

Group Dynamics: Theory, Research, and Practice

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Youth and Clinician Evaluation of Emotional Communication in Short-Term Counseling Groups

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Objectives: Group interventions are recommended to prevent psychological difficulties in siblings of children with a disability. However, emotional communication and support in such groups have not previously been described or evaluated. This article describes two studies to provide such knowledge. **Methods:** Study 1 examined communication patterns following expressions of negative emotions in counseling groups for siblings of children with a disability. We videotaped and transcribed communication patterns in 17 counseling group sessions for siblings of children with a disability aged 11–16 years. We applied content analysis to identify communication patterns following expressions of negative emotion(s). Study 2 examined youth- and clinician-evaluated supportiveness of the four most frequent patterns from Study 1. Reenacted video examples of the patterns were shown to 136 school pupils aged 11–16 years and 68 clinicians, who rated each pattern for supportiveness using visual analog scales. **Results:** In Study 1, the communication was found to be either *child-centered* or *adult-centered*. Frequent adult-centered communication patterns were *interviewing*, *informing*, or *avoiding*. Child-centered communication often followed a *consenting* pattern, in which other children expressed having similar experiences. The four patterns were all rated low to medium on support by youths and clinicians in Study 2. Youths found the avoiding pattern to be more supportive than clinicians, and girls and older youths differed from boys and younger youths in their evaluation of the consenting pattern. **Conclusions:** The results of the two studies highlight the importance of training group leaders in child-centered communication and the ability to facilitate communication patterns experienced as supportive by youths.

Highlights and Implications

- Group communication following emotional expressions was often adult-centered. Most frequent were communication sequences with an interviewing, informing, avoiding, or consenting pattern.
- Youths rated the most common communication patterns medium to low on support, but some group differences were observed: Girls and older youths found consenting patterns more supportive than boys and younger youths. Youths rated avoidant patterns as more supportive than clinicians.
- Formal training of counseling group leaders is needed, with special focus on techniques to increase child participation and child-centered communication.
- Future research should further explore prosocial behavior and support in counseling groups.

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Child group interventions may improve psychological health in vulnerable children (e.g., Hartling et al., 2014; Niemelä et al., 2010). Therefore, group interventions are often offered to children in settings such as at school or in the hospital, and by various providers such as nurses, social workers, psychologists, and school counselors (e.g., Nolbris et al., 2010; Lochman & Wells, 2002).

Siblings of children with a disability represent a potential target group for such group interventions as they have an increased risk of developing psychosocial problems compared to peers (Vermaes et al., 2012). Factors associated with this elevated risk include experiencing distressing events related to the disorder, such as life-threatening events (Vermaes et al., 2012) or behavior disruptions and violence (Benderix & Sivberg, 2007), poor family functioning, lack of emotional support (Inclendon et al., 2015), lack of knowledge about the disease (Lobato & Kao, 2002), and lack of support from peers (Carpenter & LeVant, 1994).

Group interventions for siblings of children with a disability have shown promising effects on the psychological wellbeing of siblings of children with a disability (Hartling et al., 2014; Smith et al., 2018). Based on a review by Hartling et al. (2014), it is evident that interventions provided to siblings of children with a disability often fall within the definition of counseling groups. Counseling groups are short-term interventions, for small groups of children (5–8 participants), who are experiencing continuing or temporary problems that cannot be solved by merely providing information (Gazda, 1969). The aim of counseling groups is to provide social support in response to individual challenges and thereby stimulate growth and prevention of future problems (Shechtman et al., 1997).

The effect of counseling groups is related to communication in the group. One of the factors found to be beneficial for the wellbeing of the children attending counseling groups is the extent to which children share information about themselves, that is, how much they self-disclose, in group sessions (Shechtman et al., 1997). Psychotherapy groups are different from counseling groups in terms of the target group (clinical vs.

nonclinical), aim (remediation vs. prevention), and length (long-lasting vs. short term; Gazda, 1969). Nevertheless, there are more studies of communication in psychotherapy groups, which may inform studies of counseling groups. In psychotherapy groups, children are typically less verbally active than group leaders, and their utterances are mainly self-disclosures (Leichtentritt & Shechtman, 1998). Communication in psychotherapy groups has also been found to be highly dependent upon group leader behavior. For example, asking questions, modeling self-disclosure, and providing structured activities have been found positively related to the amount of self-disclosure in children (Leichtentritt & Shechtman, 1998). Group communication is also related to the stage of group development. For example, with time children participate more verbally and in a more developed and productive way (Leichtentritt & Shechtman, 1998; Shechtman & Yanov, 2001).

One of the aims of counseling groups is to provide social support (Shechtman et al., 1997). Therefore, it is relevant to focus on how counseling groups respond to disclosures of personal experiences during group sessions. Studying the use of helping skills in counseling groups, Shechtman & Yanov (2001) found that confronting a child's thoughts was the most frequently used skill group leaders used, followed by providing interpretations of the child's experience. Providing feedback about how the child is seen was a skill that group leaders rarely used. Among children, confrontations were most frequent, followed by feedback. However, interpretations were rare. Feedback was the skill most likely to be followed by a productive response, such as cognitive or emotional exploration or insight in the group. However, confrontation, feedback, and interpretation combined make up only a small proportion of the verbal behaviors that may follow a child's self-disclosure in groups (Leichtentritt & Shechtman, 1998).

It is reasonable to expect that self-disclosures in counseling groups may involve expressions of negative emotion. In a previous study of counseling groups for siblings of children with a disability, we found that children expressed a range of negative emotions, both explicitly and implicitly, when talking about their experiences (Vatne & Zahl, 2017). In

their review of the literature on how and when expressing emotions help, Kennedy-Moore and Watson (2001) provided insight into research showing how responses from others containing empathy, acceptance, containment, validation, reassurance, but also other perspectives on the topic of distress may reduce distress. On this basis, we argue that group interactions in relation to emotional self-disclosure in counseling groups should be given more attention in research.

Conceptual frameworks provide specific advice on how psychotherapists should continue the conversation when a child becomes upset during sessions. Examples include to follow the child's focus, to validate the child's experience, and to be cautious with the use questioning (Friedberg & McClure, 2002; Øvreeide, 2009). The extent to which such advice is followed in real life counseling group sessions is not known. Research on children's prosocial behaviors in everyday life group settings have described how the presence of adults may reduce children's prosocial behaviors (Bergin et al., 2003; Caplan & Hay, 1989). In our previous study of counseling groups, the group leader, and not the other participants, provided the immediate response when a child expressed a negative emotion, and the response was often of a nature that encouraged the child to tell more about the experience (Vatne & Zahl, 2017).

So far, research on communication in counseling groups has looked at small segments from the communication in a session, typically involving only a couple of turns (Vatne & Zahl, 2017; Shechtman & Yanov, 2001). However, in group counseling sessions, an emotional topic brought up by one of the participants may potentially be discussed in longer communication sequences, by several participants, and in various ways. In the current study, we will examine communication sequences that follow the expression of negative emotion in counseling groups and look for patterns. That is, prominent ways in which children and group leaders respond to and continue to discuss the emotional topic.

Describing common communication patterns does not, however, provide an answer to whether counseling groups, through the way participants interact, fulfill the aim of providing support. Adults and children may have different perceptions of what constitutes supportive behavior, and when it comes to what children consider to be desirable group behaviors, we need to turn to the

children themselves for answers. Among several prosocial behaviors mentioned by adolescents in a focus group study, facilitating emotional regulation in others was the most salient behavior (Bergin et al., 2003). However, the study also found that behaviors were considered prosocial or not based on the context and interpretation of the agent's intentions. For example, to ignore someone's crying was considered prosocial if it was done "to help someone keep up appearances." Furthermore, to give a compliment was considered negative if it was perceived as done out of self-interest (Bergin et al., 2003). The above-mentioned findings were from an everyday life context, and do not necessarily apply to a counseling group context. However, such findings indicate that what children consider supportive in counseling groups may be complex. More knowledge about such patterns may benefit counseling group providers and participants.

Further complicating issues in determining the supportiveness of counseling groups include that there may be age and gender differences in children's evaluation of supportive behavior. Whereas boys mention self-disclosure as an important therapeutic factor in counseling groups (Shechtman et al., 1997), boys have also been found to have difficulties with self-disclosure and expression of feelings and to be less comfortable and less active in groups that emphasize relationship compared to girls (LeCroy, 1986; Shechtman & Vurembrand, 1996). Age differences in perception of support are also to be expected due to the changes in socio-emotional cognition such as increased sensitivity to changes in emotional expressions of others and increased prosocial behavior (Rosen et al., 2018; Van der Graaff et al., 2018).

To sum up, counseling groups are interventions for small groups of vulnerable children that experience similar challenges in life, such as siblings of children with a disability. When siblings of children with a disability come together in counseling groups, we know that they express negative emotions when disclosing personal challenges and that the group leader tends to be the one to respond. However, we know little about how the group continues to discuss the topic. Counseling groups aim to provide social support, but against their knowledge, group leaders may stimulate group interactions that are not as supportive as intended, or indeed are contra-supportive. New knowledge about what constitutes supportive group communication may inform the development of

guidelines and training programs for counseling group leaders, as a step on the way to optimize the delivery of counseling groups.

The current study aims to provide such new knowledge by addressing the following questions: (a) What are prominent communication patterns in counseling groups following a child's expression of negative emotion? (b) To what extent do youths and clinicians perceive the communication patterns as supportive? (c) Do youths and clinicians differ in their evaluation of support? (d) Are there gender or age-related differences in the youths' perception of support? To answer these research questions, two separate, but related, studies will be presented. The methods and results of the two studies will be presented separately before a joint discussion.

Methods Study 1

Study 1 aimed to answer research question one: What are prominent communication patterns in counseling groups following a child's expression of negative emotions?

Participants and Recruitment

Participants were 7–18 year old siblings of children with a disability. They were recruited when they attended to 5 days residential courses at Frambu resource center for rare disorders in Norway together with their families. The families self-refer to these courses. The courses aim to support families of children with a disability. Parents attend lectures and group discussions about the disability and related challenges, and children with disorders and their healthy siblings attend to kindergarten/school at the center, with school activities, leisure activities, and counseling group sessions.

Children and parents were mailed information about the study before the residential course. Verbal information was provided in a joint meeting for all course participants on the first day of the course. Consent forms and a questionnaire covering demographics were completed by participants after the meeting. The study was approved by the local Institutional Review Board for Research Ethics.

As the courses are disorder specific, the participants of the counseling group in this study all had siblings with a similar disability. The groups met for three thematic sessions, one daily, from the second day of the residential course. The main topics of the three sessions were: (a) An open

discussion about the disorder of their brothers and sisters, (b) an open discussion about the family initiated with presentations of paintings made by the children, and (c) an open discussion about emotional challenges initiated with pen-and-paper tasks. The aims of the counseling groups included to help the participants express their experiences related to being a sibling of a child with a disability. Further aims include to increase the participants' knowledge about the disability of their sibling through group discussions and to highlight possible solutions and coping strategies to challenges expressed in the group. All sessions were videotaped.

The group leaders of the groups in this study were two clinical psychologists, three education specialists, and one master's-level psychology student. Four were female and two were male. With the exception of the student, all group leaders were regular employees at Frambu resource center for rare disorders with a mean age of 44.6 years ($SD = 8.9$) and a mean of 18.8 years of clinical experience ($SD = 9.4$).

The group leaders were to explore experiences and stimulate spontaneous conversation between group members. Each group was led by two professionals. One acted as a group leader and was mainly responsible for directing the conversation. The other acted as a facilitator and was responsible for facilitating communication through attention to child cues, commenting, and asking questions.

Of the 104 families approached, 80 (77%) consented and joined sibling-age matched counseling groups (for youths aged <13 and >13 years, respectively). For this study, video data from groups with participants aged 11 years or older were selected to reduce the variation in developmental status among participants. The description of the groups is found in Table 1.

Analysis of Group Communication

Group sessions were transcribed, and expressions of negative emotions identified using the Verona Coding Definitions of Emotional Sequences (VR-CoDES; Del Piccolo et al., 2011; Zimmermann et al., 2011). VR-CoDES is a communication analysis system that allows for the quantification of communicative behavior. Using VR-Codes, expressions of negative emotion are coded as either explicit expressions of concerns (e.g., stating "I am sad") or implicit expressions of emotion as verbal cues (e.g., stating "I get a headache from all the fuss he makes"; Zimmermann

Table 1
Overview of Groups in the Study

Group	N children	Mean age (range)	Gender % (n) boys	N adults present	Sessions
1	6	11.8 (11–13)	16.6 (1)	2	3
2	6	14.3 (13–16)	16.6 (1)	1*	3
3	6	13.3 (12–14)	0.0 (0)	2	3
4	5	12.2 (12–13)	40.0 (2)	1*	2 (3)**
5	3	12.6 (12–13)	33.3 (1)	2	3
6	4	13.0 (11–15)	25.0 (1)	1*	3

Note. * No facilitator present. ** One session not videotaped due to technical error.

et al., 2011). Through the use of VR-Codes, responses to the emotional expressions can be coded as to whether they are providing or reducing space for further disclosure of the emotional experience (Del Piccolo et al., 2011). See Vatne and Zahl (2017) for further description of the coding.

Identification and transcription of emotional sequences was conducted by a project assistant and subsequently reviewed by the authors. An emotional sequence was defined as the sequence of communication lasting from an expression of a negative emotion (a cue or concern as defined by VR-CoDES) until the group discussion of the specific emotion, or the situation eliciting the emotion, ends.

A conventional content analysis (CCA; Hsieh & Shannon, 2005) of the transcribed sequences was conducted by two of the authors together using the N-VIVO software (Fraser, 1999) to identify prominent patterns of communication in the emotional sequences. Each emotional sequence was first read in entirety. Then, the text was read word-by-word to derive codes by highlighting the exact turns that appeared to capture key behaviors of the participants. In this part of the coding process, specific child and adult behaviors and the nature of the communication (i.e., monologue, dialogue, and group talk) were derived as codes in an initial coding scheme. The next step of the process entailed cross searches in N-Vivo looking for prevalent combinations of child and adult behavior and nature of communication. Sequences identified as similar were carefully read, and prominent patterns of communication with related subcategories were identified through this process. N-Vivo automatically reports the number of sequences coded within each category.

Results Study 1

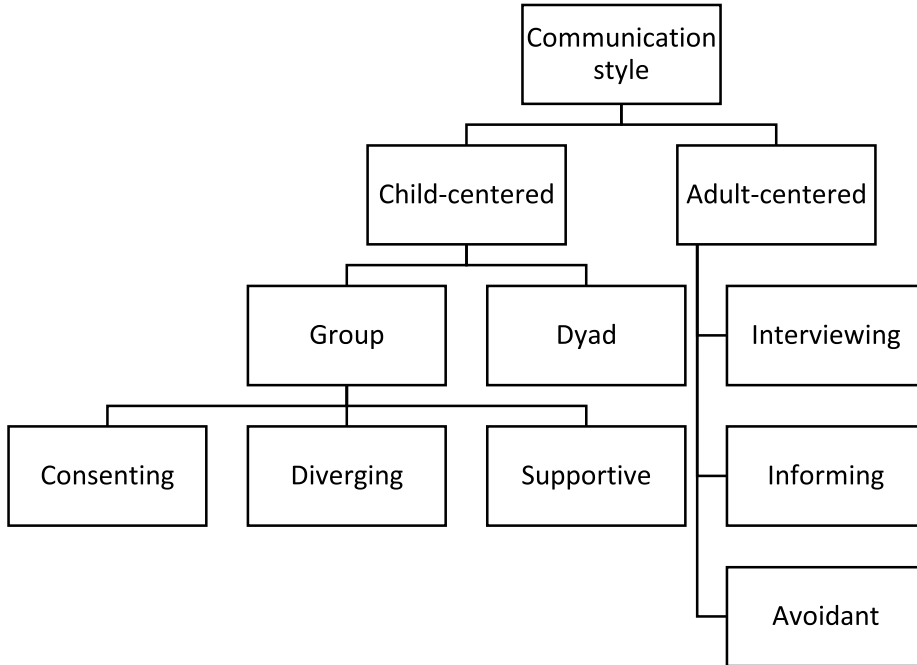
Ninety-nine emotional sequences were identified and transcribed. We identified two main patterns regarding communication style across the sequences. These were labeled *adult-centered*, identified in 39.4% of the sequences, or *child-centered*, identified in 47.1% of the sequences. These two categories were mutually exclusive. Some sequences (13.5%) could not be categorized into these two main categories and were coded as *unsure of centration* (for description, see Figure 1).

Adult-centered sequences were characterized by the topics discussed or questions asked being initiated by the group leader and not derived from previous child statements. These sequences were characterized by little child participation. Adult-centered sequences could be further categorized into the subcategories *interviewing*, *avoiding*, and *informing*.

In *adult-centered interviewing* (11.5% of total sequences) the group leader chose to pursue topics that are related but not to the core of the mentioned emotional experience, posed many questions, often close-ended, and quickly shifted from child to child without in-depth exploration and without triangulating questions between children. The following example shows a communication sequence with an interviewing pattern. The cue registered as the expression of negative emotion as defined by VR-Codes (Zimmermann et al., 2011) is underlined.

Child 1: I try to avoid bringing my friends home after school because it just gets so weird ...

Figure 1
Categories of Prominent Communication Styles



Group leader: So, what are the name of your friends?

Child: Anne, Sara, and Peter.

Group leader: What about you (child 2) who do you play with after school?

Child 2: My friend Thomas.

Group leader: And what do you do together?

Child 2: We play football.

Group leader: And you X (child 3)? Who do you play with?

Child 3: Eeeeh, sometimes a friend, sometimes my sister.

Group leader: What kind of activities is it possible for your sister to take part in?

The coding of this sequence was ended here as the topic “to avoid bringing friends home” is no longer in focus. The sequence was coded adult-centered interviewing as the group leader first fails to explore the emotional experience mentioned by the child (“gets weird”), then chooses to pursue a more general topic (name of- and activities with friends), which is not directly derived from previous child turns, by posing brief questions to several children.

In *adult-centered avoiding* sequences (13.5% of total sequences) the group leader continued without commenting or exploring the emotional experience or any closely related topic. Sequences where group leaders explicitly stated that the emotional experience would not be explored any further, and sequences where group leaders first initiated the conversation about an emotional experience but then changed the topic when a child confirmed having the experience were also included in this category. The following example is of a sequence with an avoiding pattern. The expression of negative emotion as defined by VR-Codes (Zimmermann et al., 2011) is underlined.

Group leader: Do you (directed toward the entire group) feel sad because your parents give you too little attention?

Child: Yes ... (tearful)

Group leader: Yes ... let us not talk more about that ... What do you like to do in your leisure time?

The coding of this sequence was ended here as the topic “given little attention,” and the emotion “sad” was left. What can be seen from the example is that the group leader explicitly shows avoidance by explicitly stating that the emotion (or context) will not be talked about more. In this sequence, this avoidant pattern immediately follows an initial invitation to talk about a negative emotion (i.e., sadness).

Adult-centered informing sequences (14.4% of total sequences) were characterized by the group leader responding to emotional expressions by minimal exploration and then turning to provide information about the content/context of the experience. Consider the following example:

Child: My brother hits me all the time.

Group leader: He does?

Child: Yes, really hard!

Group leader: You know (addressing the entire group), your siblings have a disorder that implies that they have difficulties expressing themselves. When they want to say something, and no one understands them, they may get really frustrated and sometimes they act out. Has anyone ever given you an explanation about the disorder?

The coding of this sequence was ended as the topic “being hit by a sibling” was left. Again, the group leader is adult-centered by following his/her agenda and not exploring the emotional cue presented by the child (i.e., “my brother hits

me”), and the sequence is further labeled informing because the group leader moves on to provide information about why the brother may act out.

Child-centered sequences were characterized by topics being initiated by children or derived from the previous child turns to which group leaders listened, facilitated (e.g., “m-m”), and explored the child experience. Thus, children were more actively involved in these communication sequences compared to the adult-centered ones. Child-centered sequences could be further categorized into the sub-categories *dyadic* and *group* depending on whether or not multiple children were involved in the sequence either verbally or indirectly as indicated through the way the group leader directed the communication (e.g., “have any of you” (directed to the entire group) versus “have you” (directed to one child)). *Child-centered dyadic* sequences (32.0% of total sequences) were in-depth explorations of an emotional experience of one child without any involvement of other children, whereas in *child-centered group* sequences (16.3% of total sequences), several children talked.

Group sequences were further categorized into *supporting*, *consenting*, and *diverging* sequences. *Supporting* sequences (1.9% of total sequences) were sequences characterized by other children validating, showing empathy, and exploring the emotional experience of a child. The following example is of a sequence with a supporting pattern. The expression of negative emotion as defined by VR-Codes (Zimmermann et al., 2011) is underlined.

Child 1: I feel like I have been a big, big disappointment to my grandparents all my life.

Group leader: A big disappointment ...

Child 1: Yes (sobbing)

Group leader: (silence)

Child 2: I feel it in my tummy when you say that. ... It's so sad that you feel this way.

Group leader: Have you told anyone about your feelings (Child 1)?

Child 1: (Shakes her head)

- Child 3: I think it may help you if you tell someone about it, maybe a school nurse?
- Child 1: It's not that I don't want to talk about it, it's just that it's difficult ...
- Group leader: That is why we think attending these groups may be ok ... What do you feel about sitting like this in a group and talk?

- Child 1: Yes, it was like they looked at him as a clown or something, I got so furious.
- Child 2: Yes, people stare all the time, I'm like "why?"
- Group leader: So, you have had the same experience (directed toward child 2)?
- Child 2: Yes! I get so mad.
- Group leader: I see ...
- Child 3: I usually look back at them.
- Group leader: You do (directed toward child 3)?
- Child 1: Me too!
- Group leader: Does it help?
- Child 1: It works for me

The coding of this sequence was ended as the topic "disappointing others" and the emotion "sad" were left. The group leader's communication is labeled child-centered because (s)he probes the child's experience by repeating one of the keywords of the emotional utterance of the child (i.e., disappointment). The sequence is further considered supportive because multiple children make attempts to show empathy (e.g., "it hurts my tummy when you say that") or to give advice (i.e., "maybe it helps if you tell someone").

Consenting sequences (10.6% of total sequences) were characterized by subsequent self-disclosure by several children who shared a common experience (both the content and the emotion), either through adult facilitation or spontaneously. In *diverging* sequences (8.7% of total sequences), several children expressed having had the same experience in terms of content, but the emotional experience differed radically (e.g., "I do not feel like you do when it happens to me"). Five sequences were coded both as consenting and diverging as they contained both statements from children having the same experience and statements from children describing having experienced a similar situation in a different way. Otherwise, there was no overlap in coding of the material. The following example is of a sequence with a consenting pattern. The expression of negative emotion as defined by VR-Codes (Zimmermann et al., 2011) is underlined>.

- Child 1: When we were on holiday in Spain everyone looked at him, all the time.
- Group leader: They did?

... (the sequence continues in the same pattern). Again, the group leader is child-centered as (s)he follows the child by asking for more information (i.e., "they did?"), also to the next child (i.e., "have you had the same experience?") Further, the example was considered consenting because the other children indeed express that yes, they have the same experience (e.g., "me too!").

Method Study 2

Study 2 is based on the results of Study 1 and aimed to answer the three remaining research questions: To what extent do youths and clinicians perceive the communication patterns as supportive?; Do youths and clinicians differ in their evaluation of support?; and Are there gender or age-related differences in the youths' perception of support?

Development of Example Videos of Prominent Communication Patterns

Short sequences (1–4 min) representing the four most frequently observed communication patterns from the Study 1 data were selected. The sequences were transcribed and rewritten into screenplays, leaving out information that

could identify the participants. Youths from a local theater group (aged 11–15 years) and group leaders from Study 1 reenacted the sequences. We aimed to optimize the authenticity of the videos by having the theater instructor, who was a member of the research team, review the original video data and provide directions on that basis.

Development of Questionnaires

Questionnaires for each video sequence were developed for the rating of support, expressed emotion, and validity of the videotaped sequences. *Support* was assessed with an item from the Therapy Process Observational Coding System-Alliance scale (TPOCS; McLeod & Weisz, 2005). Support was defined as “*actions taken by the group or group leader to make the target sibling feel better or feel cared for*” and evaluated on a numerical visual analog scale (VAS) from 0 (*lowest degree of support*) to 10 (*highest degree of support*). Group leader support and child participant support were rated on separate items.

To investigate the *validity* of the patterns of communication the last item in the questionnaire gave a short description of the communication pattern in the video (e.g., for the *consenting* subcategory: *The film I've just seen showed children expressing that they have had the same experience as the upset child*). Youths and clinicians were asked to rate their agreement with the description on a numerical VAS from 0 (*I do not agree with the statement about the conversation/communication pattern*) to 10 (*I agree with the statement*). The validity item was added to examine the extent to which raters regarded the main video content to be the same as the research team. To control for random or social desirability ratings (e.g., always agreeing), a random selection of participants received reversed order validity items (i.e., the validity items did not correspond to the researchers' description of the video).

Recruitment and Procedures

Youths in 6th to 10th grade were recruited through three public schools, two primary schools, and one secondary school. The schools were situated in different areas of [city] to balance out possible effects of socioeconomic status. Information about the project was distributed to the children and their parents by school staff. Written parental consent and youth assent were

obtained prior to data collection. The child participants were gathered in their regular classrooms and were guided through the procedure by members of the research group.

Clinicians were recruited through the administration of three youth mental health clinics and one family counseling center. Consent forms and information about the project was distributed by the clinic managers. Written consent was obtained on the day of the data collection. The clinicians were gathered in a meeting room and were guided through the procedure by the research group.

One hundred and thirty-six youths participated in the study. The youth participants were 11–16 years old ($M = 13.3$ years, $SD = 1.5$; 43.4% boys and 56.6% girls). Sixty-eight clinicians participated. The clinicians were psychologists ($n = 36$), social workers ($n = 13$), psychiatrists ($n = 9$), pedagogues ($n = 5$), trainee psychologists ($n = 3$), or family therapists ($n = 2$). Clinicians had a mean of 17.3 years of clinical experience ($SD = 11.1$) and 42.6% reported experience in working with groups for children. The clinicians were from 24 to 67 years old ($M = 47.0$, $SD = 12.3$; 11.8% male and 88.2% female).

The procedure for data collection was the same for youths and clinicians. Brief information about the purpose of the project was given and the procedure was explained. The participants received handouts with the questionnaires (one for each video) and were presented with a short introduction about the setting of the support group scene and which child they should pay attention to (called the target child) before watching each video example. After watching each video, the participants were asked to answer the corresponding questionnaire. The films were shown in two different sequence orders to balance out possible sequence effects. The study was approved by the local Institutional Review Board for Research Ethics.

Data Analytic Plan

SPSS 25.0 was used for statistical analyses. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. All assumptions for the statistical analyses performed were satisfying. Checking for desirability/confirmation bias among the youths showed no such bias. Independent sample *t*-tests were used to compare assessed support from the youth and clinician raters and to compare whether there was a

significant difference in agreement to the category. The relation between assessed quality and assessed support from both group leader(s) and other siblings of children with a disability were investigated using Pearson product-moment correlation coefficients.

Results Study 2

Youth and Clinician Evaluation of Support

The four most frequent communicative patterns: Adult-centered informative (14.4%) adult-centered avoidant (13.5%), adult-centered interviewing (11.5%), and child-centered consenting (10.6%) sequences were selected for evaluation of support through reenacted scenes. The child-centered dyad pattern was excluded from further analysis. The reason for the exclusion was that the pattern did not represent group communication as it neither involved group leader behavior that aims to include other children in the conversation nor any child participant initiative to take an active part in the conversation. The sequences selected were sequences that only displayed one pattern (i.e., no double-coded examples).

Youths and clinicians largely agreed with the category descriptions, which indicate high validity of the communication sequences (see Table 2). Inter-rater reliability in the sample was satisfying; both youths and therapists gave consistent ratings on the questionnaire as measured with two-way random Intra Class Correlation (ICC) (Landers, 2011; Shrout & Fleiss, 1979).

The further results will be presented for each of the four most prevalent communication patterns, respectively. For simplicity, the scores of youths' and clinicians' ratings of an agreement to the category, group leader support, and support for other group participants were divided into low scores (0–3), medium scores (4–6), and high scores (7–10).

Table 2
Intra-class Correlation (ICC) for Support and Validation Items, for Youth and Clinicians

Item	Youth (<i>N</i> = 136)	Clinicians (<i>N</i> = 68)
Support from siblings	.994	.992
Support from group leader	.897	.962
Agreement with category	.076	.950

Child-Centered Consenting Sequences

Youths rated group leader support in consenting sequence as medium supportive ($M = 4.4$, $SD = 2.3$), whereas clinicians rated group leader support as low ($M = 3.5$, $SD = 1.9$). The difference was significant [$t(200) = 2.651$, $p < .01$].

Youths rated child support in consenting sequences as medium supportive ($M = 4.1$, $SD = 2.5$), whereas clinicians rated child support as low ($M = 3.9$, $SD = 2.1$). The difference was not significant [$t(201) = 0.674$, $p = .501$].

Adult-Centered Avoiding

Youths rated group leader support in the avoiding sequence as medium supportive ($M = 6.4$, $SD = 2.1$), whereas clinicians rated group leader support as low ($M = 3.7$, $SD = 2.2$). The difference was significant [$t(202) = 8.461$, $p \leq .001$]. Youths rated child support in the avoiding sequence as low ($M = 3.7$, $SD = 2.1$) and clinicians also rated child support as low ($M = 2.8$, $SD = 2.0$). The difference was, however, significant [$t(200) = 3.092$, $p < .01$].

Adult-Centered Informing

Youths and clinicians rated group leader support in the informing sequence as medium supportive ($M = 5.6$, $SD = 2.1$ and $M = 5.2$, $SD = 2.8$, respectively). The difference was not significant [$t(202) = 1.120$, $p = .264$]. Youths and clinicians rated child support in the informing sequence as low ($M = 1.8$, $SD = 1.9$ and $M = 2.1$, $SD = 1.9$, respectively). The difference was not significant [$t(201) = -.978$, $p = .329$].

Adult-Centered Interviewing

Youths and clinicians rated group leader support in the interviewing sequence as medium ($M = 5.2$, $SD = 2.2$ and $M = 5.4$, $SD = 2.4$, respectively). The difference was not significant [$t(202) = -.694$, $p = .489$]. Youths and clinicians rated child support in the interviewing sequence as low ($M = 2.6$, $SD = 2.3$ and $M = 3.2$, $SD = 2.6$, respectively). The difference was not significant [$t(202) = -1.773$, $p = .078$].

Age and Gender Differences in Youths' Evaluation of Support

Youth age was significantly correlated with youth-rated group leader support ($r = -.20$, $p < .05$), which means that older youth-rated lower group leader support. Youth age was not significantly correlated with youth-rated child support. In terms of youth gender, boys rated child support significantly higher than girls (M difference = 0.5 points; $p < .05$). There were no youth gender differences on ratings of group leader support (all $p > .228$).

Boys rated child support in the consenting pattern significantly higher than girls [$t(133) = -3.774$, $p < .001$]. No significant gender differences were found for the other patterns.

Youth age was significantly correlated with rating of child and group leader support in the consenting pattern ($r = -.26$, $p < .001$ and $r = -.28$, $p < .001$, respectively), and with rating of group leader support in the interviewing pattern ($r = -.21$, $p < .05$). No relation between youth age and evaluation of support was found for the other patterns.

Discussion

This article presents two studies. In Study 1, we explored communication in counseling groups for siblings of children with a disability. We found that communication tended either to be adult-centered, which means the group leader's perspective was followed, or to be child-centered, which means the child's perspective was followed. When communication was child-centered, it was often dyadic (i.e., not involving more than two group members). The four most common communication patterns following a child's expression of emotion were informing, characterized by group leaders providing information about the topic of concern; interviewing, characterized by group leaders posing a lot of superficial or general questions to the group about the topic but missing the emotional content of the statement; avoiding, characterized by the group leaders and the group avoiding further talk about the topic; or consenting, characterized by children sharing having similar experiences as the child who expresses emotion.

In Study 2, we found that the four common patterns from Study 1 all were ranged as low to medium on support by both youths and clinicians.

Youths and clinicians differed in their evaluation of support in two of the patterns. The group leader and child behavior in the avoidant pattern were rated as significantly more supportive by youths than clinicians. The youths rated group leader support in the consenting sequences as significantly more supportive compared to clinicians. In terms of age and gender differences, boys rated child support as higher than girls, and older youths rated group leader support as lower.

Why Are Group Leaders Active and Adult-Centered?

In Study 1, the communication in the groups was characterized by an active group leader and more passive child participants. One possible explanation for this finding may be the phase of group formation. The number of sessions of the counseling groups of this study was low compared to other sibling group interventions (e.g., 3 vs. the more common 5–9; Hartling et al., 2014). Previous research has found clinicians tend to take an active role and pose many questions in the first phase of group therapy compared to later in the process (Leichtentritt & Shechtman, 1998). The group leader behaviors observed in the current study may thus be considered expected given the early phase of group development.

The children Study 1 were also found to be quite passive during the three sessions. Self-disclosure was only present in 10.0% of sequences, which is in large contrast to the 90.0% of all verbal behavior utterances found in Leichtentritt and Shechtman (1998). Again, the passivity of the children may be explained by the stage of group formation, as child participation has been found to be lower in the early phases of group therapy compared to later phases (Leichtentritt & Shechtman, 1998) and the therapeutic quality of the verbal utterances to increase with time (Shechtman & Yanov, 2001). The low number of sessions also allowed less time for bonding in the group, a process described as important for group participation (Shechtman & Leichtentritt, 2010).

A striking finding was that the communication following a child's expression of negative emotion were adult-centered in 39.4% of the sequences. The group leaders in this study frequently posed questions on topics that did not emerge from child utterances (interviewing pattern), gave information and advice after no or scarce exploration of child experience (informing

pattern), or avoided further exploration and changed the topic when a child expressed emotion (avoiding pattern). Considering the group leaders had many years of experience with leading child groups, it is surprising that their behaviors did not follow the established recommendations within child mental health practice of following the children's perspectives (Friedberg & McClure, 2002; Øvreeide, 2009).

Group leader behavior in this study needs to be seen in light of the format and content of the groups. Their frequent use of questioning may be considered as eager efforts to make the children talk. In this setting, three big topics were to be covered within a short timeframe while interacting with a passive child group. As a result, group leaders may have increased the amount of questioning. Questioning has previously been found to be a good way to make children share experiences (Leichtentritt & Shechtman, 1998). However, so are encouragement, interpretation, modeling self-disclosure, or structured activities (Leichtentritt & Shechtman, 1998; Shechtman & Leichtentritt, 2010). If the group leaders in this study had used a wider variation of techniques, we might have observed a higher degree of child participation and less adult-centered communication despite the short duration of the intervention.

In research examining medical communication, providing information, or avoiding further exploration have been identified as strategies often used by clinicians to manage their own emotional arousal during distressing conversations (Andræ, 1994). Similarly, the informing and avoiding patterns observed in the current study may result from group leaders becoming emotionally activated by children's expressions of sorrow, anxiety, or frustration. Events that are stressful for professionals are best managed when analyzed and desirable behavior practiced (Saunders et al., 1996). The results of this study may thus reflect that group leaders were unprepared for, and or unaware of, their own emotional reactions.

Why Were the Patterns Rated Low on Support?

Study 2 showed that the four most frequent communication patterns observed in Study 1 all were rated as low to medium on supportiveness by youths and clinicians. This could imply that the most common communication in counseling groups are indeed not that supportive. However,

there may be several other explanations to our findings, some of which are related to methodological aspects. First, the patterns from Study 1 that were less frequent and thus not included in Study 2, that is, the supportive and the dyadic, could be the ones that most clearly represent support. A dialogue with the group leader, as seen in dyadic sequences, may be necessary to help the child regulate their emotions before returning to the group discussion of the emotional topic. Further, the supportive pattern includes explicit expressions of support and has previously been described by youths as important prosocial behavior (Bergin et al., 2003).

Second, the quality of the reenacted videos may have been too poor to sufficiently exemplify the patterns. However, the finding that both youths and clinicians agreed on the written descriptions of the patterns (i.e., the validity items) indicates that they understood what behaviors the videos were portraying.

Third, the participants' rating of support may also have been affected by their perception of the context of the emotional expression. The relatively high ratings of support in the informing pattern by the clinicians may reflect the lack of knowledge about the nature of the groups. For example, a therapist may have believed the groups were intended to be psychoeducational groups rather than counseling groups and thus perceived informing as a proper group leader response. Previous research has also described how youths take the context into consideration when evaluating whether an act is prosocial (Bergin et al., 2003). For example, the lack of response from other children to a child in the group crying may have been considered supportive/prosocial if the raters consider the intention is not to embarrass the child who is crying. In this study, a feature of the context is the topic discussed, and the ratings of the youths should be seen in relation to this. This study did not take the topic discussed into consideration in the analyses.

Fourth, the low rating of support may be explained by the characteristics of the participants. For example, the clinicians that rated the patterns in Study 2 were not experienced group leaders. Thus, the low ratings of support in the consenting pattern, which involves two important therapeutic factors; self-disclosure and interpersonal learning opportunities (Shechtman et al., 1997), may reflect the lack of knowledge about group

therapy and limited insights into the complexity of the group leader role.

Youths' low rating of support in Study 2 may be explained by the general expectations of the youths on how adults should behave. For example, the low rating of group leader support by youths in the consenting pattern (where other children share their similar experiences as the upset child while the group leader talks less) may reflect the general developmental tendency found by Bergin et al. (2003) and Caplan and Hay (1989), which is that youths expect adults who are present to be the ones to provide support when a child is upset. This may particularly apply to more formal roles, such as the group leader role. Similarly, youths' rating of the informative pattern as medium supportive may simply reflect that providing the information is a common adult behavior when a child experiences a dilemma, and thus interpreted as something done with the intention to help.

How We Explain Group Differences in Evaluation of Support

Youths and clinicians differed significantly in the evaluation of the avoidant pattern which involves that the emotion and the topic were avoided either explicitly by statements such as "let's not talk about that" or implicitly by changing the subject. The low clinician ratings may reflect that they were experienced child clinicians who knew that emotions should be validated in professional child–adult encounters.

Youths' rating of support in the avoidant pattern was significantly higher than the clinicians. Bergin et al. (2003) found that helping others regulate emotions is one of the main aims of prosocial actions of youths. Thus, youths in our study may have interpreted group leaders' avoidant behavior as a way of letting the upset child "cool down" and regulate the emotion though reducing attention to both the child and the topic.

Girls and older youths reported children to show significantly less support in the consenting pattern compared to boys and younger youths. This may be explained by the social-cognitive development. Previous research has described that the evaluation of support depends on the interpretation of the intention behind the behavior (Bergin et al., 2003). Further, this kind of social reasoning become more developed with age (Rosen et al., 2018; Van der Graaff et al., 2018). Finally, girls are more mature in reading intentions compared to boys (Scourfield

et al., 1999). Thus, girls and older youths in this study may have focused on the intention behind the behaviors of others in the consenting pattern. Seen in the light of previous studies reporting that children expect adults to provide support in a group setting (Bergin et al., 2003; Caplan & Hay, 1989), girls and older youths may have interpreted the self-disclosure of other children in response to another child's distress (as seen in the consenting pattern) as behaviors that interfered with the group leader's possibility to provide support.

A further possible explanation of the differences in the rating of support by clinicians and youths is that there may be a difference between what is experienced as to provide immediate support (e.g., that a topic is avoided to provide time for regulation of emotion) and what is therapeutically helpful (e.g., to have the thoughts that elicit the emotions challenged). It has previously been described how therapeutic interaction in relation to expression of emotion may be unpleasant at the time, but helpful within a longer timeframe (Kennedy-Moore & Watson, 2001). In this study youths may have evaluated the "here and now" support, while therapists may have evaluated the therapeutic potential. However, counseling groups often aim for less remediation than therapy groups (Gazda, 1969), which possibly implies that the "supportive behavior" aimed for in these groups to a larger degree is actions taken to relieve the distress of a participant there and then.

Limitations

Our studies have some limitations. Reenacted movies were created to be used in the evaluation of support in Study 2. As the participants did in fact agree with the descriptions of the communication in the movies, we might conclude that they were a good way of exemplifying the patterns. However, future studies should provide multiple examples of the same pattern so ensure that the features of the actors and the topic discussed does not affect their rating of emotion and support.

Participants in Study 2 were youths at local schools. Whether they ever had participated in counseling groups themselves was not known. Future studies should preferably involve youths and group leaders who have participated in groups themselves to enhance the validity of the findings. Also, clearer description of the setting of the video taped communication examples could have

provided the participants with a better foundation to evaluate the observed behaviour.

In Study 2, participants merely rated their perception of support but were not asked about their reasoning behind their ratings. This, and a more thorough definition of support, should be included in future studies.

Implications for Practice

The results of these two studies may inform the implementation of future counseling groups and the development of training courses for counseling group leaders. Counseling groups can be arranged within a short timeframe. However, the need of building group relation and spend time on communication and tasks to achieve this is important. If the counseling groups are to be conducted with few sessions only a few topics should be selected and explored. Group leaders should focus on increasing group communication rather than engaging in dyads. In group discussions, group leaders should try to follow and explore the topics that children bring into the discussions to reduce the amount of adult-centered communication. Group leaders should be formally trained in a variety of techniques that may be used to increase group communication.

The use of communication strategies to increase the amount of supportive behavior is also important. Group leaders should explicitly state the desirability of explicit supportive behavior and reinforce such behaviors when it happens. Measures should be taken to increase self-disclosure in short-term counseling groups. Clinicians often report to conduct groups with the aim of making children share experiences and experience social support. This aim should be made explicit to the group to avoid self-disclosure being interpreted as aversive. Finally, as group leaders' own emotions may interfere with their ability to facilitate verbal participation of children and provide proper support, it is important that stressful situations and how to manage these are targeted in practical training for future group leaders.

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