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Parent Intervention With Mothers Of Children With Internalizing Problems:Analysis Of Complaints, Themes And Therapist-Client Interaction In Three Clinical Cases

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Abstract

Among the few researches on internalizing problems intervention that include parents in the treatment it is noticed a wide absence of information about the clinical process with this specific population which leads to intervention success or failure. The analysis of the intervention process is important in the context of Evidence-Based Psychology, because it describes mechanisms and their possible connections with the results, what can contribute to the development of therapists and to optimize public mental health services. In this context, the current study has as general objective describing what did happen in the process of three well succeeded interventions with mothers of children with internalizing problems. The study evaluated the frequency and types of complaints, frequency and types of content developed, as well as correlated behaviors of therapist and clients. The data were obtained by content analysis, through categorizing the sessions' reports of three single cases intervention. Non-parametric statistical analyses were proceeded. The most common complaints and themes were negative parental practice and skilful expression of positive and negative feelings. The participants complained about non diagnosed externalizing problems and had a tendency to punish the children's confronting skill. The therapist most common behaviors were reflection requesting, empathy, and interpretation. The clients demonstrated high frequency of relationship establishment. The correlations between the therapist and the clients' behaviors were debated based on the premises of the procedure and variations due to the flexibility and individualized application for each client.

Keywords: Process assessment; Therapist-client interaction; Parent intervention

Introduction

A therapeutic intervention is basically an interaction between two individuals, in which one of them, the client, demonstrates some sort of suffering and seek help to attain improvement, while the therapist is the person who have some strategies of analyses and intervention capable of diminishing the suffering and enhancing the client's quality of life. The term therapist-client interaction refers to the description of the relationship between the therapist and clients behaviors along the clinical process [1,2]. Studying the clinical process involves characterizing the contents of the intervention process, the therapist and the clients behaviors, the possible relations and functions between each behavior, the regularity of the therapist behaviors that might be correlated to the success or failure of psychotherapy and the identification of the client's process of changethrough which the therapeutic benefits are achieved [1,3].

It is expected that clinical process researches clarify specific characteristics and procedures of the intervention that had explicit results in order to enable the comprehension on how the change process works, promoting the research replication and the development of therapists [4-6]. It is recommended that intervention research should (a) make the description of the procedures plain and precise, specifying the relevant behaviors related to maintaining and overcoming problems [4]; (b) identify tendencies in the complaints and typically relevant repertoire for the treatment of a given diagnose; (c) validate intervention guides in which are included flexible adaptations according to the clients demands, promoting the individualized application of procedures [4].

The most mentioned complaints that lead parents to search treatmentfor their children are aggressiveness and disobeying, which are typical externalizing behaviors related to negative parental practices [7-10]. Internalizing problems, i.e. anxiety and depression, are rarely recognized by parents as a reason for prevention or treatment [11] and interventions guided to these problems remain little studied in comparison to externalizing problems [6]. There is growing evidence that parental practices have an important role in developing and maintaining internalizing problems. Overprotection, lack of support and care or negligence [13], negative affection, punishment or negligence to negative emotions of the children [14], excess of demands or criticism [15], parental inconsistence, number of conflicts in the family [16] and marital problems [17], have been linked to internalizing problems. Despite these facts, little studies assess prevention programs directed to parents [12] while procedures that are focused on the child are predominant [6].

The literature on evidence-based psychotherapy point out that the therapeutic relationship has substantial and consistent contributions for the result of psychotherapy, regardless of the specific type of treatment, in addition to being one of the reasons for the clients to improve or not [5]. On the field of parent intervention on behavior problems the analyses of therapists and clients behaviors during therapy have enabled some hypothesis on the mechanisms through which positive parental practices are developed or improved.

For an example, it is suggested the importance of establishing a welcoming and empathic environment to favor the analyses and objectives with the collaborations of parents. Empathy tends to facilitate the agreement and engagement towards the implementation of necessary changes in the family environment [18]. Besides, it is known that therapist supporting behaviors happened more often with parents

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that later quit the treatment [19]. In addition, the effects of empathy may be temporary or insufficient to produce the necessary motivation on parents to change their practices with their children. In this way, the excess of empathy may contribute for pessimism and abandonment [19].

During a parent intervention research, it was found that the therapist's recommendations seemed to facilitate the occurrence of client's request and agreement, and reduce the client´s establishment of connections between the events; while the therapist´s empathy did not produce significant changes in the client's behaviors during therapy [7].

Among the few researches about parent intervention to treat internalizing problems [12] it is noticed the absence of information about the therapeutic process with this specific population and demands. In this context, the present work aimed to investigate which complaints, parental practices and behaviors of therapist-client interaction feature a parental intervention considered successful to reduce internalizing problems of children. Specific objectives were to identify (a) the frequency of different types of complaints of the participants; (b) the frequency of themes discussed on interpersonal relationship; and (c) comparing and correlating the behaviors of therapist and clients.

Method

Participants

Three mothers of children with internalizing problems at a clinic level took part in an individual parental intervention, all of them accepted the terms of the consent. P1 was 33 years old, married, had two children, one was 8 years old diagnosed with internalizing problems, and the youngest was 5 years old. P1 was attending college and worked as teacher assistant in a special education context. P2 was 39 years old, divorced with two children, 21-year-old young women, and an 8 year-old boy, diagnosed with internalizing problems. P2 had studied until secondary school and worked as a housekeeper and caretaker of the elderly. P3 was 30 years old, mother of a 10-year-old girl and a 6-year-old boy, the first was diagnosed with internalizing problems. P3 had completed high school and worked as a manicure and craftswoman.

Three observers participated in the phases of the session's reports categorization. One of them was the therapist responsible for the clinical treatment of the three participants, while the other two were students on the last grade of Psychology and had no contact with the cases or reports before the research.

Materials

Each participant sessions' reports were used as data source. They were produced through paraphrasing or summarizing the client's and therapist's speech, instead of literal transcript of the audio of each session.

An observation protocol composed by five axis of independent categories was created for the record and categorization of the variables important for this study regarding the clinical process:

Axis I: Composed of a list with different educational social skills themes according to the intervention procedure [21] and a label with the possible interlocutors each theme could be developed in one session (children with internalizing problem, other children, husband or ex-husband, other family members as parents or siblings).

Axis II: Consisted of a blank space without previous categories for the descriptive record of specific and explicit complaints that were reported each session by each client. The complaints were freely described and their contents were later analyzed.

Axis III: Based on the Multidimensional System for Coding Behaviors in Therapist-Client Interaction [from the Portuguese Sistema Multidimensional para a Categorização de Comportamentosna Interação Terapêutica- SiMCCIT] [22], through which broad categories of verbal vocal behavior of the therapist were selected and measured according to the frequency: Empathy, Requesting report, Information, Requesting reflection, Recommendation, Interpretation, Approval, and Disapproval. Facilitation, silence and other vocal responses of the therapist neither were nor adopted in the present study for the coding was performed on paraphrased statements that didn't contain similar records.

Axis IV: Also based on SiMCCIT [22], through which were selected and measured some of the broad and some of the specific categories of the clients vocal verbal behavior, in agreement with the objectives of the current study. The broad categories of the clients behaviors were Goals, Establishing Relationship, and Agreement. The category reporting Improvement was adopted on its subtypes: Therapeutic benefits(for the clients), Positive Change of others (children, spouse, other family members, and the like), Self control and Self Awareness.

Procedure Treatment and Data Analysis

Phase 1 - Study and train the categories: a) study of parental intervention procedures adopted in the interventions [21] and the Informative Booklet for Parents [23], by which was made possible to learn about the themes to be categorized in Axis I; b) study of Multidimensional System for Coding Behaviors in Therapist-Client Interaction – SiMCCIT [22] to comprehend the used categories for coding the verbal vocal behaviors of therapist and client; c) systematic training of the observers for the use of SiMCCIT with the *Clic*® software [22]; d) analysis of clinical case studies elaborated during the pre-test phase with the three participants, in order to understand particularities of each case.

Phase 2- Training consensus among observers: after studying and practicing the use of each category this phase was started with the aim to assess the level of concordance among observers [24] and to train the consensus of divergences to achieve a satisfactory level of agreement above 70% [25]. The calculus of the level of agreement was according to the formula: % of agreement = [number of agreed events / (number of agreed events + number of disagreed events)] x 100. Even though 70% of level of agreement is considered satisfactory it was chosen to use 80% as minimal concordance, specially for the axis without previous categories for the data coding. Regarding the indexes lower than 80% the divergences were identified and the material used in Phase 1 was studied again until it was reached an agreement on the most adequate category. This procedure was performed in fifteen session reports (the first five of each client). The criteria for the next phase were obtaining 80% of agreement in the four axis without the need of discussion for consensus.

Phase 3- Final concordance test among observers: 30% out of the total of each client's session was selected for the test (approximately three sessions of P1, three of P2, and four of P3), with the objective to assess the level of agreement among observers regarding the four axis of the observation and register protocol classification. The chosen sessions were the ones that followed those analyzed in Phase 2. Differently from Phase 2 there was no communication among observers and there was no discussion for consensus. The levels maintained a regular satisfactory level above 80% among all sessions. In order to counting the data, the third observer who was the therapist played the judge role in the cases where there were divergences.

Phase 4- Independent categorization: the reports of the remaining lessons (total of 21 for the three participants) were randomly selected and divided equally among the three observers for independent categorization, in a way the categories wouldn't be compared in this phase.

Phase 5- Statistical analysis and interpretation of results: the frequency data of each category according to the four axes of analysis of the three client's sessions were tabulated in spread sheets and exported to SPSS [26]. It is noted that the relative frequency of verbal behavior categories of interaction between client and therapist was calculated along all the sessions in function ofthe total of the therapist or the clients behavior that could be categorized (not on the total of possible behaviors in the session, for the therapist behaviors of facilitation and silence as well as other clients behaviors were not measured).

In order to compare the frequency of interactive verbal behaviors, identifying similarities and significant differences among the three cases conducted, it was performed the Kruskall-Wallis statistical test. To identify similarities and significant differences in interactive verbal behaviors, comparing two cases at a time, it was performed the Mann-Whitney U test. Spearmann rho test was used to correlate positively and negatively different verbal behaviors of interaction between therapist and client during the clinical process of each session.

Results

The results obtained through the analysis of the clinical process of three cases were organized according to the categorization axis in the protocol: (a) complaints; (b) themes, and (c) verbal vocal behaviors of the therapist-client interaction.

CATEGORIES	P1 (14)*	P2 (15)**	P3 (17)***	Total
Internalizing Problems	9 (64.3%)	8 (53.3%)	6 (35.3%)	22 (47.8%)
Externalizing Problems	7 (50%)	5 (33.3%)	10 (58.8%)	22 (47.8%)
Social Skills	7 (50%)	3 (20%)	2 (11.7%)	14 (30.4%)
Other children behavior	6 (42.8%)	0	10 (58.8%)	16 (34.8%)
Negative parental practice	10 (71.4%)	12 (80%)	13 (76.5%)	35 (76.1%)
Marriage problems	1 (7.1%)	10 (66.6%)	10 (58.8%)	21 (45.6%)
Problems with other family member	2 (14.2%)	12 (80%)	5 (29.4%)	19 (41.3%)

* P1 had 14 sessions in total.
** P2 had 15 sessions in total.
*** P3 had 17 sessions in total.

Table 1: Number of sessions and relative frequency in which each complaint category was presented by the clients.

Complaints

After content analysis the complaints statements were counted according to the categories "internalizing problems of the focus child", "externalizing problems of the focus child", "social skills of the focus child", "behavior problems of other children", "negative parental practice", "marriage problems", and "problems with other family members". The results about the relative frequency of each type of complaint clients had are described in Table 1.

According to Table 1, it can be noticed that the most frequent complaint along the intervention procedure was related to negative parental practices, considering each client individually or the total of sessions of each participant (76.1%). This data reveals that three clients reported about problematic aspects and difficulties in their practice of interacting with the children more than any other type of complaint.

The total frequency of complaints of all the mothers on internalizing and externalizing problems of the focus child during the treatment was the same (47.8% of the sessions). In the three cases the CBCL [11] diagnostic evaluation pointed out clinical level only for internalizing problems in the parents report; in despite of that, during the spontaneous report in the sessions when talking about the daily interaction with the child the problems considered externalizing were as frequent as the internalizing problems diagnosed. In P3 case, externalizing problems were a more frequent complaint than internalizing (58.8% and 35.3% respectively)

The complaints on marriage problems were more frequent for P2 and P3 (66.6%, and 58.8% of the sessions respectively), according to Table 1. P1 and P3 had children that were younger than the one diagnosed with internalizing problems, they also reported problematic behaviors in the interactive repertoire of this children. P2 was the participant who complained the most about other family members (80% of the sessions) as her mother, siblings, and former mother-in-law. Its interaction difficulties with these family members had direct implications to the focus child.

Thematic intervention content

The results of categorizing the content developed in the interventions are presented in a way that it can be identified the number of sessions each theme about social behaviors were developed for each family interlocutor of each client. These data are shown in Table 2.

For all the participants the child with internalizing problem was the

	P1 (C1)	P1 (C2)	P1 (H)	P1 (OF)	P2 (C1)	P2 (EX-H)	P2 (OF)	P3 (C1)	P3 (C2)	P3 (H)	P3 (OF)
Conversation	3	0	0	0	1	1	1	5	1	5	0
Questions	2	0	0	0	3	0	0	2	0	2	0
Positive Feelings	9	1	1	0	3	4	3	11	3	2	0
Rights	2	1	0	0	4	1	2	2	1	0	0
Opinions	6	5	0	0	3	2	5	3	0	2	0
Assertiveness	2	1	0	0	1	3	6	2	1	2	2
Negative Feelings	7	3	1	0	6	3	4	3	1	5	4
Requests	1	0	0	0	1	0	1	6	2	3	1
Criticism	4	3	0	1	1	2	2	3	1	3	1
Consistency	4	5	2	0	1	1	1	2	3	2	0
Hindering attitudes	0	2	0	0	2	0	0	4	4	0	0
Ignore and provide consequences	4	3	0	0	1	0	0	4	1	1	1
Rules and negotiation	4	5	0	0	3	1	1	9	6	1	0
Other	3	2	2	0	1	5	1	3	3	1	0
Total	51	31	6	1	31	23	27	59	27	29	9

C1: child with internalizing problem; C2: other child; H: Husband; Ex-H: ex-husband; OF: other family members (mother, parents, or siblings).

Table 2: Number of sessions in which each theme was discussed considering each interlocutor of each client.

interlocutor to whom social behaviors were more frequently developed as predicted by the procedures. For P1 and P3 the social behaviors were also developed for the relationship with the other children, for P2 and P3 analysis and development of repertoire for the relationship with ex-husbands and husband respectively were also included. P2 was the participant that needed the most to develop social behaviors to relate with other family members, for example the mother, siblings, and former mother-in-law. Such results on the development of interpersonal skills with different interlocutor along the procedure are consonant with the data on the distribution of complaints on the clients' different family relations.

In Table 2 it is also possible to observe the results that are highlighted in interpersonal themes more frequently developed with specific interlocutors. It is noted that the most frequently skills developed with the children with internalizing problem (C1 in the label) were expressing positive feelings (9 sessions with P1; 11 sessions with P3); demonstrating of agreement or disagreement of opinions (6 sessions with P1); expression of negative feelings (6 sessions with P2); making, receiving, and refusing requests (6 sessions with P3) and establishing limits with negotiation (9 sessions with P3).

Verbal-vocal behaviors of the therapist-client interaction

The results of the categorization of verbal vocal behaviors of the interaction between therapist and clients enable the characterization of similarities, differences, and tendencies of association between the repertoire of therapist and client in the clinical process. According to Table 3 the most common categories of the therapist behavior were Requesting reflection, Interpretation, and Empathy. With a lower frequency, though expressive, the behaviors of Approval and Recommendation are observed. The behaviors with less frequency of the therapist were Requesting report, Information, and Disapproval. Among the four measured categories of verbal vocal behaviors of clients it was observed the expressive relative frequency of Establishing relationship (P1: 53.1%. P2: 58% and P3: 65.6%)

Here are presented the comparisons results of each verbal behavior category average in the three cases, which enabled the identification of statistical significant resemblance and differences in the verbal interaction between therapist and clients in the studied sample. Such results are presented in Table 4. Among the therapist behavior (categories 1 to 8) it can be said that four of them were similarly

	P1	Freq. (%)	P2	Freq. (%)	P3	Freq. (%)
Empathy	369	20.15	337	15.74	352	13.3
Requesting Report	101	5.51	123	5.74	134	5.1
Information	75	4.1	73	3.4	153	5.8
Requesting reflexion	459	25.06	546	25.52	401	15.3
Recommendation	222	12.12	258	12.05	397	15.1
Interpretation	339	18.51	453	21.15	765	29
Approval	256	14	306	14.3	402	15.1
Disapproval	10	0.55	45	2.1	34	1.3
Agreement	150	18	130	12.7	104	12.4
Improvement	144	17.3	144	14.1	115	13.7
a) Therapeutic benefits	30	3.6	60	5.9	28	3.3
b) Change of others	54	6.5	37	3.6	48	5.7
c) Self control	3	0.4	16	1.6	9	1.1
d) Self awareness	57	6.8	31	3	30	3.6
Establish relationship	442	53.1	594	58	548	65.6
Goals or planning	97	11.6	155	15.2	69	8.3

Table 3: Total and relative frequency of the therapist and client behaviors.

Comparison between k independent samples (Kruskall-Wallis)				
	P1	P2	P3	
	Average			*P* value
Empathy	25.00	26.83	19.32	.253
Request report	21.46	23.90	24.82	.777
Information	20.96	19.63	29.00	.098
Request Reflection	26.36	28.13	17.06	.042*
Recommendation	18.86	20.67	29.82	.047*
Interpretation	15.50	21.00	32.29	.002**
Approval	18.18	22.50	28.76	.085
Disapproval	15.25	29.87	24.68	.010*
Agreement	29.75	24.63	17.35	.034
Therapeutic benefits for the client	22.46	29.20	19.32	.101
Positive changes of others	27.68	22.00	21.38	.365
Self control	20.82	24.03	25.24	.481
Self awareness	26.46	23.67	20.91	.505
Establishing Relationship	20.25	28.83	21.47	.166
Goals	24.21	32.87	14.65	.001**

Table 4: P Average and value for the therapist and clients behaviors. Kruskall-Wallis Test among the three participants.

Comparison between two independent samples (Mann-Whitney)			
	P1 x P2	P1 x P3	P2 x P3
	P value		
Request Reflection	.621	.040*	.027*
Recommendation	.813	.017*	.069
Interpretation	.270	.000**	.016*
Disapproval	.002**	.059*	.295
Agreement	.270	.013*	.114
Goals or action planning	.041	.023*	.000**

* $p \leq 0.05$.
** $p \leq 0.01$.

Table 5: Mann-Whitney comparison of therapist and clients behaviors between the participants (P1xP2; P1xP3; P2xP3).

emitted among the cases (Empathy, Requesting report, Information, and Approval), while other four categories of the therapist behaviors were different in the relationship with the clients (Requesting reflection, Recommendation, Interpretation, and Disapproval). With regards to the verbal vocal categories of the clients it was observed similarities in five categories (Therapeutic benefits, positive change of others, self control, self awareness, and Establishing relationship), while two behavior categories occurred significantly different (Agreement and Goals).

The differences found in the repertoire of therapist and clients in the cases can be better visualized when the cases are compared to each other (Meann-Whitney test). According to Table 5, significant differences were found in the therapist behavior about Requesting reflection, it was less frequent to P3 than to P1 or P2; more recommendations for P3 than P1; more interpretation for P3 than P1 or P2; disapprove less P1 than P2 and P3. The meaningful differences among the clients behaviors are identified because P1 presented higher emission of reporting agreement than P3, who established less goals and planning than P1 and P2.

The verbal vocal behaviors of therapist and clients were also correlated in order to demonstrate the tendencies for association of different behaviors of the therapist, clients, and from the therapist towards the clients. These results can be seen in Table 6.

The correlations found among different behaviors of the therapist and

	P1	P2	P3
Empathy	RR (.559*) TB (-692**) GO (.659*)	TB (.-584*) CO (-.563*) ER (567*)	RR (.588*) SC (.494*) GO (.642**)
Request Report		RR (.629*)	RR (.525*) DI (.556*)
Information	DI (.736*) SC (.614*)	RR (.580*)	
Request reflection	EM (.736**) AG (.566*) GO (.691**)	RR (.629*) IN (.580*) GO (.567*)	EM (.588*) RR (.525*) ER (.672**)
Recommendation	GO (.621*)	GO (.536*)	
Interpretation		GO (.612*)	
Approval	TB (.592*)	AG (.560*) SC (.567*)	
Disagreement	IN (.736*)		RR (.556*)
Agreement	RR (.566*) ER (.583*) Goals (.642*)		

RR: Request reflection; Rre: Establish relationship; AP: Approval; DI: Disapproval; EM: Empathy; IN: Information; REC: Recommendation; INT: Interpretation; AG: Agreement; TB: Therapeutic benefits; CO: Change of others; SC: Self control; SA: Self awareness; GO: Goals.
*Significant correlation at 0.05 level (2 extremities).
** Significant correlation at0.01 degree(2 extremities).

Table 6: Positive and negative correlations (Spearmann's rho test) between therapist-therapist and therapist-client.

	P1	P2	P3
Therapeutic benefits of the client	EM (-.692**) GO (-.535*)	EM (-.584*) CO(.559*)	CO (.560*)
Positive change of others		EM (-563*) TB (.559*)	
Self Control	IN (.614*) SA (.554*) ER (-.604*)	AP (.567*)	EM (.494*)
Self Awareness	SC (.554*) GO (553*)		
Establish Relationship	AG (.583*) SA (-.604*)	EM(.567*)	
Goals	EM695*) RR (.553*) AG (.642*) TB (-.535*) SA (. 553*)	RR (.567*) REC (.536*) ER (.627*)	EM (.642**) RR (.536*)

RR: Request reflection; Rre: Establish relationship; AP: Approval; DI: Disapproval; EM: Empathy; IN: Information; REC: Recommendation; INT: Interpretation; AG: Agreement; TB: Therapeutic benefits; CO: Change of others; SC: Self-control; SA: self-awareness; GO: Goals.
* Significant correlation at 0.05 level (2 extremities).
** Significant correlation at 0.01 degree (2 extremities).

Table 7: Positive and negative correlations (Spearmann's rho test) between client-client and client- therapist behaviors in the three cases.

clients may reveal patterns of behaviors and the development of processes that are common to the cases, as well as particularities that had been differentially functional for each client. Among the positive correlations that involve different behaviors of the therapist some are shown to be more important, as those that deal with Requesting reflection, in which the interaction between P1 and P3 was associated to Empathy, and in the interaction with P2 and P3 it was associated to the Requesting for report. In the interaction with P2 there was the association of both Information and Interpretation to the Requesting reflection.

There were also positive correlations that dealt with the therapist and the clients behavior, according to Table 6. The reports of Self control of clients were linked to different behaviors of the therapist in each case: to providing Information for P1, Approval for P2, and Empathy for P3. The clients behavior of establishing goals (or planning actions) was also linked to different behaviors of the therapist, according to each case: for P1 and P3 Goals were correlated to Empathy of the therapist; for P1 and P2 it was associated to Requesting reflection, and for P1 Goals was also related to Recommendations provided by the therapist.

In addition the clients' behavior of Establishing explanatory relationship was correlated to the Requesting reflection (for P3) and Empathy (for P2). The reports of clients Agreement with the therapist were linked to Requesting reflection (P1) and Approval (P2). Additionally, the therapist's Approval was also correlated to P1 reporting Therapeutic Benefits and P2 reporting Self control. According to Table 6, among the negative correlations it was found that the more the therapist expressed Empathy, the less frequent the reports of Therapeutic Benefits and Positive changes of others tended to be for P1 and P2.

According to Table 7 positive correlations were also found between different behaviors of the clients, specially for P1: the Self control reports of this client were associated to Self awareness; both the reports of Agreement and Self Awareness were correlated to Establishing Goals for P1, as well as Establishing explanatory relationship were associated to reporting agreement of the same client. For P2 and P3 some positive connections were found between reporting their own therapeutic benefits and positive behavior changes of others. On the other hand,

for P1 the more report of therapeutic benefits the less the tendency of setting Goals. For the same client, P1, the behavior of establishing explanatory relationship was negatively associated to reporting Self control.

Discussion

The analysis of the interaction process between therapist and clients of an intervention that was considered well succeeded enables an investigation of interpersonal variables responsible for the results and changes in therapy. In this study the frequency of the type of complaint, the frequency in which social behaviors were developed, and the correlations between verbal vocal behaviors of the therapist and clients were the object of analysis through the categorization of a semi-structured intervention process, individually applied to three mothers of children with internalizing problems.

The complaints categorization results revealed that the three participants demonstrated as the most frequent complaint their negative practices and difficulty to interact with the children, it suggests consonance with the characteristics predicted by the intervention [21], in which the mothers are the clients and the structured focus of the procedure are educative parental practices. It can be said that the mothers understand the role their behaviors play on their interaction with the children as a mechanism to produce behavior problems, therefore, they started paying attention to their behavior in family contingencies and reported their difficulty in interactive practices. The structured characteristic of the procedure in providing at the end of the session a register sheet with exercises or tasks related to the social behaviors analyzed and shaped in session [21], may have eased for mother to learn how to identify their interactive practices as a target of change.

Even though the diagnostic assessment have identified clinical level only for internalizing problems in the sample studied, the fact that mothers have complained about internalizing and externalizing problems with the same frequency corroborate the idea that aggressiveness and disobey are the problems that most disturbs parents [8]. It is possible that demanding evaluation or excessively critic practices [15] typically associated to internalizing problems have increased the probability of occasional opposing or confronting behaviors of the children, which became a complaint with a similar or greater importance (for P3) to internalizing problems at a diagnostic level. The same analysis seem to be applied to the massive frequency in which the mothers (mainly P1) would complain about the children social skills, which confirm that confronting behaviors considered socially competent in other contexts are seen as problems in the interaction with the mothers. These results corroborate the findings of Leme and Bolsoni-Silva (2010) [27], that state that mother of children with behavior problems would intricate the learning of social skills of the children because those behaviors were punished by them.

The complaints of problems with other children, husband, and other family members had variable frequency depending on each case, demonstrating that even though it wasn't the focus of the procedure such complaints were contemplated at the rate such problems would produce suffering to the participants and have impact in the parental relationship, assuring the flexibility of the procedure [4]. For instance, P2 had been divorced for seven years and due to several divergences with the ex-husband and former mother-in-law regarding the child's education and the time spent with the father's family, a great number of conflicts took place [16]. In P3's case she complained she had noticed several divergences on the education of the children and major dissatisfaction to the husband's conjugal interaction patterns [17]; by reporting frustrated attempts of negotiation in the past and during the intervention, client P3 set as a complementary focus to the sessions the goal to consider the divorce and preparing herself for the implications that such choice would have in her life. Those complaints were brought spontaneously by the mothers and were welcomed by the therapist, while the complaints of internalizing problems were brought either spontaneously or provoked by the therapist questions that took into consideration the family contingencies and structured aspects of the procedure [21].

The analysis of the social behaviors developed in the sessions reveal characteristics of the constructional intervention model [28] pertained in the intervention procedure adopted [21]. The constructional model considers the matrix or contingency network in which problems regarding behavioral resources are inserted, enabling a functional evaluation of interdependence among different behaviors. The consequent intervention may be considered constructional as it gives more importance to expanding existing behavioral resources and the construction of alternative repertoire to eliminate the complaints [28]. In this sense, by the analysis of independent contingencies that deal with the complaint the interpersonal repertoire predicted by the literature and recommended by the adopted procedure [21] are developed with emphasis to the expansion or creation of functional alternative repertoire.

The most common social behaviors discussed with the three clients in the current study are consonant to recommendations of the literature on internalizing problems. The substantial frequency of developing the theme "expression of positive feelings, empathy, paying compliment, giving and receiving positive feedback, and thanking" seem to be related to the replacement of risky negative practices connected to negligence or little welcoming, backing up, and supporting [13]. The frequency of the theme on "expression of negative feelings, giving and receiving negative feedback" may be useful to change risky mother patters as those marked by negative affection or negativity [14] and punishment to the children's negative emotions [14]. Excessively demanding or critic practices [15] were replaced by socially skilful alternatives for P1 (to whom the theme "expressing opinions of agreement or disagreement" was substantial) and P3 (to whom the theme "ask and deny requests" was frequent). For example, for P1 it was noted a great difficulty in validating and dialoging about the daughter's divergent opinions, while P3 would make abusive request to the daughter and would punish any refusal to any circumstance. Some behaviors were more relevant at each case and were approached only the necessary for a generalization for the parental relationship, granting the adaptation of the process to the specific demands of clients [5].

Complaints and alternative social behaviors were discussed through the therapist coordination in their relationship with the clients. One of the goals of clinical processes research consists in identifying possible regularities or differences in interpersonal skills and techniques used by clinicians in managing psychological interventions with proved affectivity [1]. In this sense, by comparing the frequencies and correlations among the therapist and clients behaviors in the current study with other intervention studies with parents, mother, or caretakers, differences and similarities were found.

In Silveira (2009) [29], the most common behavior categories of the therapist, considering only occurrence (disregarding duration) were Approval (37.9%), Recommendation (19.2%), and Requesting report (10.9%), while the less frequent were Disapproval (1.1%), and Empathy (5.9%). In the current study, the therapist behaviors with higher frequency along the procedure were Requestingreflection(P1: 25.06%;

P2: 25.52%; P3: 15.3%), Interpretation (P1: 18.5%; P2: 21.15%; P3: 29%;), and Empathy (P1: 20.15%; P2: 15.74%; P3: 13.3%), at the same time, the least frequent were Requesting report (P1: 5.51%; P2: 5.74%; P3: 5.1%), Information (P1: 4.1%; P2: 3.4%; P3: 5.8%), and Disapproval (P1: 0.55%; P2: 2.1%; P3: 1.3%).

As it seems, the expressive frequencies in the occurrence of Interpretation found in the present study (between 18.5% and 29%) are different from both interventions used as comparison [7,20], unless duration not frequency is considered then Interpretation can be said to be high expressed bythe therapist [20]. There are similarities in the low frequency of Disapproval [7,20], which may indicate a concern of the therapist in being an audience the least punitive possible [30].

It was noticed that in (Silveira et al. 2010) [20] the frequency of the therapist Approval is much higher (37.9%) while in this study the most significant occurrences were Requesting Reflection (P1: 25.06%, and P2: 25.52%), and Interpretation (P3: 29%). One of the most common categories in Silveira and colleagues (2010) [20] intervention. Requesting report appears as one of the least frequent therapist behaviors during intervention analyzed in this study; in addition. Empathy was one of the most common behaviors in this study and one of the least frequent in Silveira et al. (2010) [20]. In contrast, the therapist behavior during baseline in Kanamota (2013) [7] have some similar patterns to this one, chiefly regarding the frequency of Empathy (from 14% to 19.4%), Requesting reflection (12.3% to 24.5%), and Recommendation (11% to one of the clients).

Regarding the therapist behavior of *Requesting report,* both Kanamota (2013) [7] and Silveira and colleagues (2010) [20] had approximate frequencies (between 10.9% and 18.6%) and were higher than in the current study (about 5% for each client). It is possible that such difference is due to the method of data collection, since in this study paraphrased reports of the sessions were used with summarized questions for obtaining report, which doesn't happen in procedures with literal transcripts [7] and video footage of sessions [20]. On the other hand, it is known that the considerable expression of Empathy demonstrates a pattern of the therapist to speculate about feelings, establish an affective environment, and express comprehension regarding the conditions lived by the participants [31]. Elliott et al. (2011) [32] identified that empathy not only favors welcoming and acceptance, however it ease the client's behavior of reporting about other aspects of its life, providing data for the functional analysis of the therapist. This analysis enables the assumption that the high frequency of Empathy from the therapist in these conducted cases have compensated the low frequency of Requesting report. In this case, it is possible that these two categories of the therapist behavior may have similar roles in producing the clients' self-report.

Excess of Empathy is said in the literature to be related to the reduction of occurrences of more directive behavior related to changes, as Orientation and Interpretation [33], which doesn't seem to have happened in the analyzed intervention, taking into consideration the substantial frequency of Recommendation, and mainly Interpretation. Moreover, the results obtained by parental intervention which was marked by numerous occurrences of Empathy by the therapist, contradict the findings that state that high frequency of support by the therapist lead to small therapeutic changes [33], since the reports of Improvement vary from 13.7% to 17.3% among the three clients. Finally, it is important to mention that particular characteristics of therapist and clients have favored the high frequency of Empathy. It seems likely that due to the difficulty the mothers of children with internalizing problems had to commit to the treatment, the therapist had used more frequently welcoming behaviors and demonstration of understanding. As well, the mother would present several reports of conflicts and negative feelings associated to it, high frequency of avoidance, excess of criticality, and great sensitivity to social evaluations. This characteristic of the clients may have frequently evoked Empathy.

The comparisons between the frequency of the clients behaviors in this intervention to those obtained by Kanamota (2013) [7], and Silveira et al. (2010) [20] are harder to establish as in this study the relative frequency was calculated based on only four categorized behavior categories of the clients, differently from the other two interventions that the categorization covered the total of the clients' behaviors. In this perspective the possible analysis refer to the characteristics of the cases in particular.

Some significant differences were found for P1 which was the client that presented more Agreement and to whom the therapist addressed less Disapproval. P1 accepted the procedures and analysis during the sessions and called attention to the importance of the intervention and the therapist qualities at the end of the sessions, when evaluations were solicited. It is possible that this happened because P1 presented relevant behavioral resources for overcoming the problems and accepting the need to change, which diminished the probability of the therapist to disapprove or disagree with the client. P2 was the client who most established Goals.Which can be explained by the frequency in which behavior rehearsal exercises were performed along the sessions. As P2 presented conflicts and interpersonal complaints with different family members and had little behavior resources, the client frequently planned during the sessions how it would be the emission of behaviors that were focused in the session, rehearsing its application in the family environment.

Several differences were found in the interaction between the therapist and P3 in comparison to the other cases. Towards P3 the therapist addressed lessRequests for reflections, more Recommendation, and more Interpretation. On its turn, P3 was the client who presented less Agreement and established less Goals. The lower frequency ofrequesting reflection for P3 (15.3%) probably was due to how frequently she would avoid respond contingently to some occurrences. It is believed that it is not because of the aversiveness of this behavior for the client. Whichpresentedhigh frequency of establishing relationship (65.6%), however, it is due to a bigger necessity to report cases, feelings, and difficulties in the past and present to relate with other family members. Nonetheless, a possible negative side effect of low frequency in Requesting reflection is the reduced frequency in setting Goals, in other words, there were fewer opportunities for P3 to plan action courses during the sessions, as done by P2.

The higherfrequencies of Interpretation and Recommendation for P3 were probably alternative manipulationof the therapist to overcome the difficulty in Requesting reflection for this client, granting the presentation of explanatory analysis of contingencies as well as providing advices, incentives for action, and models of relevant behaviors facing lack of behavioral resources [9,29]. In agreement with Kanamota (2013) [7], Recommendation for P3 was emitted contingently to the behavior of avoiding reflection on the responsibility of its practices and its effects on her daughter and other family members, which worked as a sign for the therapist to interpret and recommend more frequently. However, differently from the findings of Donadone (2009) and Kanamota (2013) [7], the high frequency of Recommendation for P3 didn't favor high frequency of Agreement, which indicates the client's resistant pattern.

Correlation analysis suggests possibilities of association between the therapist and the clients behaviors. The correlations between the

therapist behaviors suggest both patterns predicted by the intervention procedure used and the variations of the therapist interaction repertoire, depending on each client [5].

Some correlations found between Requesting reflection and other behaviors as Empathy, Requesting report, Information, and Interpretationare highlighted. In this intervention model the therapist is expected to create favorable conditions for the client to analyze the contingencies of the focused interactions and the correlated behaviors may have helped the therapist soliciting the client to observe itself, establish explanations, synthesize facts or ideas, or foresee future events. The therapist Requesting Report usually facilitates the emission of Establishing relationship by the client [22], which was confirmed in the current study by P3; it was also found in this study the association of Agreement (P1) and Goals (P1 and P2), which positively suggest that the emphasis of the procedure on reflecting about the contingencies related to the problem might be well accepted and favor the planning of the changes.

The association between Empathy and Establishing relationship (P2), setting Goals (P1 and P3) and Self control (P3) corroborate with the thesis that behaviors that demonstrate the therapist's support and comprehension may increase the clients' engagement and exposure [32]. On the contrary, negative correlations between Empathy and Improvements such as Therapeutic benefits (P1 and P2) and Positive changes of others (P2) contradict this hypothesis. As the reports of improvements had high frequency and the intervention led to satisfying results in the final evaluations, the hypothesis is that the high frequency of Empathy didn't stop parents to improve their interactive practices [33], however may disfavor these two subtypes of Improvement report to contribute for the pessimism or to inadvertentlyreinforce reports of complaints by overvaluing them [19]. In consonance, during the experimental phase, the increase in frequency of Empathy during intervention with mothers, Kanamota (2013) [7] didn't notice systematic changes in the reports of Improvement.

Other correlations between the behaviors of therapist and the clients explicit how the adopted intervention model works on producing the mothers change. The connection between the therapist Approval and clients Improvement (from the sub group Therapeutic Improvements for P1 and Self control for P2) suggest about the effects of the differential reinforcement regarding relevant behaviors in the shaping process and corroborate the results and expectations in the literature [20,22]. The correlation between Approval and Agreement (P2) may indicate that paying a compliment and stressing positive aspects of the clients' behaviors might favor the therapy acceptance. The association between Recommendation and Goals (P1) is expected in the sense that advices, guidance, and techniques favor the client to establish future improvements. Planning strategies for solving the therapy complaints. It also seems understandable that the type of Self awareness Improvement of the client (P1) is linked to establishing Goals, for this behavior approaches discovering, accepting or understanding of events so far unknown, creating new points of view and possibilities [22]. The Goal formulation of P1 positively associated to the reports of Agreement may be a sign of the success of the therapy in encouraging objectives of changing in a collaborative way [18]. Negative correlations between Goals and Improvement were found by Silveira et al. (2010) [20], similarly to P1's results that the more she reported Therapeutic benefits the less she would formulate Goals. It is possible that identifying improvement on the own repertoire may have diminished the possibility of P1 to engage in planning other objectives and necessary changes.

The positive correlations between the subtypes of Improvement Therapeutic benefits and Positive changes of others (P2 and P3) emphasizes the main presupposition of this model of parental intervention, which states that increasing the variability and frequency of parental practices considered socially competent are directly related to overcoming the behavior problems of children and improvements in the quality of the parental relationship [7,9,21].

Conclusions

The objective of this study was to describe and analyze the variables on the clinical intervention process with three mothers of children with internalizing problems. The aspects of the therapeutic process analyzed included different types of complaints of mothers, the themes on parental practices discussed, as well as the therapist's and the clients' behaviors.

Some findings suggest some aspects to which therapists must be aware when treating mothers of children with internalizing behavior. It is possible that externalizing problems gain a status of a strong complaint and become more spontaneously reported than internalizing problems at a clinical level. It is relevant that the therapist helps parents to deal with family problems which may be directly or indirectly intervenient in the parental relationship. The skilful expression of positive and negative feelings seems to be especially important practices for the interaction between parents and children with internalizing problems. These findings confirm the importance of responsiveness and other skills related to dealing with children's emotions with this population [13,14].

Some frequent therapist behaviors during the intervention might be favored by the characteristics of theintervention program, as Request reflection, Interpretation and Empathy. The main differences in therapist's behaviors that were found may refer to the variations in the studies regarding the categorization method, individual or group treatment, characteristics and particularities of population and therapist. In the case of mothers of children with internalizing problems high frequency of Empathy may be needed due to difficulty to commit, the presence of several family conflicts, high probability of avoidance, difficulty in expressing feelings, and high criticism. The individual patterns of the therapeutic interaction with each client reflect the flexibility of both, the procedure and the therapist, as recommendations prescribed by process research [5].

One of the main accomplishments of this study was to create a categorization protocol that permitted identifying different variables of the process pointed out as relevant in the literature of behavior problems. Some methodological limitations of this study need to be considered; such as choosing paraphrased reports of the sessions as source of data, and absence of categorization on the total of verbal vocal behaviors of the clients. In this sense, it is recommended that future researches may consider the categorization of the total behavior events of therapist and clients emitted during the intervention process and also compare process variables from the beginning to the end of the intervention. The systematic investigation of clinical process might directly contribute to the development of therapists by the identification of regularities and differences in clinical processes with different populations.

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