taking any language classes nor was he enrolled in school.

Analysis

Toby's repeated attempts to establish connections with people in his life were thwarted by geographical disruption and death. His initial place attachments were severed when divorce irrevocably changed his family life, then again when he left Oregon for Chicago. Yet in Oregon and Illinois he was grounded emotionally, which allowed him to develop some place attachment. His move to Japan was void of a secure emotional connection or familiarity with the topography, linguistic, or cultural spheres he would now inhabit. Further, he was unsure if he would have access to the technology needed to maintain a relationship with his aunt, brother, and friends.

Yet he still showed a desire to be in relationship. The social worker attempted to nurture this while preparing him for a variety of possibilities once he reached Japan. His desire to be with his father and his fantasy of reconnecting with him were rooted in his belief that his grief would move his father to care for him. Yet this attachment behavior, designed to draw his father into a relationship, can lead to chronic stress and distress. The social worker was concerned that if his father was neither available nor

responsive to Toby's needs, this stress would become acute and Toby would be in crisis. Given Peter's track record, Donna was concerned about the quality of parenting Toby would receive from Peter and his new wife. She was also concerned that Toby would have to compete with the new stepsister for love and attention.

The social worker needed to match her pace to the family; while she anticipated many of the challenges that would ensue and encouraged Liz and Donna to explore other custodial options, they were unable to alter the situation. While Donna hoped to keep Toby with her, after Liz's death she supported Liz's memory by remaining inactive in the face of another overwhelming loss. Following separation from a parent, children often fantasize about being reunited with their noncustodial parent and receiving the love and nurturing they believed they had to give up. In Toby's case the reunion did not affirm his hopes and dreams. It offered him no solace and after 1 year living with his father, he returned to the US to live with his brother in Oregon. While he was now forced to face the loss of his second parent, he is reconnected to his geographical and emotional home through his brother.

Discussion

Positive outcomes for children's long term development and adaptation to their new social and physical environments depend, in part, on the degree to which attachment disruptions are anticipated and planned for and the degree of choice children have in making changes (Brown and Perkins 1992). With parental death following a long illness, the chronicity of the disease allows for the possibility of preparing children in advance for these drastic changes. Clinicians can anticipate the major emotional, relational, and geographic changes before children or families are aware of them, yet should not outpace families as they attempt to move forward. Ties to a clinician or therapeutic setting in place throughout the transition may function as a powerful transitional object, supporting children and families through the devastation of loss and into the uncertainty of establishing a new future. Clinicians can work to shore up the client's emotional immune system to support coping, adaptation and continuity throughout the transition. Attachments to the therapeutic relationship and environment established during the trauma of parental loss can provide continuity and connection to deceased parents to minimize loneliness and support self worth. This continuity will anchor children emotionally, allowing them to grieve multiple, potent losses.

Assessing the strength of children's bonds to their deceased parent is essential, since stronger attachments predict more devastating disruptions. Therapeutic

interventions should focus on building self-esteem and supporting the development of a healthy continuous identity, particularly since attachment disruptions can precipitate feelings of worthlessness in children (Bowlby 1980). Clinicians must recognize that within the chaos of severe and confusing disruptions in which children feel limited agency, opportunities exist to enhance mastery and connect newly constituted families to familiar environments. Children should be encouraged and helped, wherever possible, to maintain ties with friends, teachers and community members. Maintaining connections with peers, mentors, teachers, and community environments provides continuity to children in addition to supporting continuous identity development. For emotional and pragmatic reasons, family caretakers may not be able to assist children new to the household in maintaining meaningful ties to these people and environments. Yet, children today are technically savvy, and access to the internet is a powerful way for them to maintain and nurture these connections. Healthy, "normal" moments exist and must be recognized, nurtured, and celebrated. These moments become islands of relief, and may accumulate so that children can begin to build new, powerful attachments to their new surroundings.

Bereaved and reconstituted families encounter difficulties when they are unable or unwilling to adapt their structural organization to changing circumstances (Minuchin 1974). Interventions that frame presenting problems as structural problems alleviate blame; they are designed to alter this structure so that families can adapt to novel situations and environments. Following a foster care model, pre-placement meetings can facilitate common goals that bring everyone in on the same page (Messing 2006). Involving children, parents and soon-to-be custodians in building a plan is essential. Structural family therapy techniques that frame adults as stable caretakers and leaders will support children's sense of safety. Building a reliable and consistent structure in the new home will help children integrate and feel welcome in a new family environment. To create such a structure, clinicians must work with custodial adults and children to find a balance between their old and new routines. With the help of clinicians, this structure can be established, tested, and refined.

Children must be supported as they construct mental representations of pre- and post-illness family life. Living in an environment in which caretakers deny children's accounts of family life undermines a child's ability to ask questions and seek emotional support. Emotional and tangible space must be created for children to preserve those memories that are uniquely theirs. This can be accomplished with journaling, scrapbooking, art projects, music compilations, home movies, or other creative mechanisms.

When the clinician cannot continue to be a tangible presence for children following the death of a parent, they can work with children to consolidate new and stable representational models (Bretherton and Munholland 1999; Waters and Waters 2006) for children to build trust within new environments. Even after termination, the seeds planted during the course of developing the therapeutic relationship may remain for children as they approach new environments believing they are worthy of care.

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