

Vulnerable children of mentally ill parents: towards evidence-based support for improving resilience

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The increasing prevalence of mental illness among parents always represents a stressor affecting the biopsychosocial development of a child. However, due to varying inherent resilience factors, not all children are affected to the same extent. The presence of evidence-based resilience factors is able to minimise or prevent the adverse effects associated with the parental disorder. Fostering an attachment to a healthy adult – including professionals in the social field – and providing information about the disorder are regarded as two important preventive factors. The need for specific individualised intervention programmes for this group of forgotten children is highlighted, and a specific method of assessment is presented.

Keywords: vulnerable children, resilience, mentally ill parents, intervention.

The increasing vulnerability of children

There is no doubt that the general vulnerability of our society to psychiatric disorders is increasing, and the issue of child and adolescent mental health is becoming apparent in many European cultures. World Health Organisation data indicate that in 2020 depression will be the second most prominent disorder after coronary heart diseases (Eikermann, 1998; Müller-Schloher, 2004). More and more children and adolescents will live in a situation in which at least one parent has a psychiatric disorder. In 2008, around three million children and adolescents (approximately 3%) are expected to live with a mentally ill parent (Pretis and Dimova, 2003) in the European Union.

The Social Innovative Network

The Social Innovative Network (SINN) is a centre which provides specific bio-psychosocial screening for vulnerable

children in the context of the mental illness of a close relative (mostly parents) and educational support to Early Intervention Services in Austria. In close cooperation with social welfare services, the staff of SINN (a psychiatrist, a child psychologist and a special educator), based on the voluntary participation of parents, assess the resources of and possible threats to young children and design individualised intervention programmes for the families. Currently, one new family joins our centre every week.

It is our main goal to activate resources in vulnerable family systems, primarily within the system (for example, grandparents, aunts, neighbours) and secondarily by means of professional services (for example, home visiting services, day care, psychotherapy) in or near the child's natural context.

In order to assess resources and developmental threats within a vulnerable family system, a 'resilience map' is used (see Figure 1 below). This map is empirically based, and synthesises perceived, relevant resilience factors of the child, the family and the relevant environment. This is achieved through structured interviews with the parents and social worker, observation of the child's interactions, psychological and pedagogical testing, and network analysis. (For education professionals without a psychiatric background who need to assess a child's resilience and risk, a simplified list of questions to assess this can be used (see Table 2).)

Within the screening process – mostly together with the child's extended family – different areas of resilience and risk are identified (see Figure 1). This helps the SINN team, the parents and the social welfare services to suggest and design individual intervention programmes that use the child's observed resilience resources and focus individually on the threats to their resilience. Suggested interventions are usually provided by local services. After six months, an evaluation of the suggested individual interventions is carried out. The interventions and resulting strategies allow the child and adults to create a 'space of protection' for the child in potentially stressful or threatening situations.

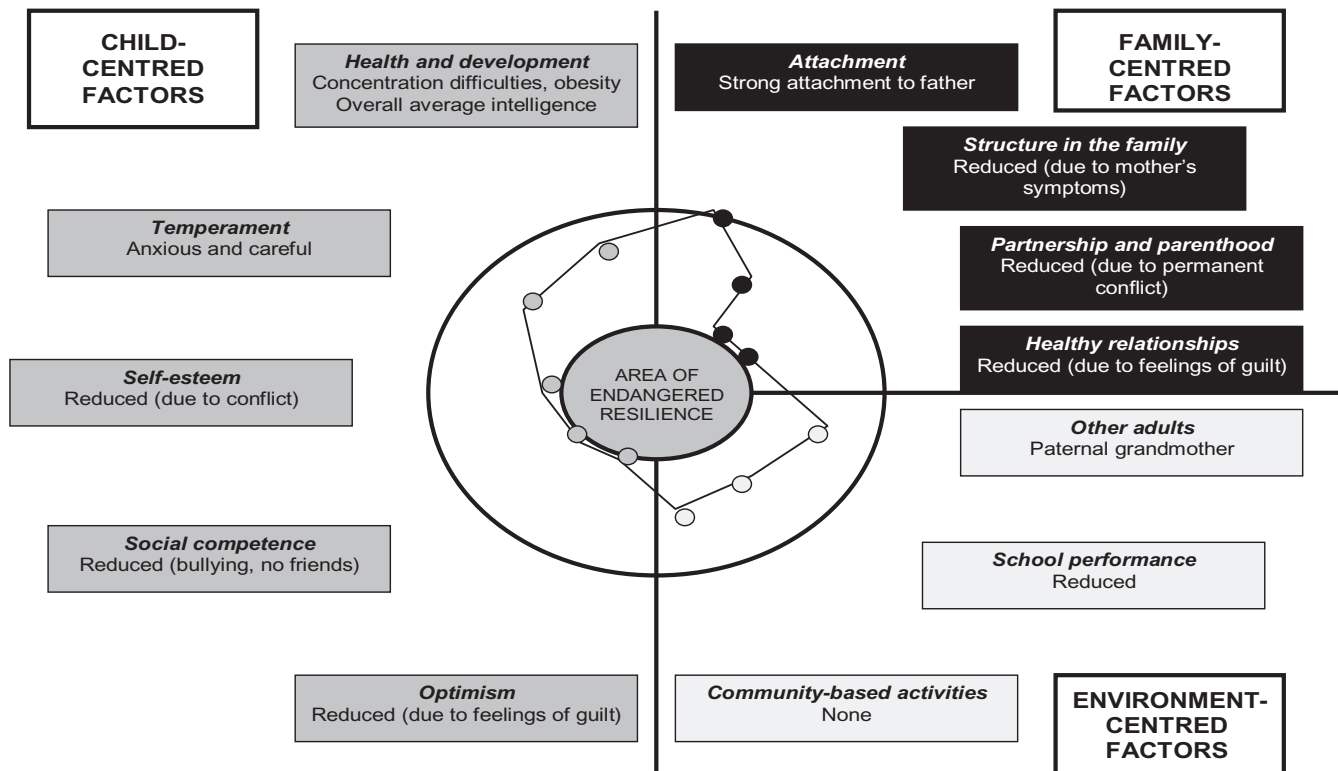


Figure 1. Sarah's individual resilience map

Case study: Sarah

At 10 years old, Sarah (names in this article have been changed) was referred to the Centre because the Child Welfare Administration were concerned about her family situation and how it was affecting her. Sarah's mother suffered from a severe schizophrenic disorder. Her father, who lived with them but was not married to her mother, was working long hours in the security business. He felt extremely excluded within the family context because Sarah's grandparents, due to her mother's severe symptoms, made all the decisions in the family. Her father showed high potential for aggression against her grandparents, and had openly threatened them with physical aggression.

Sarah was not allowed to talk about her mother's illness. She felt guilty as her grandparents blamed her for her mother's symptoms and hospitalisation. She felt helpless in the midst of the conflicts between her grandparents and her father, and also had some problems in school arising from difficulties associated with poor concentration and her obesity.

Sarah and her family were enrolled within the Centre programme. Following the approach developed at the Centre, we created an 'individual resilience map' for her (see Figure 1), which enabled us to learn about her strengths and needs, taking into account her whole family system. Working from this, we were able to recommend an individualised programme for her.

Sarah's resilience map showed us the necessity of recommending interventions regarding:

- self-esteem, social competence and general optimism using her cognitive resources, including strategy building and the provision of concrete information about her mother's illness;
- the position of her father within the family structure using his strong attachment to Sarah;
- community and peer-group-related activities.

The resulting programme developed with Sarah focused on:

1. dialogue between the professional team (comprising a psychiatrist and psychologist) and the whole family unit to increase the family's awareness of Sarah's needs;
2. the design of an individualised intervention programme for the family, focusing especially on developing cognitive strategies for Sarah in response to her concerns (such as 'How I can protect myself?'; 'What I can expect from my mother in the context of her illness?');
3. continuous evaluation of the intervention (15 sessions) by Sarah's social worker.

After drawing up the resilience map, we used several sessions together with Sarah to identify personal cognitive and behavioural strategies to cope with her grandparents' behaviour towards her. Before our intervention, she felt paralysed when they shouted at her and accused her of causing her mother's symptoms to worsen. During our sessions, Sarah found out that she could be 'quicker than her grandparents',

and escape distressing situations by leaving the ‘hot spot’. Now, as soon as her grandparents appeared, she would go to her study or into the garden. She also learnt through psycho-education that she was not responsible for her mother’s symptoms or frequent hospitalisation, and, furthermore, what she could reasonably expect from her mother in terms of attachment and sensitivity to her needs.

The position of Sarah’s father in the family was strengthened with the social worker’s support. He applied to be his daughter’s legal representative, although this step brought some tension as Sarah’s mother and her grandparents resisted this. (Despite being cognitively unable to fulfil the role, Sarah’s mother had been her representative up to that point as the couple were not married.) Sarah felt much more secure within the new family structure. In addition, we suggested that Sarah join a youth group to enhance her social competence with her peers.

After six months, all the interventions described above had led to an observable decrease of distress in the family system, and an improvement in Sarah’s performance at school.

Identifying vulnerable children

Very often vulnerable children like Sarah are ‘forgotten’ by professionals as:

- they do not comply with the classical criteria for disability or neglect;
- they do not have a strong lobby (unlike children with disabilities);
- professionals primarily tend to focus on the symptoms or treatment of the mentally ill parent.

Recent findings indicate that there is still a lack of early identification in the school setting and an absence of a shared understanding of relevant issues across services and agencies (Bibou-Nakou, 2004). Surprisingly, professionals, including teachers, do not always adequately recognise psychiatric disorders in parents (Bauer and Lüders, 1998) or they tend to minimise the impact of the parent’s illness on their child’s development (Küchenhoff, 2001).

Among parents with a mental illness, there is also a strong tendency to underestimate the effects of their illness on their children. They often try to hide symptoms, supposing that their children are not able to recognise their behavioural changes. However, even young children are good observers. They are often acutely aware of symptoms which signal the onset of an episode of mental illness, even if the parents try to conceal them, and can describe them from a child’s perspective, reporting that: ‘My father is sleeping more often’; ‘He is always sad, irritated and intolerant’; ‘Mother does not leave home’.

Living with a mentally ill parent continually challenges the coping mechanisms of young children, and absorbs energy in terms of the child’s global functioning. A parent’s psy-

chiatric disorder can always be assessed, therefore, as a non-specific chronic stressor affecting the biopsychosocial development of the child. No wonder that children in these circumstances usually show very non-specific symptoms of stress – comparable to those of children whose parents suffer from other chronic diseases. In addition to the effects upon children’s own mental health of their parent’s unpredictable behavioural changes, there are also genetic risks. Between 10% and 50% of children from families in which both parents suffer from mental disorders go on to develop mental illness themselves (Pretis and Dimova, 2003).

Resilience and strengthening vulnerable children

The symptoms of stress in a child living with a parent who has a mental illness depend to a large extent on age and personal resilience. However, strengthening protective factors and fostering the resilience of vulnerable children through professional support contributes to the maintenance or enhancement of a child’s mental health and prevents long-term impairment.

Despite the ongoing scientific debate about the concrete underlying mechanisms of resilience (for example, in terms of a general protecting or buffering effect between the child and their circumstances; Opp, Fingerle and Freytag, 1999), the concept of resilience can be regarded as a universal capacity, which allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity (Dimova, 2007). And adverse situations – even though they are underestimated by both professionals and parents – are numerous in a child’s life.

Adverse effects of parental psychiatric disorder on young children

Lack of ability to predict their parent’s symptoms can lead to a child’s:

- perception of helplessness in the situation;
- disorientation;
- guilt;
- fearfulness.

Repeated hospitalisation and separation from a parent for unknown periods of time can lead to a child’s:

- separation anxiety;
- extreme concern about their parent.

The child may also experience:

- a ‘reality gap’ between their ‘own world’ and the world of their ill parent;
- a tendency to take on the parental role – ‘parentification’.

Table 1. A selection of evidence-based resilience factors associated with the three resilience categories (for the complete list, see Pretis and Dimova, 2003)

	<i>Resilience factor</i>	<i>Empirical evidence</i>
Child-centred factors	Good health and developmental parameters	Dunst <i>et al.</i> , 1989
	Easy temperament or good genetic basis	Weed, Keogh and Borkowski, 2006
	Self-esteem, self-efficacy, hardiness	Rende, Plomin, Reiss and Hetherington, 1993
	Optimism	Schwarzer, 1993
Family-centred factors	Social competence	Gillham and Reivich, 2004
	Stable attachment, emotional availability of 'literacy'	Goldstein and Brooks, 2002
	Family structures, rules, rituals, lack of poverty	Ahmann and Bond, 1992
	Positive partnership and parenthood	Egeland, Carlson and Stroufe, 1993
	Healthy (caring) relationships or separation from unhealthy background	Biringen, 2000
Community-based processes	Relationships with other adults or peers	Werner, 1999
	(School) performance or specific interests	Carro <i>et al.</i> , 1993
	Other community activities, participation	Werner and Smith, 1989
		Criss, Pettit, Bates, Dodge and Lapp, 2002

There are three resilience categories of evidence-based resilience factors which contribute to children's mental health, and combine with active processes within the child themselves and their family system (see Table 1). These are:

1. child-centred factors;
2. family-centred factors;
3. community-based factors.

There is growing evidence that specific programmes for vulnerable children, designed to strengthen resilience, show preventative effects even though these effects tend to be small to moderate (Horowitz and Garber, 2006). Increasing the interactions between mothers and infants by, for example, baby massage, fostered mother–infant attachment during postnatal depression (Onozawa, Glover, Adams, Modi and Kumar, 2001). Depressed mothers, with the support of psychotherapy, were better able to interpret the emotion expressed on their children's faces (Free, Alechina and Zahn Waxler, 1996). Outcomes from an early stimulation programme for mothers and infants (aged 0–6 months) showed that, following the programme, vulnerable mothers found it easier to perceive their child's mood and imitated more of their verbal and facial expressions (Moreau, Lev-elle and Roy, 1998). Adolescent children (aged 20–21 years) from families at high psychiatric risk who had taken part in a five-year counselling programme had fewer psychiatric symptoms than a similar group who had not undertaken the programme (Aronen and Arajärvi, 2000). Generally, intervention programmes tend to integrate support at different levels: family consultation, family support and advocacy groups, family education, family psycho-education and psychotherapy. All of these interventions show potential benefits for families of patients with serious mental illness (Marsh, 2001).

Meeting the needs of vulnerable children

Especially in acute phases of mental illness, there is a high risk that the needs of the children are not met due to the parent being overwhelmed by their symptoms. The primary caregiver may stay in bed all day, sometimes reacting intolerantly to the needs of their children. They may isolate themselves at home because of a general anxiety disorder. They may be occupied the whole day with obsessive behaviours (such as cleaning).

Children may show generalised anxiety or extreme worry about their parent. Hospitalisation may happen unexpectedly or dramatically, resulting in the child arriving home from school to find an ambulance is at the front of the house or that their parent is not there. In these acute phases of their parent's mental illness, a vulnerable child may become less able to concentrate, exhibit mood swings, or perform less well at school. However, even in phases of remission, a decreased 'emotional literacy' of parents with psychiatric disorders can often be observed (cf. www.camhee.eu), resulting in a detrimental effect on their child.

Promoting attachment and attention from healthy adults

The secure attachment of a young child is most threatened when parents suffer from a psychiatric disorder. Changing communication patterns, high unpredictability of behaviour and hospitalisation represent massive threats to a secure base for the child. Brown (1996) describes the self-reported chaos, disruption, social isolation, abuse and neglect of people who grew up with a schizophrenic parent. With this in mind, major efforts should be made to strengthen the attachment of the child to at least one other healthy adult.

This could be – in the best case – a close relative such as a healthy parent or aunt, but could also be a Foundation Stage teacher or social worker.

Our programme promotes the formation of healthy attachments. For example, for Paul (aged two years and five months), we recommended that a surrogate mother be employed during the day, as his mother, who had severe personality disorder, was not able to provide him with age-appropriate stimulation. The surrogate mother enabled stable compensatory attachment and structure for Paul. Mary (aged five) went to live with her healthy father after our intervention, as her mother, who had anxiety disorder, found caring for two children distressing.

How can teachers cope with a child's need for attachment and a secure base from the professional point of view? Usually the child's distressing situation at home is hidden or they are expressly forbidden to talk about the problems. If the child's basic needs are not met at home, professionals in other settings might often observe non-specific changes in the child's behaviour:

- Janet (aged three years) frequently shouted at her mother and intermittently displayed explosive behaviour in the Foundation Class – her mother had clinical depression.
- Stefania (aged five years) did not want to go to Foundation Class because she was reluctant to leave her mother even for a second – her mother had clinical depression.
- Sabrina (aged eight years) had low marks at school – her mother had schizophrenia.
- Andreja (aged 13 years) stole a mobile phone – her father had severe symptoms of burn-out.

It is important that these changes in children's behaviour are recognised and associated with possible stressors. However, we do not propose that professionals in the wider psychosocial field (such as teachers or social workers) offer direct support or therapy to vulnerable children in acute situations. However, they are usually the first professionals to be in contact with the child, to notice the changes, and to be in a position to offer basic support.

Being empathetic towards the child, recognising their emotions (such as worry, fear, guilt), and helping the child to address their feelings directly is often the first important step towards obtaining appropriate help. Concrete questions – 'Are you afraid of something?'; 'Are you worried about someone?' – can open a door into the child's world. However, the goal of this dialogue should not be to uncover family secrets, but to assess if the child needs further professional help.

The 'Child-centred resilience screening list for professionals' provides a series of simple questions which allow an initial screening of the child's resilience factors and associ-

ated stressors (see Table 2). The questions focus on three concepts usually easily understood by a child:

1. I have;
2. I can;
3. I am.

'I have' factors can be regarded as external resources – for example, in terms of belonging or social support. 'I can' factors are skill-related aspects. 'I am' factors reflect the child's internal resources in terms of self-representation. It is important to emphasise that the questions in the list can be regarded as catalysts, which can lead to further dialogue. For example, if the question, 'Do you have somebody who loves you?', is answered in the affirmative, the follow-up questions 'Who loves you?' and 'How do you know?' can be asked.

Through use of this screening list, the vulnerable child can perceive that the professional is a reliable communication partner for their worries. It is important in communicating with the child to focus especially on their feelings and not to give up easily. Our experience shows that while children are not always able to talk about stressors in the family, they are often able to talk about their feelings. Fostering resilience in a caring or educational context means first making sure that the child knows that they do not have to feel alone. An assessment of the child's resilience factors will provide a detailed picture for the professional which they can use to plan further support.

If these first contacts with the child indicate that their resilience resources might be under threat (suggested by a high percentage of 'No' or 'I'm not sure' answers), the child's healthy parent should be contacted. Next, the child's worries should be discussed to enable joint strategies or a specific intervention to be identified. If a healthy parent is not available, further steps should be discussed within a professional team, which may include the teacher, the school principal and a social worker.

Children need information

Only 25% of children aged six to ten years are informed about their parent's mental disorder. Young children are even more likely not to be informed at all. The provision of age-appropriate information for children explaining the behaviour and emotions shown towards them by their parents is regarded as one of the most challenging, but also most important, factors in safeguarding child and adolescent mental health. However, informing children always requires the informed consent of the parents – or, at least, the parent who is in good mental health. Front line health specialists (such as psychiatrists, child psychologists, paediatricians) should be the first professionals to face this challenge. Only in extreme situations (for example, sudden hospitalisation or attempted suicide of a parent) should other professionals step in.

Table 2. Child-centred resilience screening list for professionals

	<i>I HAVE . . .</i>	<i>Associated question</i>	<i>Yes</i>	<i>No</i>	<i>Not sure</i>
'I have' factors	People around me I trust and who love me, no matter what I am doing (= attachment) [†]	Do you have somebody who loves you?			
	People who set limits for me, so I know when to stop before there is danger or trouble (= structures, rules, rituals)	Do you have somebody who tells you what you are allowed and what you are not allowed to do?			
	People who show me how to do things right by the way they do things (= performance/developmental stimulation)	Do you have somebody who shows you how to do things (e.g. eating with a spoon)?			
	People who want me to learn to do things on my own (= self-efficacy, self-esteem)	Do you have somebody who encourages you to do things on your own?			
	People who help me when I am sick, in danger or need to learn (= social competence, social support, health)	Do you have somebody who helps you when you are sick or need help with your homework?			
	<i>I CAN . . .</i>	<i>Associated question</i>	<i>Yes</i>	<i>No</i>	<i>Not sure</i>
'I can' factors	Talk to others about things that frighten me or bother me (= healthy relationships)	Can you talk to somebody about things that frighten or bother you?			
	Find ways to solve problems that I face (= self-efficacy)	Can you solve problems? (Which ones?)			
	Control myself when I feel as if I am doing something not right or dangerous (= hardiness, optimism)	Can you judge when a situation is dangerous for you? How do you do that?			
	<i>I AM . . .</i>	<i>Associated question</i>	<i>Yes</i>	<i>No</i>	<i>Not sure</i>
'I am' factors	A person people can like and love (= attachment, self-esteem)	Do you feel yourself welcomed by . . . ?			
	Glad to do nice things for others and show my concern (= social competence)	Do you feel glad, if you can do nice things for others – for example, for . . . ?			
	Respectful of myself and others (= positive relationships, rules)	Are you or others proud of yourself?			
	Willing to be responsible for what I do (= social competence, community based activities)	Do you take responsibility for something or somebody – for example . . . ?			
	Sure that things will be all right (= optimism)	Do you think things will turn out positively – for example . . . ?			

Note: † Scientific constructs are in parentheses.

Information about their parent's mental illness is crucial for children because it enables them to predict their parent's behaviour, and to recognise that there is an external explanation for it and that it is not their fault. In the example given above, Sarah wrongly attributed her mother's agitation to her own behaviour: 'My grandparents told me that I was responsible for my mother having to go to hospital again!' No wonder that these children, when they become adults, report massive 'feelings of guilt' and 'helplessness'.

Even young children are able to cope with disorder-relevant information if it is:

1. given in a child-friendly and developmentally appropriate way: for example, some children might label the mental illness as 'crying disease' or 'sleeping disease' (depression), 'shopping disease' or 'roaming around disease' (bipolar disorder) or 'jumping thoughts disease' (schizophrenia).
2. solution-centred: reassuring children that seeing a doctor will help their parent, that drugs can make their parent better, that a loved adult will look after them.

Information about the parent's mental disorder reduces distress in children and provides them with a more realistic

picture about their loved one (for example, what can I expect from my mother if she is crying?). Therefore, the first questions when enrolling a child in our resilience programme centre around their understanding of their parent's illness: how do they explain their parent's behaviour; which labels do they use? For example, Jane (aged seven) and Jean (aged nine) described their mother's illness as follows: 'My mum suffers from crying disease. Then our father asks us to bring her flowers and to comfort her. She also has to take some medicine, and then it is better. She cries less.' With the informed consent of their father, we discussed with Jane and Jean the extent to which they were involved in their mother's treatment. However, as stated above, it is important that children do not feel responsible for the mental health status of their parents and realise that, in most cases, their own behaviour is not connected with the signs of the illness. During the programme, both girls learned to recognise when their mother was well or depressed, and they stopped trying to comfort her during phases of depression. Under no circumstances should children be used as therapists for their parents!

Future challenges

A parent's mental illness always represents a stressor for a child, even though, due to individual resilience factors, not

all children will show symptoms of distress. As young children do not usually have the opportunity to self-advocate, future efforts should focus on increasing public awareness about the needs of the children of mentally ill parents. Current projects and European initiatives (such as www.camhee.eu) or networks (such as 'Crossing bridges', Tanner, 2000) strengthen both the availability of information directly available for, and public sensitivity to the needs of, these forgotten children. Furthermore, the specificity of the stressors for the children requires individualised intervention programmes. Early intervention programmes in terms of multi-pronged approaches that attend to the individual characteristics of the child and parent, clinical co-morbidities, and the broader family and social contexts (Avenevoli and Merikangas, 2006) will be necessary, as the number of vulnerable children will increase during the next decades.

In addition to direct, family-orientated programmes like the 'resilience map' programme described above, it is necessary to develop programmes to train professionals. Current European strategies enabling health and social services to support families and children show promising outcomes in terms of improving skills, work-related satisfaction and motivation of professionals (Solantaus and Toikka, 2006; Toikka and Solantaus, 2006). As with the young boy introduced above, fostering resilience in children of mentally ill parents is like finding pieces of a scattered puzzle – but it is worth investing in support for these children so that they can create a meaningful picture.

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