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Superiority of group counseling to individual coaching for parents of children with learning disabilities

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Abstract
Two interventions for parents of children with learning disabilities (LD)—individual coaching and group counseling—were compared. Participants were 169 parents, non-randomly assigned to three experimental conditions: coaching ($n = 45$), group counseling ($n = 93$) and control ($n = 31$). Variables included outcomes (parental stress and parental coping), personal (perceived social support) and process (bonding with therapist/group). Findings indicated more favorable outcomes for parents in both treatment conditions compared to control, more favorable outcomes on the stress index for parents treated in groups compared to individual coaching, and bonding was the most consistent predictor of outcomes. The discussion focuses on the power of group counseling for parents of children with LD.

Keywords: parents; treatment; learning disabilities

Introduction

The study focuses on treatment for parents of children with learning disabilities (LD). Some of these children constitute a daily challenge for their parents, due to academic, social, emotional and behavioral difficulties (McPhail & Stone, 1995; Morrison & Cosden, 1997; Turnbull, Hart, & Lapkin, 2003). Parents of these children are under great stress (Adelizzi & Goss, 2001; Al-Yagon, 2007; Brannan, Heflinger, & Bickman, 1997), often feel helpless and depressed (Bandura, Barbaranelli, Caprara, & Pastorelli, 1996; Turnbull & Turnbull, 1986) and, as a result, their parental functioning is less effective (Barkley, Fischer, Edelbrock, & Smallish, 1991; Stone, 1997). Assisting these parents is important for the parents' sake as well as for the child. Indeed, research supports interventions to improve parents' coping skills; however, less attention is given to their feelings and well-being. This raises the question: What constitutes an effective intervention for parents? In the current study we compare group counseling and individual coaching—two formats of treatment within a similar theoretical model (expressive supportive)—in respect of outcomes, and attempt to explain these outcomes in terms of individual and process variables.

Literature review

Learning disabilities are neurological dysfunctions that affect cognitive and affective aspects of human beings. As a result, some learning functions, cognitive information processing, and interpersonal skills may be affected (Turnbull et al., 2003). Indeed, children with LD, particularly those who have ADHD symptoms, were found to have lower academic self-concept and achievements than children without LD (Leichtentritt & Shechtman, 2009). They were also found to have higher levels of loneliness and depression (McPhail & Stone, 1995) and more frequent interpersonal conflicts and delinquency (Barkley, 1997).

Parent-child relationships directly affect the level of problems that children demonstrate (Barkley, 1997). The more parents are attuned to their children's needs, and the more supportive and warm they are, the fewer the child's emotional and social difficulties (Morrison & Cosden, 1997; Spekman, Goldberg, & Herman, 1992). In contrast, the more parents are authoritarian and punitive, the greater the child's adjustment symptoms (Eisenberg, Fabes, & Murphy, 1996; Stone, 1997).

Parents of children with LD have adjustment problems as well. Compared to parents of non-LD

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children, they are under higher stress, tend to blame themselves more often, express less satisfaction with their parental role (Smith, Majeski, & McClenny, 1996), demonstrate a lower level of self-efficacy and a sense of helplessness (Bandura et al., 1996), and feel more anxious and depressed (Al-Yagon, 2007; Veisson, 1999). Consequently, they tend to be less supportive of their children and more punitive (Barkley et al., 1991). Assistance for these parents is not very common, as most attention is directed to the children, primarily their academic difficulties.

Nonetheless, there are parental interventions reported in the literature. These are mainly educational, aimed at training parents to cope with their children with LD. Reported outcomes of these interventions have been positive. Educational interventions with parents of autistic children, for example, showed a decrease in parental stress (Baker-Ericzen, Brookman-Frazee, & Stahmer, 2005; Feldman & Werner, 2002; Koegel, Bimbela, & Schreibman, 1996). Another cognitive group intervention with parents of children who are intellectually challenging (Nixon & Singer, 1993) indicated a decrease in parental self-blame, negative thoughts, and depression symptoms. Barkley and colleagues (1992) compared three types of treatments for parents of children with ADHD: behavioral management treatment, training in problem solving and communication, and family therapy. All three were effective in reducing negative communication, conflict, anger, and mother's level of depression, as well as in improving the adjustment of the children. Webster-Stratton (1984, 1985) used video presentations to train parents of children with conduct disorder. Results pointed to improved parental coping skills and enhanced problem solving skills among the children. Finally, Shechtman and Gilat (2005) conducted expressive-supportive groups with mothers of children with LD. The mothers showed a reduction in stress, an improved perception of the child, and higher parental sense of control. In the current study we use this same type of group, but go a step further by comparing outcomes to individual treatment of a similar orientation. This is the first paper to compare outcomes of individual and group treatment of the same orientation for the target population. Considering the emotional needs of parents of children with LD and the high demand for services of this population, it is important to know which intervention is the most helpful as well as the most cost-effective.

Past comparisons of individual and group treatments have shown similar outcomes for both types of treatment (Fuhriman & Burlingame, 1994; McRoberts, Burlingame, & Hoag, 1998; Shechtman, 2004). Conclusions in the literature suggest that, at least in terms of cost effectiveness, groups are preferable to individual treatment, but group and individual treatment formats for parents of LD children have not previously been compared.

Research also points to different processes in these types of treatments. Holmes and Kivlighan (2000) indicated that climate and interpersonal learning are more frequent in groups, whereas self-awareness, identification, and problem solving are more frequent in individual treatment. Fuhriman and Burlingame (1990) also stipulated that different therapeutic factors operate in each type of treatment.

The therapist-client relationship seems to be an important factor in both treatments. In individual treatment, it is so highly appreciated that it is referred to as the "common factor" (Greenberg & Pinsof, 1987; Horvath, 2005). In groups, too, relationships are critical, but in this case it is the bond with both the group members and the therapist that enhances outcomes (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005; Burlingame et al., 2007; Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce, 2005).

The therapist-client relationship is considered a process variable, but there are also individual differences among clients, such as perceived social support (Boutin, 2007; Cheung & Sun, 2001; Lieberman &Golant, 2002). Perceived social support is an important factor: the greater it is, the better the outcome (Hanks, Rapport, & Vangel, 2007). In the current study, the focus of treatment is on support; therefore, it could be expected that increased support will have an impact on the outcomes.

Based on this literature, we expected: (a) Positive outcomes in both treatment types compared to non-treatment/control. Specifically, we expected a reduction in parental stress and improvement in parental coping, in the two treatment groups. (b) Based on the inconsistent results in the literature regarding the superiority of group treatment over individual treatment, we hypothesized that no difference in outcomes between the two treatments would be found. (c) Based on the literature suggesting that process and individual variables affect outcomes, and considering the different type of treatment, we hypothesized that different process and individual variables will predict the outcomes in each treatment type; and (d) based on the literature, we expected different therapeutic factors in the two treatment types: emotional awareness-insight, self-disclosure, and problem definition-change will be more frequent in individual coaching, while relationships-climate and other- versus self-focus will be more frequent in group counseling.

Method

Participants

Participants included 169 parents of children with LD: 93 in group counseling, 45 in individual coaching and 31 parents on a waiting list. Of these, 70% were mothers. Children's ages ranged between 6 and 18, and 70% of them were boys. All came from middle-class families residing in cities in central Israel. No differences were found in demographic characteristics between parents in the three conditions.

In addition, there were 42 therapists (ages 31–55): 30 coaches and 12 group therapists. All were professionals with an educational background in psychology, social work, school counseling, and learning disabilities. In addition, they were trained in the same institute in either group counseling (the expressive-supportive model) or coaching (same model), at least for one academic year (56 hours), and were supervised by experts in group counseling or coaching every two weeks, throughout the intervention.

The Interventions

The interventions in both formats followed the expressive-supportive modality (Shechtman, 2007). This modality focuses on emotional expressiveness in a highly supportive climate. In terms of group counseling they may be characterized as "affective-support" groups (see Kivlighan & Holmes, 2004, for the categorization), which is similar to expressive supportive modality. The counseling groups were process-oriented, but semi-structured. All groups followed a structured manual, to permit universality among group therapists. In each session, a specific topic was introduced and participants shared their experiences. Topics included: The meaning of being a parent of a child with LD; the difficulties of the child with LD; the dialogue between parent and child; day-to-day dilemmas within the family; the parent's vision of the child's future; confrontation with the educational system; the parent as a case manager; and parents' advocacy. Individual coaching followed the same expressive therapy principles. A strong focus was placed on the exploration of parents' emotions regarding their child with LD. Similar topics came up, but the intervention was tailored to the specific difficulties of the parent or child, and more attention was given to analyzing behavior patterns and guiding parents toward change. No formal supervision of study therapists took place; however, we believe that therapists were adherent to the treatment manual because they were supervised in a group format in weekly sessions during the intervention.

Instruments

Parental stress in parent-child interactions was measured by the Parenting Stress Index (PSI)–short form (Abidin, 1995).The short form includes 36 items, such as "I find myself giving up more of my life to meet my children's needs than I ever expected." Responses are given on a 5-point scale (strongly agree, agree, not sure, disagree, strongly disagree), with a high score indicating higher levels of parental stress. Test-retest reliability over a 1-year interval ranged from .55 to .70, and reported internal consistency ranged from $\alpha = .80$ to $\alpha = .87$ (Abidin, 1995). Validity of the short form was based on a comparison with the full scale (r ranged from .73 to .92) (Moran, Pederson, Pettit, &Krupka, 1992).The scale has been used in Hebrew (e.g., Shechtman & Gilat, 2005) with reported good internal consistency ($\alpha = .78–.92$).

Parental coping was measured by the Coping with Children's Negative Emotions Scale (CCNES) (Fabes, Eisenberg, & Bernzweig, 1990), which measures parents' responses to 12 difficult situations that their child may face (such as being teased by peers or embarrassing oneself in public). The scale contains three negative responses (distress, punitive, minimization; for example: "I tell my child that if he/she starts crying, he/she will have to go to his/her room right away"), and three positive responses (encouraging, emotion-focused, and problem focused, for example: "I comfort my child and try to make him/her feel better"). For each situation, mothers were asked to rate on a 7-point scale how likely they would react with a negative or positive response.

Construct validity has been demonstrated in several studies: Eisenberg and Fabes (1994) found associations between parental reactions and children's social competence. Shechtman and Birani-Nasaraladin (2006) found correlations between children's reduced aggression and change in mothers' responses (e.g. $r = .60$ with encouragement). Test-retest reliability ranged from .56 to .83, and internal consistency ranged from $\alpha = .60$ to $\alpha = .90$ (Fabes et al., 1990).

Perceived social support was measured by the Social Provisions Scale (SPS; Cutrona & Russell, 1987), which examines six components of perceived support. It consists of 24 items, with four items per subscale: attachment (emotional support), reassurance of worth (esteem support), social integration (membership in a group of people with similar interests and concerns), guidance (information support), reliable alliance (tangible support), and the opportunity to provide nurturance (giving support to others). Examples of items include, "There are

people I can depend on to help me if I really need it." "There are people who depend on me for help."

Reliability for the total scale is .91 and subscale reliabilities range from .66 to .76 (Cutrona & Russell, 1987). The SPS correlates significantly with measures of social network size, satisfaction with social network, and attitudes toward support. It correlates negatively with loneliness and depression across a range of populations. A Hebrew version of this scale has been used (Harel, Shechtman, & Cutrona, 2011) with an internal consistency of $\alpha = .90$ for the total score, which was used in the current study.

Therapeutic bonding was measured by the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) which consists of 36 items in three categories: task, goal, and bonding, with 12 items per category. Internal consistency ranged from $\alpha = .87$ to $\alpha = .93$. In line with aims of the present study, we used only the bonding scale, with the therapist and group members. Sample items include: "I believe the therapist cares about my health" and "I don't feel comfortable with group members."The scale has been used in a Hebrew version (Toren & Shechtman, 2011) with an internal consistency of $\alpha = .89$ and $\alpha = .91$ for the therapist and group members, respectively. Responses were given on a 7-point scale, with higher scores representing higher bonding.

The Critical Incident Questionnaire (CIQ; Yalom & Leszcz, 2005) was used to identify the most important events and meaningful processes for participants in each type of treatment. The question is open-ended and reads as follows:

> Of the events which occurred in the sessions, which one do you feel was the most important for you personally? Describe the event, what actually took place, the group members involved, and your own reaction. Why was it important for you? How was it helpful?

The content has been analyzed with the Group Counseling Helping Impact Scale (GCHIS) (Kivlighan, Multon, & Brossart, 1996) in order to capture the therapeutic factors in the therapy process. The original scale is composed of 28 items in four components: emotional awareness-insight; relationships-climate; other- versus self-focus; and problem definition-change. A fifth component—self-disclosure—was added in the present study. Each critical incident was assigned by two independent raters, to one or more of the five categories. Full inter-rater agreement (for all five components) was achieved for 77% of the cases; in the other cases they agreed on four of these five.

Procedure

"Nizan" is a national institute for children with LD. In 2008 a decision was made by the staff to provide help to parents as well. Two groups of professional workers received a year of training to assist parents in small groups or in individual coaching. There was no cross-over of therapists and intervention conditions. In the second year parents were offered12 weekly sessions in one of the methods of assistance. Individual coaching was 1 hour long and group sessions were 2 hours long. All sessions were administered in the evenings. Parents were recruited through published flyers in the schools and in various agencies of "Nizan." Parents who felt a need for assistance were admitted with no special criteria. Parents were referred to group intervention when a group was available in their geographical area. All the others were referred to individual coaching. Only a few parents (three) preferred individual coaching over group; in such case they were referred to the coaching conditions. In both types of treatment parents were encouraged to attend as couples; however, in most cases, only one parent attended (70% of participants in both treatments; this includes 10% of single mothers). Attendance rates were very high, which we attribute to their high need for assistance and the cost of treatment.

The outcome questionnaires (parental stress and coping) were administered at three different points of time: before treatment (following the intake interview in Nizan), immediately after treatment (following termination) and 6 months later (when the participant met again with the group or individual coach). Parents on the waiting list completed the questionnaires at two times only—pre and post. The process questionnaires (perceived social support, and therapeutic bonding) were administered twice (at the third session and at termination) and the CIQ (therapeutic factors) was administered once, at termination. All questionnaires were completed anonymously, but with an identification symbol (identification number) to permit a comparison between time measurements. Table I presents the number of participants in the three research conditions, and return rates of questionnaires.

Table I. Participants in the research conditions and return rates of questionnaires

	Participants *n*	Full pre and post data *n* (%)	Follow-up data *n* (%)
Group counseling	125	93 (74%)	55 (44%)
Coaching	50	45 (90%)	32 (64%)
Waiting list	94	31 (33%)	–

Data Analysis

The first two hypotheses were examined with repeated measures MANCOVAs for parental stress and coping by treatment condition (group counseling, coaching, control) and time (pre-post) (3×2), controlling for parent's gender and child's age. Due to some pre-test group differences these hypotheses were re-examined with MANCOVAs for the adjusted gains scores (change score controlling for the pre test scores) using Scheffe post hoc tests. For the purpose of testing differences in the process variables, repeated measures MANCOVAs were used similarly (3×2). The third hypothesis was examined with multiple hierarchical regressions in which outcomes were the post scores of parental stress and coping. Predictors were entered in three steps: treatment condition, parent's gender and child's age at the first step, the pre-test score of each outcome at the second step (respectively), the process variables at the third step. Differences between post-test and follow-up scores were examined for the two treatment conditions with repeated measures MANCOVAs for parental stress and coping by treatment condition and time (2×2). Finally, the fifth hypothesis was examined by calculating the frequency of the therapeutic factors (derived from the Critical Incident Questionnaire), and examining condition differences with Mann-Whitney U tests (Z).

Results

Initial Tests of Data and Possible Confounding Effects

First, in order to establish the reliability of the instruments with the current population, Cronbach's alpha was measured for each scale: $\alpha = .93$ for parental stress, .88–.83 for parental coping positive and negative, .90 for perceived social support, and .84–.87 for bonding with the therapist and the group.

Second, in order to minimize the number of subscales used in the parental coping instrument the intercorrelations among them were measured. They ranged from $r = .58$ to $r = .75$ for positive responses and from $r = .39$ to $r = .62$ for negative ones. The intercorrelation between positive and negative scales ranged from $r = .34$ to $r = .01$. A factor analysis (rotated varimax) indicated two factors: positive (46% of explained variance, eigenvalue = 2.76) and negative (26% of explained variance, eigenvalue = 1.56). Therefore, these two factors were used for further analyses.

Third, to overcome multicollinearity the correlation between bonding with the therapist and the group was measured. The high correlations between the two measures (.93) justified the use of a single alliance variable.

Fourth, in order to capture the impact of background variables, the relationship between parent's gender and child's age and gender and between parental stress and coping were examined. Parental stress tended to be higher for mothers than for fathers ($t(176) = .70$ to $t(176) = 2.99$, $p < .01$). Other differences by parent and child's gender were non-significant. Several correlations of child's age with stress and coping were significant ($r = -.16$, $p < .05$ to $r = .31$, $p < .001$). Differences in stress and coping by parents' place of living, place of birth, and occupation were non-significant. Thus, the study hypotheses were examined while controlling for parent's gender and child's age.

Fifth, in order to test for differences between treatment conditions pre-test differences in parental stress and coping were examined. Significant differences were found for parental stress (up to $F(2,164) = 14.50$, $p < .001$, $\eta^2 = .15$), being lower in the group counseling condition. No differences were found for parental coping. Thus, study hypotheses 1 and 2 were examined with both repeated measures analyses of variance and analyses conducted on the adjusted gain scores.

Sixth, to be able to rely on the follow-up measurement, differences between participants with and without follow-up data (follow up data $\times$ treatment condition $\times$ time) were tested. No difference was found.

Finally, groups are often studied in a nested way due to the assumed dependency of scores within a group. Because this research included a comparison of data for participants in group and in individual treatment, such analyses were not possible. Therefore, differences between the nine small groups were measured. No differences were found between the nine small groups (small group $\times$ time).

Power analyses indicated that for the given sample size ($n = 169$), power was .96 to detect differences in change scores among the three conditions (expecting an effect size, partial η^2, of .16). For the given sample size ($n = 87$), the post-follow-up comparison of the two conditions had a power of .84 (expecting an effect size of .16). (The analysis of the pre-post data between the group and coaching conditions, under the hypothesis of no differences, was conducted exploratorily, as there was not sufficient power to test for no differences.)

Outcome variables (parental stress and coping) were rather normally distributed: skewness ranging from -1.10 ($SE = .26$) to 1.25 ($SE = .19$), and kurtosis ranging from $-.95$ ($SE = .51$) to 4.05 ($SE = .37$). No outliers were found. Intercorrelations among

them at the three times ranged between $r = -.32$ ($p < .001$) and $r = .15$ (ns.), and thus do not point at multicollinearity.

Outcomes: Parental Stress and Coping

The first hypothesis suggested that outcomes (stress and coping) would be more favorable for parents in both types of treatment than for those in the control group. The second hypothesis suggested that no difference in outcomes would be found for parents in the two experimental/treatment conditions.

Table II presents means and SD for parental stress and coping in the three conditions. For purposes of clarity, outcomes for parental stress are described first, and outcomes for parental coping follow. Parental stress decreased only for parents in group counseling and actually increased for those in the control condition. Statistical analysis (Repeated ANCOVA 3×2 for condition and time, respectively, with control over parental gender and child's age), focusing on the time by condition interaction, confirmed more favorable outcomes for parents treated in groups. Analysis of change within each group revealed a pre-post significant decrease of parental stress in group counseling and an increase in the control group (see Table II). (Observed power for group counseling is .63, control group 1.00).

Due to initial differences on scores for parental stress, adjusted gains were computed for the three conditions. Results indicated that parental stress in group counseling decreased more than in coaching, and that it decreased more in both treatment conditions than in the control condition ($F(2,164) = 33.89$, $p < .001$, $\eta^2 = .29$).

Finally, a comparison of post-scores and follow-up on stress (see Table III) in group counseling and coaching indicated a significant condition difference, $F(3,79) = 9.06$, $p < .001$, showing a significant difference between group counseling and coaching: $F(1,81) = 18.53$, $p < .001$, $\eta^2 = .18$ (observed power = .99). No time $F(3,79) = 2.45$, $p =$ ns, and no condition-by-time change, $F(3,79) = .73$, $p =$ ns, were found. These results clarify that outcomes were stable 6 months later, and remained more favorable for parents in the group counseling condition than for parents in the coaching condition.

With respect to parental coping, gains are discernible in both treatment conditions compared to control (Table II). A MANCOVA with Repeated measures (3×2), with control over parental gender and child's age, indicated a condition-by-time interaction on both positive and negative responses. Post hoc analyses within conditions indicated progress in both treatment conditions, but no change in control (see Table II) (for positive responses: observed power in group counseling is .97, in coaching .66; for negative responses: observed power in group counseling is .99, in coaching .86). A test of adjusted gains confirmed that both treatments were more effective than no treatment, with no difference between treatments (for positive responses: $F(2,164) = 3.07$, $p < .05$, $\eta^2 = .04$, for negative responses: $F(2,164) = 3.38$, $p < .05$, $\eta^2 = .04$).

Finally, results on the post-followup measurement (see Table III) indicated no difference for condition, $F(6,77) = .68$, time, $F(6,77) = .57$, or condition-by-time interaction, $F(6,77) = .92$, $p =$ ns for all. These results suggest that gains remained stable for both treatment conditions after 6 months.

Table II. Means, standard deviations and *F* values of outcome variables by condition and time ($n = 169$)

	Group counseling ($n = 93$)		Individual coaching ($n = 45$)		Control ($n = 31$)		Time × condition	Interaction:		
	Pre *M* (*SD*)	Post *M* (*SD*)	Pre *M* (*SD*)	Post *M* (*SD*)	Pre *M* (*SD*)	Post *M* (*SD*)	$F(1,164)$ (η^2)	Control $F(1,164)$ (η^2)	Individual coaching $F(1,164)$ (η^2)	Group counseling $F(2,164)$ (η^2)
Parenting Stress Index										
Total score	2.60 (.51)	2.45 (.55)	2.98 (.56)	3.06 (.55)	2.98 (.77)	3.54 (.47)	16.04*** (.16)	5.36* (.03)	.37 (.002)	27.82*** (.15)
Parental Coping with Child's Negative Emotions										
Positive responses	5.22 (.85)	5.47 (.81)	5.42 (.90)	5.63 (.77)	5.44 (.84)	5.43 (.82)	3.12* (.04)	15.43*** (.09)	5.70* (.04)	.14 (.001)
Negative responses	2.97 (.90)	2.65 (.71)	3.08 (.95)	2.65 (.87)	2.89 (.67)	2.92 (.98)	3.11* (.04)	14.76*** (.09)	9.32** (.06)	.27 (.002)

*$p < .05$, *$p < .01$, ***$p < .001$.

Note. MANOVA for parental coping:
time: $F(2,161) = 1.26$, ns, $\eta^2 = .02$; condition: $F(4,320) = 1.50$, ns, $\eta^2 = .02$; time by condition: $F(4,320) = 3.31$, $p < .05$, $\eta^2 = .04$.

Table III. Means and standard deviations of outcome variables by time (post-test and follow up) by condition ($n = 87$)

	Group counseling ($n = 55$)		Individual coaching ($n = 32$)	
	Post *M* (*SD*)	Follow up *M* (*SD*)	Post *M* (*SD*)	Follow up *M* (*SD*)
Parenting Stress Index				
Total score	2.50 (.55)	2.82 (.80)	3.07 (.54)	3.24 (.65)
Parental Coping with Child's Negative Emotions				
Positive responses	5.54 (.80)	5.29 (1.08)	5.71 (.73)	5.68 (.91)
Negative responses	2.66 (.75)	2.77 (.93)	2.65 (.94)	2.76 (.89)

Table IV. Means and standard deviations of the process variables by condition and time ($n = 169$)

	Group counseling ($n = 93$)		Individual coaching ($n = 45$)		Control ($n = 31$)	
	Pre *M* (*SD*)	Post *M* (*SD*)	Pre *M* (*SD*)	Post *M* (*SD*)	Pre *M* (*SD*)	Post *M* (*SD*)
Perceived social support	3.39 (.41)	3.49 (.42)	3.44 (.38)	3.56 (.35)	3.45 (.36)	3.47 (.33)
Therapeutic bonding	5.83 (.81)	5.95 (.71)	6.43 (.52)	6.53 (.45)	–	–

Note. ANOVA for perceived social support:
time: $F(1,164) = 8.15, p < .01, \eta^2 = .05$; condition: $F(2,164) = .47$, ns, $\eta^2 = .01$, time by condition: $F(2,164) = .42$, ns, $\eta^2 = .01$.
ANOVA for therapeutic bonding:
time: $F(1,197) = 1.40$, ns, $\eta^2 = .01$, condition: $F(1,197) = 16.18$, $p < .001$, $\eta^2 = .16$, time by condition: $F(1,197) = .02$, ns, $\eta^2 = .001$.

In sum, the first hypothesis was fully supported—outcomes were more favorable for the two types of treatments compared to no treatment. The second hypothesis was partly rejected, as differences in outcomes were observed between the two types of treatment on the Parental Stress Index, with more positive outcomes for parents in group counseling. These gains were stable at 6 months follow-up. Some values of the observed power are moderate and thus interpretation of the results should be cautious.

Prediction of Outcomes

The third hypothesis suggested that process and individual variables would be associated with outcomes and would affect outcomes differentially by type of treatment. To test this hypothesis, first, pre-post differences were measured. A significant condition difference was found on therapeutic bonding in favor of parents attending group counseling ($F(1,197) = 16.18$, $p < .001$, $\eta^2 = .16$, observed power = 1.00). For perceived social support, there was only a time difference, suggesting that all participants gained on this scale ($F(1,164) = 8.15$, $p < .01$, $\eta^2 = .05$, observed power = .81); however, a look at the mean scores obtained suggests no difference for parents in the control group (Table IV).

This was followed by regression analyses in which the outcomes were the post score of the measure of parental stress and the two measures of parental coping (positive and negative responses) (see Table V). Predictors were treatment condition, parent's gender, child's age (step 1), pre-test score (step 2); pre-post means of the process variables: perceived social support and therapeutic bonding (step 3). Results suggest that condition was a significant predictor of reduced parental stress. Child's age was predictive of parental stress, so that the higher the age, the greater the stress. The pre-score was the best predictor of parental stress and coping: the higher it was, the higher the scores following treatment. Beyond treatment condition, parent's gender, child's age and pre-test score,

Table V. Multiple regressions predicting outcomes (parental stress and coping) by individual and process variables ($n = 128$)

	Parenting Stress Index			Parental Coping with Child's Negative Emotions					
	Total score			Positive responses			Negative responses		
	B	*SE*	*β*	*B*	*SE*	*β*	*B*	*SE*	*β*
Treatment condition	−.23	.05	−.37***	.05	.07	.06	−.05	.06	−.06
Parent's gender	−.03	.08	−.02	−.01	.12	−.01	.01	.12	.01
Child's age	.04	.01	.21**.	.01	.02	.02	−.01	.02	−.06
Pre-test score	.51	.07	.46***	.43	.07	.48***	.45	.06	.52***
Social support	−.07	.11	−.04	.11	.17	.05	−.49	.16	**−.23****
Therapeutic bonding	−.19	.06	**−.21****	.28	.10	**.24****	.21	.09	**−.18***
	$R^2 = .60$, $F(6,121) = 29.19$***			$R^2 = .36$, $F(6,121) = 11.44$***			$R^2 = .40$, $F(6,121) = 13.27$***		

*$p < .05$, **$p < .01$, ***$p < .001$.

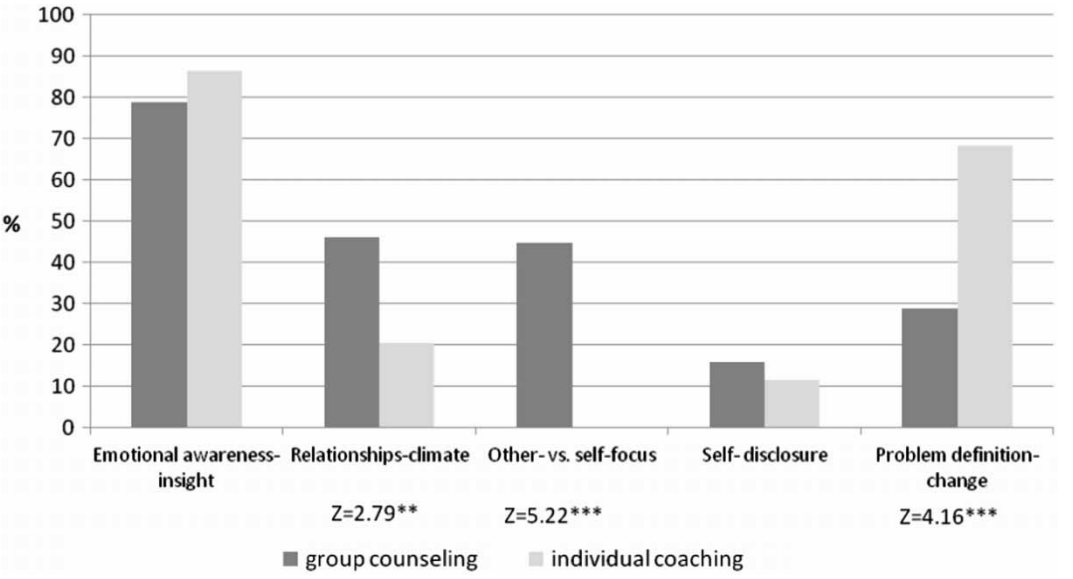

Figure 1. Distribution of the therapeutic factors by treatment condition ($n = 120$). $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

therapeutic bonding was a consistent predictor of lower parental stress at post-test, as well as of higher positive and lower negative parental coping. Higher perceived social support was associated with lower negative parental coping. Interestingly, the addition of the interaction between treatment condition and the process variables was not significant for any outcome measure.

In sum, the third hypothesis was partly supported. The regressions indicate that the individual variable of perceived social support and the process variable of therapeutic bonding predict some of the dependent variables beyond initial and background variables. Bonding was the most consistent predictor: the higher the scores of participants on bonding with the therapist (coaching) or with the therapist and group members (group counseling), the more favorable the outcomes on parental stress and coping. The third hypothesis was not supported as differential predictions by treatment condition were not found.

Critical Incidents

To understand the meaningful processes for participants in each type of treatment, their verbal response to the question "What was meaningful to you in treatment?" was assigned to one or more of the four categories suggested by Holmes and Kivlighan (2000) and/or to a fifth category of self-disclosure. It was hypothesized that emotional awareness-insight, self-disclosure, and problem definition-change would be more frequent in individual coaching, while relationships-climate and other- versus self-focus would present more in group counseling. Results indicated similar frequencies of emotional awareness-insight and self-disclosure in both types of treatment, higher scores in relationships-climate and other- versus self-focus in group counseling, and more frequent problem definition-change in individual coaching (Figure 1). Thus, the hypothesis was supported to a considerable extent.

Discussion

The study compared outcome and process variables in the treatment of parents of children with LD, in three experimental conditions: group counseling, individual coaching, and non-treatment (waiting list). Results indicated more favorable outcomes in terms of reduced parental stress for participants in group counseling. In contrast, no change in stress was apparent for parents receiving individual coaching, while scores for the control parents actually increased with time. With regard to parental coping, there were positive outcomes in both treatments, and no change in the control group.

Of the individual and process variables, therapeutic bonding increased with time only for parents who attended group counseling, whereas perceived social support increased in both treatment conditions. Bonding appears to be the most frequent predictor of outcomes, associated with reduced scores on stress, as well as gains on positive and negative parental coping. Social support predicted a reduction in parental stress and in negative responses (coping). Finally, differences between the two treatments were found in the therapeutic factors gleaned from parents' descriptions of critical incidents.

Outcomes

We expected positive outcomes following both group counseling and individual coaching, based on literature which suggests that any treatment is better than no treatment at all (Flannery-Schroeder & Kendall, 2000; Shechtman, 2004), as well as research that has supported both types of treatment (Boutin, 2007; Elksnin & Elksnin, 2000; Flaherty, 1999; Greenberg, Korman, & Paivio, 2001; Johnson et al., 2005; Shechtman & Gilat, 2005). Differences between treatments were not expected, based on studies that compared individual and group interventions and found, overall, no difference between them (Fuhriman & Burlingame, 1994; Hoag & Burlingame, 1997; McRoberts et al., 1998; Shechtman, 2004).

However, the results clearly indicate better outcomes on parental stress reduction in group counseling. This is surprising, since each parent/couple in individual coaching had a full hour for themselves with experienced therapists, whereas in groups they shared their therapy time with several other participants.

We tend to attribute these results to the unique population investigated in the current study and to the group processes in the counseling sessions. All participants were under high stress, dissatisfied with their own functioning, and reacting impulsively to their children's difficulties. In individual coaching, they took the role of the client who has problems and needs guidance. In contrast, in group counseling, they met people with similar difficulties. This sense of universality in itself helps to reduce frustration and sense of failure (Yalom & Leszcz, 2005). In the group, they could identify with others, imitate others' behavior, and learn from the interpersonal interaction (Burlingame, Fuhriman, & Johnson, 2004; Solomon, Pistrang, & Barker, 2001; Spiegel & Classen, 2000). They could also compare their difficulties with others, sometimes discovering their own situation to be less extreme. But most important might have been the interpersonal interaction in the group, which naturally leads to altruistic behavior and a sense that they could be helpful to others. Indeed, the analysis of critical incidents indicates that the therapeutic factors of relationships and other- versus self-focus were more frequent in group counseling than in individual therapy, supporting our attribution of outcomes to the group processes.

Interestingly, although parents who received individual coaching had more time to self-disclose and develop insight, the amount of self-disclosure and of emotional awareness-insight was similar in the two treatments. Thus, even though therapist time was shared with others in group counseling, there were nonetheless opportunities for self-exploration, and the group processes may have encouraged the development of insight. In short, it seems that in group therapy there are processes that compensate for the time factor. Based on these results, and considering cost effectiveness, groups are highly recommended to help parents of children with LD.

Process Variables and the Association with Outcomes

Bonding appears the most frequent predictor in both individual and group therapy. This is not surprising considering the wealth of literature on its importance (Bordin, 1980; Burlingame et al., 2004; Greenberg & Paivio, 1997; Orth-Gomèr, 2009; Sherman et al., 2004; Yalom & Leszcz, 2005), considering it "the common factor" in therapy (Greenberg & Pinsof, 1987; Horvath, 2005). Interestingly, in group counseling, the correlation between bonding with the therapist and with group members is very high (over .70), making it one factor. This raises the question as to why participants do not differentiate between the two. Do they consider the group as a whole? Does their attitude to the therapist affect their feelings for others in the group? These questions remain open, but the importance of relationships stands out and should be considered in training and supervising therapists, as well as in their work.

Perceived social support increased with time and was associated with reduced stress and reduced negative coping responses. The increase of social support may be a result of support provided by the therapist in individual therapy and the therapist and group members in group therapy. This in itself is an important outcome, considering that social support is a pretty stable construct, difficult to change. A sense of social support is crucial to human beings in many areas (Antonucci, Lansford, & Ajrouch, 2007; Heiman, 2002; Hogan, Linden, & Najarian, 2002), and knowing that it can be enhanced in therapy is important. It is not surprising, then, that it reduced stress. Being less stressed helps parents to respond more positively to their children (Hanks et al., 2007; Valentine, 1993).

Limitations and Contributions

The research has a number of limitations. First, generalization of the results to other populations, problems, or places is limited. Second, completely random assignment of the population to the two treatment conditions was impossible. It would be clinically wrong to force clients to treatment conditions that they resist, yet, we are aware that it is possible that non-random assignment to conditions

may have contributed to observed differences in conditions. Third, the control group was relatively small; while we could have waited longer and had more parents on the waiting list, ethically we felt it would be wrong not to address their needs as soon as possible. Additionally, there was a low response of parents in this group, because they don't see any benefits in completing the questionnaires; however, this could potentially affect the results. Fourth, parents in the control condition could not provide feedback at follow-up because they were eager to receive treatment, preventing them from receiving treatment for another 6 more months was unethical. Fifth, we did not study the impact of the intervention on the children; such a line of investigation would add validity to the results. Finally, research on groups is usually performed in a nested analysis due to the dependency of measures on the group. However, because we compared treatment in groups with individual treatment, such dependency could not have been studied. Nevertheless, we did investigate only the group population in a nested way which showed similar results.

Notwithstanding these limitations, the study is important in several ways. First, it deals with a population in need (parents of children with LD) whose problems are rarely addressed. Second, the treatment offered deviates from the common educational guidance or training programs. It focuses on the parent's emotions, encourages the release of stress, and takes the focus away from the child as the "identified patient," directing it at the parent. Instead of teaching skills, we help parents to develop insight into their own behavior and as a result change their interaction with their child. Third, the study compared two types of treatment. Our finding that group counseling is more effective than individual coaching on reducing parental stress has a practical consideration of considering the more effective treatment. In addition, group counseling appears more effective in terms of cost effectiveness. More studies are needed to explore the full spectrum of assistance available to parents who are in great need for help.

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