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RESEARCH ARTICLE

Qualitative Reflections: CASA's Trauma and Attachment Group (TAG) Program for Youth who have Experienced Early Developmental Trauma

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Abstract

Objective: We demonstrated previously that the Trauma and Attachment Group (TAG) program for youth in middle childhood significantly improved caregiver/child attachment relationships, reduced children's symptoms of attachment trauma, and increased the caregiver's ability for self-reflection. Here we examine the perspectives of both those administering and those taking part in this intensive dyad-based group intervention. **Methods**: Utilizing an ethnographic design we collected and analyzed qualitative data obtained through a focus group and interviews with program facilitators, as well as interviews with participating caregivers. Data were collected from six TAG facilitators through a formal focus group interview (n=4), and informal interviews with TAG facilitators unable to attend the focus group (n=2). Four interviews were also carried out with caregivers (three females and one male). Thematic analysis of the focus group and interview transcripts was conducted. **Results**: Three key themes were identified in the focus group and interview data: Relationship as locus of change, Group process, and Psychoeducation-based content. That the TAG program provides psychoeducation about the effects of trauma to caregiver/child dyads in a group setting appears important in supporting the effectiveness of the program. Structured parent-child play and sensory activities together ("kit-time") were also highly valued. **Conclusions**: This qualitative study suggests that establishment of a healthy and focused caregiver/child relationship may be the key mechanism to promoting change in relationships that have been challenged by adverse effects of early developmental trauma. Further evaluation may help to identify other components that contribute to the success of the program.

Key Words: *attachment, developmental trauma, relational intervention, dyadic intervention, group intervention, trauma-informed care*

Résumé

Objectif: Nous avons précédemment démontré que le programme du groupe sur le traumatisme et l'attachement (TAG) pour les jeunes de la phase intermédiaire de l'enfance améliorait significativement les relations d'attachement entre soignant et enfant, réduisait les symptômes du traumatisme d'attachement chez les enfants, et accroissait la capacité d'autoréflexion du soignant. Nous examinons ici les perspectives de ceux qui administrent cette intervention de groupe intensive sous forme de dyade et de ceux qui y prennent part. **Méthodes**: À l'aide d'un concept ethnographique, nous avons recueilli et analysé des données qualitatives obtenues grâce à un groupe de discussion et à des entrevues menées auprès des animateurs du programme, ainsi qu'à des entrevues avec les soignants participants. Les données ont été recueillies auprès de 6 animateurs du TAG lors d'une entrevue avec

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le groupe de discussion officiel (n = 4), et d'entrevues informelles avec les animateurs du TAG qui n'ont pas pu assister au groupe de discussion (n = 2). Quatre entrevues ont aussi été menées avec les soignants (3 femmes et 1 homme). Une analyse thématique du groupe de discussion et des transcriptions des entrevues a été menée. **Résultats**: Trois thèmes principaux se sont dégagés du groupe de discussion et des données d'entrevues: la relation en tant que centre du changement, le processus du groupe, et le contenu basé sur la psychoéducation. Il semble important que le programme TAG offre la psychoéducation sur les effets du traumatisme aux dyades soignant/enfant dans le cadre d'un groupe pour soutenir l'efficacité du programme. Le jeu structuré parent-enfant et les activités sensorielles faites ensemble (« kit-time ») étaient aussi très appréciés. **Conclusions**: Cette étude qualitative suggère que la formation d'une relation soignant/enfant saine et ciblée puisse être le principal mécanisme favorisant le changement dans les relations qui ont été affectées par les effets indésirables d'un traumatisme développemental précoce. Une évaluation additionnelle serait utile pour identifier d'autres éléments qui contribuent au succès du programme.

Mots clés: *attachement, traumatisme développemental, intervention relationnelle, intervention dyadique, intervention de groupe, soins des traumatismes*

Introduction

Some children who have experienced early attachment-related trauma do not readily attach to new caregivers. The opportunity to attach may be further delayed if the child's emotions and behaviours associated with past experiences of terror and shame challenge their caregiver's ability to attach in return (Kinsey & Schlosser 2012; Arvidson et al., 2011; Pearlman & Curtois, 2005; Hughes, 2004). Researchers have proposed that when healthy reciprocal relationships are established, children placed into care later in their lives can demonstrate flexibility in attachment capacity (Arvidson et al., 2011; Rushton, Mayes, Dance, & Quinton, 2003). Those interventions that promote attachment and seek to reduce behavioural symptoms of trauma have been recognized as potential solutions that allow both members of the caregiver/child dyad to learn strategies for engagement and relationship building in spite of the challenges (Kinsey & Schlosser 2012; Arvidson et al., 2011; Puckering et al., 2011; Sprang, 2009; Rushton et al., 2003). Edmonton-based CASA Child, Adolescent and Family Mental Health (CASA), developed an intervention with the above-mentioned research in mind, titled the Trauma and Attachment Group (TAG) program. TAG is an intensive, caregiver/child dyad-based therapeutic group intervention for children in middle childhood (ages 5-11) who have attachment related diagnoses as a result of early developmental trauma.

The TAG intervention's effectiveness in increasing caregiver/child attachment and parental reflective functioning, and decreasing trauma related behavioural symptoms, has been previously investigated (Ashton, O'Brien-Langer, & Silverstone, 2016). The study team expanded on that research through the use of ethnographic data collection methods. These methods, described below, investigated *how* the TAG program generated its positive treatment effects. This paper highlights findings from a focus group with TAG facilitators, and individual interviews with several caregivers who have participated in the intervention.

The Larger Study

This paper reports findings from two qualitative data collection strategies that were part of a larger ethnographic study of the TAG program. The ethnographical approach was chosen to evaluate the TAG program as it offered an opportunity to explore the program's long-running, multifaceted complexity through the use of a wide variety of data collection methods (Higginbottom, Pillay & Boadu, 2013; Reeves, Kuper & Hodges, 2008; Tong, Sainsbury & Craig, 2007).

The initial phase of this research involved retrospective analysis of pre- and post-intervention caregiver-rated questionnaire scores. Findings demonstrated potential for positive change on all program outcome goals and supported its effectiveness as an attachment-based intervention (see Ashton et al., 2016 for details of this phase of the overall study).

Follow-up data collection methods presented in this paper, explored how TAG generated the positive changes experienced by its participants. Methods included a focus group with TAG program facilitators and individual interviews with caregivers who participated as a part of a dyad in the program. These qualitative approaches were chosen to provide insight into TAG culture and uncover the experience and roles of the various players in the intervention. While the perspectives of youth participants would have been valuable, constraints on time and resources limited recruitment at this time.

Ethics approval for this study was obtained from the Health Research Ethics Board at the University of Alberta. Written informed consent was obtained from all participants. All participants were given pseudonyms, which were used to identify quotes chosen to support the analysis below.

Transcription

The focus group and interviews were transcribed *verbatim* (Rubin & Rubin, 1995). Each transcript was compared to the audio recording to ensure accuracy. Transcripts included, where possible, all "ums", "ahhs", "uh huhs", and pauses or emphases in speech.

Current Methods

Focus Group Procedure

Focus groups were chosen for this ethnographic evaluation of the TAG program as the group interaction quality allowed for individual participants to "react and build upon the responses of other group members" (Plummer-D'Amato, 2008a). This "interaction data" appeared to offer a unique perspective over other interview techniques and increased the richness of the exploration (Lambert & Loiselle, 2008; Plummer-D'Amato, 2008a).

All TAG staff who facilitated the intervention between September 2011 and December 2014 were invited to participate. This time period was selected to better coincide with the data provided in the quantitative data collection component of this study (Ashton et al., 2016). Following an opportunity to obtain answers to questions about the study, and provide written consent, four previous and current facilitators (consisting of two Registered Social Workers, one Occupational Therapist, and one Registered Psychologist) participated in the focus group.

The focus group was two hours in length and was conducted in English at CASA offices at the request of the facilitators. Focus group facilitation was carried out using a moderator guide (Vaughn, Schumm, & Sinagub, 1996) by the lead author, a Canadian Certified Counsellor with 15 years' experience with group facilitation. Facilitation assistance was provided from the second author, a member of CASA's Evaluation and Research team, who is experienced in focus group facilitation. In order to promote a safe environment for self-disclosure, and to reduce censoring and conformity, prior establishment of clear ground rules for participation was provided to participants (Redmond & Curtis, 2009; Plummer-D'Amato, 2008a).

Focus group discussion was based on the main qualitative research question: "What are the mechanisms of change inherent in the TAG program?" and followed up with transitional questions (Plummer-D'Amato, 2008a) supporting the flow of conversation on the topic (Redmond, & Curtis, 2009; Vaughn et al., 1996). Concluding the focus group, the moderator summed up the preceding discussion and asked if participants had anything more to add that the moderator did not ask (Higginbottom et al., 2013; Redmond & Curtis, 2009; Plummer-D'Amato, 2008a).

To aid in the ability to report on group dynamics as well as to track what was discussed (Plummer-D'Amato, 2008a), the assistant took general notes about the discussion. She noted non-verbal cues between participants and kept track of who spoke in response to a given question. The focus group was recorded on an audio recording device and transcribed immediately following the group to facilitate more rigorous analysis. To support early stages of analysis, the moderator and assistant continued with a debriefing session following the focus group, which was also recorded and written up in a separate transcript (Creswell, 2009).

Focus Group Analysis

Though a more typical approach to interpretivist/qualitative design is to allow the data to "speak for itself" through an inductive approach to data analysis (Higginbottom et al., 2013), there is no "universally accepted" method for focus group analysis (Plummer-D'Amato, 2008b). In line with ethnographic methodology the focus group transcript was examined through both an inductive and deductive analysis process (Galman, 2013; Griffee, 2005; Joffe & Yardley, 2004). This combined process was intended to provide further "interpretive understanding" of the data (Fereday & Muir-Cochrane, 2006). To afford an opportunity for peer review (Tracy, 2010), both the facilitator and the assistant for the focus group participated in this process.

The primary objective in analyzing the focus group transcript was to understand TAG facilitators' beliefs about the *mechanisms* of change that produce positive outcomes for participants. Furthermore, notes and transcript from the focus group and of the debrief meeting between the moderator and assistant, were used to examine the relationship between facilitators (Sandelowski et al., 2012; Lambert & Loiselle, 2008). This process revealed how their interactions, philosophies, and process may themselves be underlying mechanisms of change within the TAG program.

The process of inductive coding was undertaken by the first writer through a process, which involved repeated reading of the transcript until certain themes became apparent and breaking down the writing into words emphasized by the participants (Doody, Slevin & Taggart, 2013; Griffee, 2005). Finally, these words were written on individual pieces of paper, grouped into code-related arrangements (Doody et al., 2013; Griffee, 2005), and used to tell a descriptive story of the TAG program (Galman, 2013; Griffee, 2005).

To uncover ways in which the focus group participants (TAG facilitators) directly answered the research question, the focus group transcript was also analyzed using a deductive coding process (Galman, 2013; Joffe & Yardley, 2004). Codes were devised from text that addressed questions asked during the focus group and then grouped into themes. Peer review during this process encouraged adherence to rigour and trustworthiness of the findings (Doody et al., 2013; Tracy, 2010).

Finally, guided by the research question and the proposed meaning the focus group participants placed on their experience, the study team concurred on the overall themes extracted through coding to shape the final interpretation outlined in the results section of this chapter.

In-depth Interview Procedure

TAG participants (caregivers) enrolled in the program between the time period of September 2011 and December 2014, were mailed study information letters and consent forms. Five caregivers returned consent forms. Three of these individuals returned our phone requests and were interviewed. One participant came from a family where the second caregiver in the home was also in attendance throughout their involvement with the TAG program. This second caregiver (TP4) also agreed to participate in our study.

The lead author adopted a "responsive interview model" (Rubin & Rubin 1995) for use in participant interviews. This interview style was chosen, because of its ability to combine therapeutic interviewing skills, like active listening, with "techniques for ordinary conversation", like curiosity and rapport building (Rubin & Rubin 1995). All interviews were held in locations chosen by the participants. With an informal "interview plan" as a guide, and following an opportunity to obtain answers to questions about the study, caregivers were asked to recount their experience as a participant of the TAG program. Initial interviews lasted from 30-120 minutes (with most lasting approximately 60 minutes). One participant provided follow-up information through email correspondence. All participants were provided with contact information and were invited to access publications and other outcome data in addition to their own transcripts.

Three participants involved in interviews were adoptive parents and one was a foster parent. Three of the caregivers were female and one was male. Their experience of parenting children not born to them (i.e. foster, adoption, kinship) spanned from 1-21 years at the time of their participation. The youth represented by interview participants were all boys between the ages of 9-11 years old at the time they attended the TAG program. Similarly, to others who attended the TAG program, these youth presented with complex mental health diagnoses and a variety of social, behavioural, relational, and school problems (see Ashton et al., 2016 for more information on TAG participants).

In-depth Interview Analysis

Thematic analysis and coding for the interviews with TAG participants followed a slightly different trajectory than was used for the focus group. Themes were identified by the first author following reading and re-reading of the interview transcripts (Doody et al., 2013; Rubin & Rubin, 1995). After potential themes were identified, text supporting the themes was extracted and a summary was created to allow comparison between interview themes (Doody et al., 2013). This information was then compared with relevant literature, focus group findings, and was discussed with a peer reviewer to reduce selective perception and add to the overall trustworthiness of the analysis (Doody et al., 2013; Tracy, 2010).

Study Quality

It is recognized that, by the very nature of being responsible for data collection, the researcher's presence influences the process (Tracy, 2010; Reeves et al., 2008; Tong et al., 2007). With regard to rigour, though complete detachment is not achievable in interpretivist design, reliability and validity were supported through continuous consultation throughout the design and implementation of this study (Mayan, 2009; Crang & Cook, 2007; LeCompte & Schensul, 1999). Several elements of quality (Tracy, 2010) were enforced throughout including the way this study accounted for validity. Participant quotes were drawn directly from transcribed interview data. Research questions were continually revisited through the design and data collection processes. Focus group findings were utilized to inform the interview questions, in an effort to learn through participant interviews if TAG philosophies transferred to practice. Detailed attention was paid to question design, breadth of sample through data collection methods, and transcription accuracy. "Recognizability" of findings (Konradsen et al., 2013 was employed in the current investigation by: verifying findings with members of the study team, bringing thematic ideas back to interview participants for reflection, involving neutral peer reviewers, and comparing back with current literature on the topic (Konradsen et al., 2013; Tracy, 2010; Lambert & Loiselle, 2008; Griffee, 2005). Additionally, journaling was utilized to encourage reflexivity regarding personal assumptions, biases and values, and to understand how they came into play during various stages of the research (Tracy, 2010; Rubin & Rubin, 1995).

Results

In order to better understand and identify mechanisms of change inherent in the TAG program, data was generated from a focus group with facilitators and in-depth interviews with caregivers who participated in the program during the years represented in the quantitative portion of the study (Ashton et al., 2016). To add to the richness and trustworthiness of the findings, the study team consulted regarding major themes revealed in in-depth interview analysis and compared them to findings extracted from focus group analysis (Lambert & Loiselle, 2008). Because many similarities between focus group and interview data were identified, results will be presented in tandem. For ease of reading, all pauses, "ums and ahhs", and interviewer comments/communication have been removed from quotations included below. Quotation text in italics are those words that were emphasized by participants.Analysis converged on three core mechanisms of change (themes) that were reflected by both facilitators (labeled FG participant 1-4 in the text below) and participants (labeled TP1-4 in the text below): "Relationship as locus of change", "Group process", and "Psychoeducation-based content".

Theme 1: Relationship as Locus of Change

What became progressively clear during analysis was that *relationships* were viewed to be the key mechanism of change in the program. This theme was divided up into three key relationships, those between the caregiver and the child, the caregiver and the facilitators, and, lastly, among the facilitators themselves.

Caregiver/child relationships

A key mechanism of change in the TAG intervention identified by both caregivers and facilitators was the focus on the caregiver-child dyad rather than on each party as an individual, a unique feature of the TAG program. A focus group participant clarified the rationale behind this treatment decision: "the wounding happened in relationship and so the healing happens…in relationship" (FG participant 1). This relational focus, enhanced through activities like "kit time" (a 30-minute daily session where the caregiver/child dyad spend uninterrupted time participating in activities chosen by the children and then adapted to include things both enjoy doing together) is considered key to TAG program structure. One facilitator explained, "It's the one to one time, whether it's the "kit time" or other times, that's really going to be the medicine that helps them through the attachment and trauma" (FG participant 2). A caregiver concurred: "(kit time) was largely the attachment part. That work has to be done on both sides, not just the child, the parent as well" (TP1). Another participant agreed:

…(time spent doing 'kit time') was *really* eye opening as well, because it just makes your bond stronger. It definitely changed the relationship between us. And…(the child in TAG) would *brag* about it to the other kids, right? 'Oh, it's 'kit time', you have to go and leave us alone' (laughs) right? So, they were very territorial about it. (TP3)

TP4 proposed that just the *process* of crafting the "kit" itself built relationship through allowing the dyad to learn about one another. He shared, "it's what works well with time spent together with the two of you…just because your son or daughter *likes* this…doesn't mean you two are going to interact *well* with that" (TP4). In addition, he proposed kit time development empowered his son through learning to eliminate and invite activities into their time together.

Caregiver/facilitator relationships

Focus group and interview analysis also revealed that TAG facilitators attempted to build relationships with caregivers and model self-reflection required in building and maintaining relationships. Efforts were made, in essence, to "parent" the caregivers, in order to encourage the same in the caregivers toward their children. One facilitator explained this as an attempt to "mimic the message, by not making promises and breaking them…trying to, like, role model what we would want in parenting" (FG participant 3). This relationship focus often meant the group was fluid in its implementation to adapt program content to "support (parents) to *be* ready for the group" (FG participant 3). Facilitators also emphasized the need to meet the "case sensitive" needs of each family. One explained, "Some kids need more medicine, some kids need more support at school. Some parents need more support, more phone calls…it's an individual approach within the context of TAG" (FG participant 2). Member checking with participants clarified this finding in their words:

I have to think a big part of it is the total non-judgment…and the kindness and understanding, as well. So, you could tell (the facilitators) and they weren't going to say, 'Well, you were a bad parent!' They'd kind of say, 'Well, hey, yeah, that's what happens. That's normal. (It's) a reaction we would *expect.*'…it just sort of, gave you that comfort and they just let us *learn* from them, right? (TP1)

I think, my very *favourite* part of TAG was, very much I guess, was like my kids with kit time, was having one-on-one with the facilitators. You could ask them questions and they would draw you out in a way that you don't think about. (TP3)

Lastly, there was acknowledgment by both facilitators and caregivers that the majority of the therapeutic caregiver/child relationship building occurred outside of group time. As a result, caregivers needed support, "almost more than the children because they have all the responsibility, you know, problems- (they) are up at night, etc, etc. So we have to give them a lot" (FG participant 2). A caregiver agreed:

I'm the one doing the majority of the therapy. You're trying to operate *through* me, so that in each relationship I have with (my son)- or each interaction with him, I'm doing what you want me to do. So, I would have prepared *me* a whole lot more, and built the relationship with *me*, so that I would feel good about the situation. (TP2)

In the families where this facilitator/caregiver relationship was thriving, there appeared to be an amplified opportunity for healing extending beyond the walls of the therapeutic milieu.

Facilitator/facilitator relationships

A third element of the program that echoed the relationship theme existed in the way the TAG facilitators described their relationships with each other. Working together as a team appeared to encourage facilitators to be more transparent, vulnerable, and self-reflective, and in turn, better facilitators. One explained that "being on the same page with your co-facilitators, touching base about how that went" (FG participant 3), was a critical part of effective group facilitation. Several facilitator participants had been providing trauma therapy in TAG for over ten years. These participants reflected that this inter-team support was a key protective factor against facilitator burn out. It appeared to help them remain optimistic that "healing happens and can

happen and should happen" (FG participant 1). This optimism can be translated to caregivers facing ongoing behavioural effects of trauma.

The "interaction data" from the focus group also supported this theme. Participants were observed actively drawing one another out and encouraging further reflection. The facilitator participants supported each other's responses through non-verbal and verbal acknowledgment, while referring to one another for further insight. Participants leaned in as others spoke, as in active listening techniques, and appeared to take care to not misrepresent the views of others in the room.

Theme 2: Group Process

Offering TAG in a group setting (as opposed to individual/family counselling) appeared to strengthen the opportunity for change, according to both caregivers and facilitators. One facilitator hypothesized that TAG's effectiveness was based in the group process. He stated, "(parents) feel safe, they feel validated, they feel they can come to TAG and 'oh, these people believe me, I'm not crazy. I get support and I get to tell my story'" (FG participant 2). Collaboratively, caregivers' reported feeling that they were not alone in their struggles helped them to normalize their experience. It also gave them a community of people to learn from and share with at a time in their lives where they felt vulnerable and ostracized. One caregiver shared that, "…seeing different ways other parents connected… actually seeing some of the challenges and seeing other parents dealing with challenges," (TP2) was what she found useful in attending the TAG program. Others agreed:

…sometimes the *biggest* benefit that I saw was…finding out that *wow*! You know what? Some of these extreme reactions and extreme experiences we're having? We aren't the *only* one having them! And even if you didn't hear *anything* to solve it, you came away knowing you weren't alone, and that knowledge alone gave you so much strength. (TP4)

(The facilitators) talk about that. It takes a village. That's what that is. We all work together, and we all talk to each other and work through it. I *often* think about (the other participants), wonder how they're doing, how the kids are, those kind (sic) of things. But yes, definitely you all get involved. You all support each other. (TP3)

Another caregiver expanded that the opportunity to share his experience with other parents aided in his understanding of his child's needs and how to respond to them:

The group scenario, the group discussions, is so critical, because, you have shared experience. You see people going through the same thing, which helps you feel not alone. The way *you* deal with that and the way (the other families) deal with that; and the way *their* kid reacts and the way *your* kid reacts; and the way *other* family members react; can create a completely unique situation. (TP4)

Importantly, it wasn't just the caregivers that benefitted from the opportunity for group connection. Youth also benefitted from the presence of caring adults in the group. One mother shared:

The children built relationships with the other adults because they would comment (on their work) and maybe one would get them more than the other (adults). (The caregivers) would see something that (a child in the group) had done, that someone else didn't pick up on. So (the children) did build that trust with the other parents. It gave them an opportunity to realize that there are other people, other parents, that they could trust and they *could* go to. (TP3)

Theme 3: Psychoeducation-based Content

A third key mechanism of change inherent in the TAG program appeared to be the psychoeducation facilitators provide regarding the effects of trauma on various levels of functioning. Caregivers were encouraged to understand behaviour from a base premise of "connection before correction". Facilitators explained that in regards to brain and biology, there are four elements in any interaction: "the caregivers' past and present, and…the child's past and present" (FG participant 4). Seen through an attachment theory lens (George, 1996), TAG staff proposed that helping caregivers change their understanding of behaviour from "my child is giving me a hard time" to "my child is having a hard time" allowed them to refocus their reactions to the child's behaviour.

Caregivers confirmed that psychoeducation of trauma gave them a newfound awareness and a "language" to explain their experience:

These words we have for it helps us keep that perspective. There's always going to be emotion involved (but) it gives us that tool to step back and say 'yes, I'm very emotional, ok, maybe this is *why*'. I don't know, for me, being able to understand the *why*, kind of just helps to normalize it and just, makes it more manageable. (TP1)

I have incorporated, a *lot*, a lot, a lot. I did come out of (TAG) with a new understanding, and I have been fostering for 21 and a half years! So, I did come out of there with a way better understanding of trauma, and how children *react* to that. So things, that before I would have said "oh, you're being ridiculous", now, I look at in a totally different way. And that's a *huge* thing for me, because I didn't just apply that to the kid that was in TAG. I can apply that to *all* my children. (TP3)

One participant explained that the awareness she had regarding her increased ability to advocate for her son was her biggest takeaway from TAG. She shared, "I think (it) is the most important thing that TAG told me. It gave me that insight that I can challenge the system to make it work for me. And for (my son)." (TP2)

Discussion

The TAG program previously demonstrated effectiveness in increasing attachment and parental reflective functioning, and a trend toward reducing trauma symptoms (Ashton et al., 2016). This study endeavored, through the use of ethnographic data collection strategies, to understand more about what was responsible for those changes. Data analyzed for this phase of the study included information obtained through a focus group with a sub-set of program facilitators, and interviews with caregivers involved as part of the adult/child dyad during the original study period (September 2011 through December 2014).

Focus group participants provided a rich and lively discussion around the topic. The group context in which their opinions were shared may have allowed for an engaged and enigmatic response to the research questions (Plummer-D'Amato, 2008a). Witnessing the ways in which the TAG facilitation team spoke about their work was believed to provide insight into what it might have felt like to be a caregiver participant in the TAG program. In a sense, the focus group helped to illuminate not only what the facilitators believed made TAG effective, but also uncovered mechanics of how they work as facilitators. This shared engagement provided a clear picture of group dynamics and verified the use of a focus group as a data collection tool in this study.

Thematic analysis of the focus group and interview transcripts provided insight into three major themes believed to substantiate changes reflected in TAG treatment outcomes: "Relationship as locus of change", "Group process" and "Psychoeducation-based content". These themes are consistent with previous research suggesting that caregivers be included in treatment (Purvis, Cross, Dansereau, & Parris, 2013; Arvidson et al., 2011; Schore, 2005, 2001; Dozier, Stovall, Albus, & Bates, 2001; Erikson, Korfmacher, & Egeland, 1992), that group interactions may improve treatment outcomes (Deblinger, Pollio, & Dorsey, 2016; Puckering et al., 2011; Sprang 2009), and that knowledge and education enhances treatment effects (Arvidson et al., 2011; Sprang 2009; Erikson et al., 1992).

The idea that positive relationships between primary caregivers and children can mitigate the behavioural effects of early developmental trauma has been well described in the literature (Purvis et al., 2013; Arvidson et al., 2011; Puckering et al., 2011; Sprang, 2009; Schore, 2005, 2001; Hughes, 2004; Rushton & Mayes, 1997). It has been suggested that for a child managing the adverse effects of early developmental trauma, working within a secure dyadic relationship (Theme #1) may encourage the re-working of attachment schema (George, 1996). Secure relationships may further provide a safe setting to build self-concept (Arvidson et al., 2011; Hughes, 2004), work through old trauma, and feel "safe at a sensory-affective level of experience" (Hughes, 2004). This strengthened relationship has also been credited with allowing the parent to cope with behavioural effects of trauma in a more adaptable and less aversive manner (Sprang, 2009; Hughes, 2004; Rushton & Mayes, 1997).

With regard to caregiver/facilitator relationships (Theme #1), several previous studies have asserted a connection between a strong therapist/client relationship (therapeutic alliance) and improved clinical outcomes (Schmidt, Chomycz, Houlding, Kruse, & Franks, 2014; Stratford, Lal, & Meara, 2009; Horvath & Symonds 1991). It has been suggested that the relationship between therapist and client may even take precedence over therapeutic strategies or techniques (Stratford et al., 2009).

Group settings (Theme #2) have also been credited with improved treatment outcomes in mental health milieus (Deblinger et al., 2016; Puckering et al., 2011; Sprang, 2009). Whether this is due to increased social support, or from the opportunity provided for caregivers and youth to engage in self-reflection (Puckering et al., 2011), group therapy appears to be a haven for individuals who are typically feeling ostracized and alone. One of the caregiver participants stressed that this need for community extended past the completion of the TAG program, stating that the program itself "is not a cure" (TP4). Another (TP2) shared that though she was unable to find this community support at TAG, watching others do so encouraged her to actively pursue building her own community.

Lastly, many studies assert the value of including psychoeducation in treatment programs (Arvidson et al., 2011; Sprang, 2009; Erikson et al., 1992). Unique to this study, trauma-related psychoeducation (Theme #3) was provided to the caregiver/child dyad in a group setting. While no similar approach has been published for children of a similar age, one relationship-focused, group intervention with caregivers of 0-6 year olds with attachment-related problems (Sprang, 2009), credited group psychoeducation and support with significantly lower scores in parenting stress, potential for abusive behaviour in caregivers, and child behavioural symptoms than controls. This opinion was additionally reflected in other research recommendations (Rahim, 2014; Knoverek et al., 2013).

In personal communication (2015) a founding member of the TAG facilitation team explained that the program's delivery of trauma-focused psychoeducation is important to the foundational aspects of their program:

"If we can see (children's) behaviours as 'symptoms of brain development that went askew' instead of the behaviour itself – sexual boundaries, aggression, stealing - all things that people get freaked out about, we have to see these as 'no fault symptoms.' Just like coughing is a symptom of asthma, boundary issues are symptoms of RAD (Reactive Attachment Disorder). We have to calm people down and assign no value around them. Yes, we have to *change* (the behaviours), but without assigning *blame* or *badness*".

Limitations

It should be noted that the present research may be limited by the modest sample size, lack of inclusion of youth participant perspectives, and the possibility that recall bias may play a part in the retrieval of past attitudes and behaviours. In addition, we were not able to interview all facilitators and caregivers involved in the TAG program. So while the current sample size met our original data collection goals (as a function of the entire ethnographic evaluative review of the TAG program), it is important to clarify that our present interpretation is based only on the individuals who were interviewed. It is therefore, not the only potential explanation of a TAG participant's experience. Finally, the TAG intervention is provided free of charge to the participants as part of general health service coverage in Canada. We recognize outcomes may be different if a similar program required caregivers to pay for the therapy.

Conclusion

The findings presented here support the proposed effectiveness of relational intervention for healing attachment-related trauma with children aged 5-11. The results of this study contribute to therapeutic recommendations that caregivers be included in treatment, that outcomes are improved through group participation, and that facilitation of psychoeducation can enhance treatment gains.

Though generalizability is not a cornerstone of qualitative research, it is important to consider the implications of these findings in the broader community. Development of a healthy and focused connection appears to promote change in caregiving/child relationships challenged by the adverse effects of early developmental and attachment-related trauma. In addition to clinically conveying this focus, mental health care providers can advocate for social policies, which encourage families to nurture a safe and connecting environment for their children struggling with the impacts of early trauma.

TAG is a highly intensive, multimodal, multidisciplinary approach and as such required substantial time and resources to evaluate. Further research could generate a more time and cost-effective method of evaluation for interventions that include these measurable outcomes. Additionally, these findings could be tested through comparison against other programs that do not offer these core components (dyad/group/psychoeducation). Further evaluation may also help more clearly define potential demographic and program components that contribute to the success of the program, as well as to explore the costs associated with the feasible provision of such care in the general population.

Acknowledgements / Conflicts of Interest

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