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Engaging with History Taking for Adverse Childhood Experiences in Care: A Rapid Qualitative Review

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Context and Policy Issues

Increasing interest in the potential relationships between chronic childhood trauma or adverse experiences and a person's overall health has led to a growth in literature exploring the phenomena. The adverse childhood experiences (ACEs) literature is, in part, focused on demonstrating connections between childhood traumatic experiences (e.g., physical and sexual abuse, parental neglect) and long-term mental or physical health problems.[1-8] Knowing these connections exist, however, is insufficient if whom they exist within, or how they might be addressed, are neither understood nor known. While screening tools such as the ACEs questionnaire have been developed to assess the type and level of childhood trauma or adversity an individual may have experienced or be living with, there have been no clear guidelines established regarding who should be engaging in these conversations with individuals, when, and in what format or setting. While it is generally accepted that screening for ACEs during primary care visits has the potential to assess a broad and diverse population, there are few guidelines for primary care practitioners regarding best practices for assessing ACEs during history taking. For example, it is possible that different guidelines are appropriate for people who have experienced different forms of trauma, and who have varying current life circumstances, in particular those who may be classified as among typically marginalized populations.

This report provides a descriptive, thematic analysis of the available literature on how individuals have experienced engaging with history taking for adverse child experiences or childhood trauma. A special focus is placed on identifying unique situations, which may require unique guidelines, with the intent of informing the development of guidelines for best practice across diverse populations.

Research Question

1. How have individuals experienced engaging with history taking for adverse childhood experiences (ACEs) or childhood trauma as part of their care, and how have those engagements varied, for example, among:
    a. Individuals within typically marginalized populations (e.g., refugees, Indigenous peoples, active substance users)
    b. Individuals having experienced different forms of trauma (e.g., sexual abuse, residential school)

Key Findings

Participants in the five included primary studies and the one included literature synthesis noted a general acceptance of history taking for childhood trauma or adverse experiences in primary care. That being said, there was a dearth of literature exploring the perspectives and experiences of individuals within typically marginalized populations. While one included study focused specifically on refugees living in the United States,[9] the remainder engaged with a broader North American population who had experienced childhood trauma or adverse experiences. As such, though the findings within this report do offer space for reflection regarding any clinical encounter, particular emphasis on typically marginalized populations is largely absent. Furthermore, participant acceptance of history taking while generally accepted by those represented in this review, was not without bounds. The

following descriptive themes emerged from the included studies as the form these bounds may take.

- The importance of developing and demonstrating clarity regarding the purpose of history taking was spoken to across all six studies. A need for clarity was articulated in terms of a perceived need for provider awareness of the context surrounding conversations of childhood trauma or adverse experiences. Clinical languages of abuse and trauma may not always be understood or perceived as appropriate and dependent upon the purpose of the clinical visit (e.g., a prenatal obstetrics visit), emphasis could be placed on different forms of childhood trauma (e.g., perhaps a particular focus on sexual abuse). Assurance that the conversation was not standing in for any ulterior motives and that it would be completely confidential were also important to study participants – particularly among expectant or recent parents and members of the military.
- The importance of developing and demonstrating commitment to building a trusting patient-provider relationship was also noted. Rather than treating history taking as a singular performance or rapid exercise, patients expressed that they need their health care providers to foster a safe and trusting environment for the conversation. While some participants noted this was a temporal issue, where each visit added to the strength of the relationship, trust could also be built through the intensity and patience of a singular clinical interaction.
- Similar to an expressed need for clarity, the importance of taking action or providing resources, if required, once the conversation had taken place was noted across studies. This could take the form of referring patients onto professional or peer support groups, but it could also be done by the provider themselves. Knowing how to hold and work with the traumatic pasts of their patients, from the patient perspective, comes hand-in-hand with asking about those pasts.

Methods

Literature Search Methods

A limited literature search was conducted on key resources including Ovid Medline, PsycINFO, CINAHL, The Cochrane Library, University of York Centre for Reviews and Dissemination (CRD) databases and a focused Internet search. No methodological filters were applied to limit retrieval by publication type. The search was limited to English language documents published between January 1, 2008 and October 19, 2018. A supplemental search was conducted on October 31, 2018. Methodological filters were applied to limit the retrieval to qualitative studies only. The supplemental search was limited to English language documents published between January 1, 2008 and October 31, 2018.

Selection Criteria and Methods

One reviewer screened citations and selected studies. In the first level of screening, titles and abstracts were reviewed and the full-text of potentially relevant articles were retrieved and assessed for inclusion. The final selection of full-text articles was based on the selection criteria presented in Table 1.

Table 1: Selection Criteria

Population	Adults receiving care in any setting (with a special interest in primary care)
Intervention	History taking regarding ACEs or childhood trauma during care
Comparator	Not applicable
Outcomes	Descriptions of experiences engaging with history taking for ACEs or childhood trauma as part of care, including perspectives about relevance and utility, perspectives about inclusiveness, experiences with follow up care, impact on the individual and their lives, re-traumatization and other related and relevant concepts as they emerge. The particular interest is in how engagement varies among typically marginalized populations as compared to "normal" populations
Study Designs	Qualitative or mixed methods primary studies, qualitative evidence syntheses

ACE = Adverse Childhood Events.

Exclusion Criteria

Articles were excluded based upon a failure to meet the selection criteria listed in Table 1 and the following:

- Publication type of case report, commentary or editorial
- Dissertation
- Not full-text publication (i.e., abstracts)
- Primarily focused on exploring the experience of history taking of trauma post childhood (i.e., intimate partner violence)

Critical Appraisal of Individual Studies

One reviewer conducted a critical appraisal of the included primary studies. While the ten items from the CASP Qualitative Checklist[10] were used as prompts for reflection, the critical appraisal was guided by three primary questions intended to query whether and how a study demonstrated that it collected rich data and conducted a rigorous analysis incorporating reflexive practices leading to robust results that were useful for the objectives of this review: Is it credible? Is it trustworthy? Are the results transferable?[11] Results of the critical appraisal were not used to exclude studies from this review.

Data Analysis

A descriptive thematic analysis[12] intended to identify the diversity of experiences with ACE and childhood trauma history taking was conducted, primarily by a single reviewer, with some conversations with colleagues to probe for analytic clarity and depth. This meant that rather than develop themes based on the aggregative presence of similar experiences across studies, to reflect diversity and breadth themes presented in this review could come from experiences reported in as little as one included study. Approaching the analysis in this way allowed for a broader engagement with and description of the complexity involved in this form of history taking. As the research question places particular interest in the experiences of typically marginalized populations, this approach was considered appropriate to the task by providing the opportunity for fewer voices to hold equal weight in the final descriptive analysis.

Preliminary analysis began at screening through the use of memoing and subsequent conversation with colleagues experienced in rapid qualitative evidence synthesis. These early conversations and memos helped jumpstart the analytic process by both identifying forms of childhood trauma (e.g., sexual abuse) receiving greater attention within the literature returned through our initial search (included or not) as well as noting spaces where literature was virtually absent from this search (e.g., residential school survivorship). As such, a supplemental search deliberately seeking out these absent forms of trauma was developed in collaboration with a Research Information Specialist and screened in the same manner as the initial search results.

Given the small number of included primary studies (n=5) and synthesis of the literature (n=1), memoing continued to be used in lieu of formal coding.[13] This second set of memos helped to describe the findings of included primary studies and note preliminary spaces of confluence between studies. As such, a second round of memoing and diagraming used an initial, tentative set of themes to tease out findings and supporting data in the studies and explore their relationships across studies.

Included studies and memos were re-read and key findings and themes were identified and the linkages between studies were explored. Memoing and re-reading continued until themes were well-described and stable, and all relevant findings and supporting data from the included studies had been accounted for within those themes.

Summary of Evidence

Quantity of Research Available

A total of 695 citations were identified in the literature search. Following screening of titles and abstracts, 673 citations were excluded and 22 potentially relevant reports from the electronic search were retrieved for full-text review. A supplemental search was run and returned an additional 901 citations. Following screening of titles and abstracts, 883 citations were excluded and 18 potentially relevant reports from the electronic search were retrieved for full-text review. Nine potentially relevant publications were retrieved from the grey literature search for full text review. Of these 49 potentially relevant articles, 43 publications were excluded for various reasons, and five primary studies and one literature synthesis met the inclusion criteria and were included in this report. Appendix 1 presents the PRISMA[14] flowchart of the study selection.

Summary of Study and Participant Characteristics

Study Characteristics

The characteristics of the six included studies are described in Appendix 2 (Table of Included Studies). Of the five included primary studies, four were conducted in the United States[9,15-17] and one in Canada.[18] The literature synthesis was conducted in the United States[19] and included 16 empirical qualitative studies eight of which were conducted the United States, United Kingdom, New Zealand and Canada. It was not reported where the remaining eight primary studies were conducted. A limited number of studies included in the literature synthesis were relevant to this review as not all focused on history taking for childhood trauma or adverse experiences. None of the five primary studies included in this report were included in the literature synthesis.

As reported by study authors, the methods of data analysis used by included primary studies were content analysis (n=3)[9,16,18] and a thematic framework approach (n=1).[15] One primary study did not report methods for data analysis,[17] but seemed to mimic thematic analysis. The included synthesis[19] used the matrix method for data synthesis.

Four of the included primary studies used interviews as a method of data collection[9,15,16,18] and one used a single focus group.[20] The synthesis used a comprehensive literature search strategy and pre-specified inclusion criteria to identify relevant articles.[19] Four of the included primary studies reported using a purposive sampling strategy with no further details provided,[15,16,18,20] and one specifically identified using a convenience sampling strategy.[9] The literature synthesis used a comprehensive search and selected studies based on pre-specified inclusion criteria.[19]

Participant Characteristics

The participant characteristics of the six included studies are described in Appendix **3**. A total of 138 adult participants were included across the five primary studies included in this review.[9,15-18] The number of participants included in the literature synthesis was not reported.[19] Age ranges were between 18-45,[15,17] with three of the primary studies not reporting ages of participants.[9,16,18] Most participants in the primary studies were female, with a weighted average of 78.28% of participants being female. While age ranges and sex were reported for some of the studies included in the literature synthesis, not all studies received the same treatment. As such, these characteristics are exclusive of the literature synthesis, which remain unknown.

The study populations varied, with one study including parents of young children (aged six or under),[15] one study including military personal and non-military spouses; one study included refugees (from all regions of Africa aside from southern, southeast Asia, the Balkans and South America) who had fled war and were living in the United States, and two studies included females who had experienced sexual violence or adverse childhood events.[17,18] While the characteristics of study populations included in the literature synthesis was not well reported, of relevance to this review is a sample of articles including male and female survivors of childhood sexual abuse.[19]

Three studies used varying cut-off scores from the ACEs questionnaire, (i.e., ≥ 3,[15] ≥ 4[18], ≥ 1[16]) as inclusion criteria. One study focused specifically on refugees self-reporting as having experienced war trauma,[9] and another on those self-reported as having experienced sexual trauma.[17] The literature synthesis included studies that explored the experiences of individuals with self-identified sexual or physical abuse.[19]

Interventions

Of the five primary studies, three used the ACEs questionnaire as a way of determining eligibility for study participation.[15,16,18] Of these, two asked their participants to reflect specifically on the value of the ACEs questionnaire as a tool for history taking in the clinical setting.[15,16] As the other, Purkey et al.[18] was not specifically focused on history taking but rather the breadth of trauma informed care, and the particular form of history taking was not reported. The two remaining primary studies focused instead on the act of disclosure through general conversation with the care provider.[9,17] The synthesis[19] was focused on the general facets of trauma informed care and did not report any specific tool for history taking.

Summary of Quality Appraisal

Overall, the included primary studies were assessed to be of moderate quality with the literature synthesis judged as high quality. Results of the quality appraisal can be found in Appendix 4.

The criterion of credibility asked the basic question of whether the researchers were true to their participants' voices, and could be demonstrated through clear descriptions of data collection methodology, supporting descriptive analyses with raw data and reflexively engaging with the processes leading to these descriptive analyses. Two primary studies were assessed as credible,[15,16] and three were assessed as either partially credible (n=2)[17,18] or not credible (n=1).[9] The literature synthesis was assessed as credible as it clearly articulated the methodological steps involved and the reasoning behind following the chosen steps.[19]

The criterion of trustworthiness relates to ideas of dependability and confirmability and the assessment explored issues akin to internal validity of study results. The assessment explored whether the analysis attempted to push beyond a description of participant comments, whether there was analytical consistency throughout and whether the authors demonstrated reflexive engagement with assumptions. All five primary studies included in this report were viewed as partially trustworthy.[9,15-18] The literature synthesis was judged as trustworthy as throughout both the findings and discussion sections, there were clear signs of reflexive thought on how findings were presented and assumptions within these findings.[19]

The final criterion for quality appraisal was transferability, in which case the reviewers queried how relevant the study was to the current review. The assessment was made by exploring reporting of individual study participant characteristics, their situations and analyses. In this case, two studies were judged to be completely transferable,[9,15] with the remaining three being judged as partially transferable.[16-18] The literature synthesis was assessed to be somewhat transferable due to inconsistency in reporting participant characteristics across studies.[19]

Summary of Findings

Participants across the included primary studies[9,15,16,18] and the literature synthesis[19] noted a general acceptance of history taking for trauma in primary care; however, acceptance was not without bounds. The following analysis speaks to the breadth of these bounds while reassembling them within the confines of three primary thematic categories: The importance of 1) clarity regarding purpose of history taking, 2) patient-provider relationships, and 3) post-conversation resources.

The importance of clarity regarding the purpose of history taking

The purpose of history taking for childhood trauma was not always well understood by study participants.[9,15-17] At times, clarity of purpose could be obscured due to divergent definitions of what constitutes adversity or trauma. For some female survivors of sexual abuse, this simply indicated a lack of comfort with the clinical languages of trauma, abuse and adversity used by their health care providers, with terms like "hurt" being noted as preferred.[17] However, for others, clinical definitions were considered inadequate to addressing the extent of potentially traumatic events.[17] As such, participants in White et al.'s[17] study noted the importance of contextual framing. For instance, in their context of

prenatal care it was suggested that conversations include questions on “abrupt” family separations or experiences being hurt by someone in a medical profession.[17]

Similarly, clarity could be obscured by general uncertainty regarding the effect former trauma held over present health. As such, some military personnel were apathetic toward the practice of history taking,[16] while some refugee participants considered it to be out of place in visits intended for another indication: “Sometimes it’s not the subject. You’re seen for a health issue, they give you a prescription and you’re out the door.”(p52)[9] One parent in Conn et al.’s study[15] questioned how screening for their adverse childhood experiences was relevant to their child’s health.

Concerns related to the purpose of history taking could also take on a more dubious form wherein history taking was articulated as a possible front for ulterior motives.[15-17] For instance, while intensive surveillance was generally accepted as part of military life, some individuals within the United States military were concerned with the utility of their collected information and what it could be used for – “If it’s just collecting data so that they can weed out, then I don’t think [it should be done].”(p857)[16] Some participants in both White et al.’s[17] study on obstetrical practice and Conn et al.’s[15] study on pediatric primary care expressed similar concerns. In both cases, there was a noted worry that child services might be called based on the disclosure of a parent’s childhood adversities. One participant explained the thought process as, “if I have gone through all of this stuff, then I am kind of messed up in the head and I can’t take care of a baby … Or, I may allow it to happen to my baby because it happened to me.”(p424)[17]

This was tied to a concern for confidentiality of conversations. Again, some participants were worried that these history taking exercises would be used against them in some way. One participant in White et al.’s[17] study explained, “…you guys are bound by law [to report certain things] … You say it is confidential … but you are going to report me.”(p426)[17] Some members of the United States military articulated similar concerns of commanding officers being able to “sweet talk”(p856)[16] their way into viewing medical records. In some cases, these breaches of confidentiality could be reminiscent of former abuse and thus counterproductive.[19]

The importance of patient-provider relationships

In light of these expressed concerns regarding the purpose of history taking, participant acceptance was often described as dependent upon relationships with their care providers.[9,18,19]

While not specifically about the act of history taking itself, Purkey et al.[18] note the importance participants placed on building long-term relationships with their care providers and the concomitant feeling of becoming known. Long-term relationships allowed for the clinical interaction to be situated within an “atmosphere of safety,”(p207) in which participants felt their various physical manifestations of residual and ongoing trauma could be understood. One participant explained that being understood meant being able to have a serious conversation with her provider regarding something as simple as a spike in blood pressure: “And he’d say, ‘OK, something’s going on. Tell me. And we’d sit down there and talk. And, ah, you know, he’d do all the other stuff I was there for, but he understood where I was coming from.”(p207) Implicit within this example is the assumption that without this relationship, without a physician who understood her, the spike in blood pressure could have gone either the direction of waived off as aberration or compelled the physician to conduct further, unnecessary tests.

While attaining a strong relationship with one's physician could be a matter of long-term engagement as noted by Purkey et al.'s[18] participants, it could also be derived through a concerted effort on the part of the physician.[9,15,18,19] Relationships fostering a sense of understanding and comfort could be established by physician displays of genuine interest in their patients' stories. Many of the refugee participants in Shannon et al.'s[9] study remarked that while they would be interested in sharing their stories of trauma, their care providers rarely took (or were perceived as having) the time to ask. Slowing down during the appointment,[9,19] explaining reasons for asking questions about traumatic histories,[15-17] and repeating expressions of interest in hearing their patients' stories were all ways patients described that their providers could help foster a safe space for history taking.

Reeves[19] noted that experiences of childhood trauma or other adverse experiences could lead to feelings of shame, guilt and stigma that play out in a number of ways. Some female survivors of childhood sexual abuse, for example, indicated feeling dismissed or belittled by their care providers and consequently closing themselves off from future disclosure[19] Similarly, some male survivors of female perpetrated childhood sexual abuse also noted feeling brushed off by their care providers.[19] Others who had been sexually abused by males indicated experiences of homophobic reactions from their providers.[19] Some of the women in Purkey et al.'s study[18] who had experienced childhood sexual abuse and currently used controlled substances also noted conversations regarding prescriptions with their providers as anxiety ridden. Disclosure of trauma and adverse experiences may not happen immediately,[9] or ever,[19] but knowing their provider cared and would appropriately hold their trauma without condescension[18,19] was reinforced as important to patients.

Furthermore, several studies from Reeve's synthesis of the literature[19] articulated the importance of care providers acknowledging and managing power imbalances that could be reflective of former, abusive power imbalances. While there was considerable ambiguity between studies regarding the preferred from of history taking, both written and verbal accounts were described as capable of facilitating both a trusting relationship with their providers and eventual disclosure.[9,15,19] Some military personnel spoke specifically to the acceptability of following a guided ACEs questionnaire,[16] while refugee participants[9] and those from the literature included in Reeves' synthesis[19] indicated interest in the opportunity to be more expressive in either written or verbal form. Some parents from Conn et al.'s[15] study noted that face-to-face conversations allowed them to clarify their responses, which could serve as a way of mitigating power imbalances.

The importance of post-conversation resources

Even when providers foster a safe environment for conversations around childhood trauma, Reeves[19] noted that feelings of shame, guilt and stigmatization associated with former trauma (particularly sexual abuse) can serve as a barrier to disclosure for some participants. If these feelings were appropriately held by providers, and patients chose to talk about past traumas, participants noted the importance of providers having knowledge and comfort with managing trauma in their own encounter as well as offering post-conversation resources.[19]

Some participants noted that rehashing former traumatic experiences was either uncomfortable,[9] emotionally difficult or even potentially retraumatizing.[15] As such, the included study authors noted interest in ensuring there were services available post history taking. For some, this meant peer-support rather than professional services.[17] Others spoke to professional services[15] or simply the availability of a non-descript form of help.[16]

Similarly, parents from Conn et al.'s[15] study described the important role their child's pediatrician played as "change-agents"(p67) following disclosure. Rather than simply noting the presence of parent's traumatic histories, pediatricians were viewed as valuable resources for breaking from what they noted as a "cycle of adversity."(p67)

Limitations

While the findings of this report offer space for reflection regarding any clinical encounter engaging in, or meant to engage in, history taking for childhood trauma or adverse experiences, few of the search results focused specifically on the perspectives and experiences of people typically classified as within marginalized populations with this practice. Fewer still met criteria for inclusion in this report as they tended either to be survey studies or non-empirical theoretical studies. As a primary motivator for this report was to explore these perspectives in particular, it is a clear limitation of this review that their specific experiences are not reflected.

In a Canadian context, the absence of literature engaging with First Nations, Inuit or Metis living in Canada severely hampers its intended utility. Indigenous Peoples living in Canada have experienced unique and state directed forms of childhood trauma, with the residential school system and the so called Sixties Scoop being two prominent examples, The sexual, physical and emotional abuses of the residential school system, for example, are well documented in the literature, but we were unable to draw out specific implications of these and other state led adverse experiences in the context of this review, due to the absence of relevant empirical studies.

Similarly, there are notable gaps in the breadth of forms childhood trauma or adverse experiences could take as well populations these experiences could take place in. Males, for example, were largely absent from the included studies. While the literature synthesis does note the stigmatization, guilt and shame many male survivors of sexual abuse experience, their experiences were either minimal or absent in the included primary studies. Controlled substance users were also largely absent. Forms of trauma such as neglect and extreme household dysfunction were also absent from direct conversation in the included studies thought they may have been experienced by those participants only reporting ACE scores without disclosing what constituted these scores. Furthermore, the included literature only speaks to the experiences and perspectives of those individuals who were both cognizant of their childhood trauma or adverse experiences and wanted to speak to their experiences or perspectives. As interviewing or attending a focus group could potentially feel as uncomfortable as history taking in a clinical encounter, it is not surprising that these individuals are absent from the included studies. Absence of negative views of the practice, should not be taken as equivalent to the absence of any negative views.

Due to the limited scope, and quantity, of included studies it is difficult to parse out nuance across other populations and across particular forms of trauma. For example, while the forms of trauma experienced by refugees fleeing the violence of war may have some characteristic overlaps with those forms experienced by North American survivors of childhood sexual abuse, the contexts within which the traumas become embodied and understood may differ. Similarly, the chronicity and intensity of experienced trauma were left unexplored in the included studies. It is possible to imagine that these are factors that may influence one's willingness to engage with a clinician in an act of history taking.

Similarly, studies did not consistently report participant demographic characteristics that could lend to a better understanding of included populations. For those studies failing to

report, it was difficult to ascertain just what was at stake for the participants involved. Not only this, but it was difficult to translate those findings into the findings from other studies as the populations could be quite different. As noted already, specific types of childhood trauma and adverse experiences can look characteristically similar, but may be embodied and understood differently across populations. How to engage across populations may therefore likewise vary, however we were unable to explore this issue in depth due to the nature of the studies included in this review.

Another limitation stems from the lack of any studies exploring study participants' views over time. This is problematic to the results presented in this review for two interrelated reasons: disclosure is not a single event and participant perceptions about disclosure may change over time. Both points tie into and across all three thematic findings presented above. As alluded to above, building relationships with one's primary care provider rooted in trust and the belief that their intentions in talking about past traumas or adverse experiences are both positive and can be supported with appropriate resources could help foster an environment of ongoing disclosure. Following participants though this process of relation building (or not) could have been helpful in drawing out more nuanced perspectives on the role of history taking in their primary care. Rather than situating questions of acceptability or perspective within a single moment (often while sitting in the waiting room prior to an appointment), expanding inquiry across time would have allowed the opportunity to offer reflections on the mobility of acceptability and perspective.

Conclusions and Implications for Decision or Policy Making

All included primary studies as well as the included literature synthesis indicate a general acceptance of the act of history taking for childhood trauma or adverse experiences. While there was some ambiguity regarding the form that this practice should take, the ACEs questionnaire, verbal communication and other forms of written communication were all variably noted as preferred across studies. Such broad variability across a relatively small set of included studies could indicate that the uptake of only one form of history taking (e.g., the ACEs questionnaire) is not widely acceptable. Ambiguity regarding a preferred form of history taking aside, the three themes articulated in this review further bind the acceptance of the practice of history taking.

Participants across all of the included studies (primary and synthesis alike) noted the importance of clarity regarding the purpose of history taking. While the potential risks childhood trauma or adverse experiences place on adult health has been largely acknowledged within clinical communities,[1,3,4,21] this may not be true for individuals unfamiliar with or ambivalent toward the clinical literature. As such, participants articulated concerns ranging from how language and context could distort clarity to those questioning the presence of ulterior motives behind the practice. Individuals situated within the military and those attending prenatal visits or being asked about ACEs in the context of their child's pediatric visit were particularly concerned with the latter. Could commanding officers have access to these files and could the military screen you from service based on the presence of childhood trauma? Or, would child and family services be notified of the presence of childhood trauma or adverse experiences and could my child be taken away? As such, it would seem important that when engaging in conversations around childhood trauma and adverse experiences within a clinical encounter they be prefaced by a clear description of intent, potential utility and promise of confidentiality. Even so, patients may decline engaging in such conversations, and should be supported in their decision to do so.

While no Indigenous participants were included within these studies, it would be easy to imagine similar concerns with confidentiality and ulterior motives being articulated there. Long histories of abusive relationships with the Canadian state and medical field built on deficit models of indigeneity may prompt extra concern on the part of some First Nations, Inuit or Metis. The removal of thousands of Indigenous children from their homes and communities throughout both the residential school era and the Sixties Scoop was, after all, predicated on the notion that many Indigenous parents were unfit for parenting.

Another emergent theme centered around the importance building strong provider-patient relationships. For some participants, the strength of a relationship was articulated in terms of temporal length – of becoming "known to" and "understood by" their provider over years of interaction. As such, the practice of history taking for childhood trauma or adverse experiences may not always be advisable within initial primary care visits. For many non-urban Indigenous Peoples living in Canada, or other remote service users, this could be further complicated by the high turnover rates of care providers. Similarly, some individuals living in places with availability for consistent primary care providers may still not use family doctors due to a variety of factors including limited availability, discomfort with the available providers (e.g., only male providers for female survivors of childhood sexual abuse), or other social or logistical factors that can impede access.

Relationship building was also spoken to in more abbreviated terms as well. Several refugee participants repeated desires to share their stories of war trauma, but had either never been asked or the pace of their interactions with care providers limited the time to speak to their stories fully. Furthermore, some participants noted having experienced stigmatization by providers or internalized feelings of guilt and shame due to their childhood trauma (e.g. particularly survivors of childhood sexual abuse or current controlled substance users).Patients offered that their providers could indicate a willingness to build a relationship with their patients by slowing down the visit, being consistent when asking about childhood trauma or adverse experiences (across visits), being aware of and addressing power dynamics in the interaction, and realizing that disclosure may not happen right away, or ever. Due to the importance of both relationships and the contextual delicacy of those relationships, an important component of history taking should likely include provider training in trauma informed care.

This leads to a final thematic finding of this report – the importance of follow-up care. While the prevalence is uncertain, that some participants indicated the possibility of re-traumatization or increased emotional burden from history taking demonstrates the importance of offering follow-up care. Variability across studies in desired forms of follow-up care, however, also indicates that suggested avenues should be patient specific rather than one generalized strategy developed for all patients. As such, prior to engaging in conversations on childhood trauma and adverse experiences with patients in their care, providers should develop an awareness of the breadth of resources available in their local community. This includes particular awareness of those resources oriented toward and considered appropriate by typically marginalized populations (e.g., Indigenous Peoples and substance users) as some traditional forms of follow-up care (e.g., psychotherapy or rehabilitation centers) may be considered patriarchal and perpetuate feelings abuse for some individuals in these populations.

In sum, while history taking for childhood trauma or adverse experiences was generally considered acceptable among participants in the included studies, a one-size-fits-all screening intervention is not necessarily warranted. The considerable variability regarding

how patients described their preferences for such encounters across the studies included in this review, indicate the need for provider flexibility, empathy and wide knowledge base.

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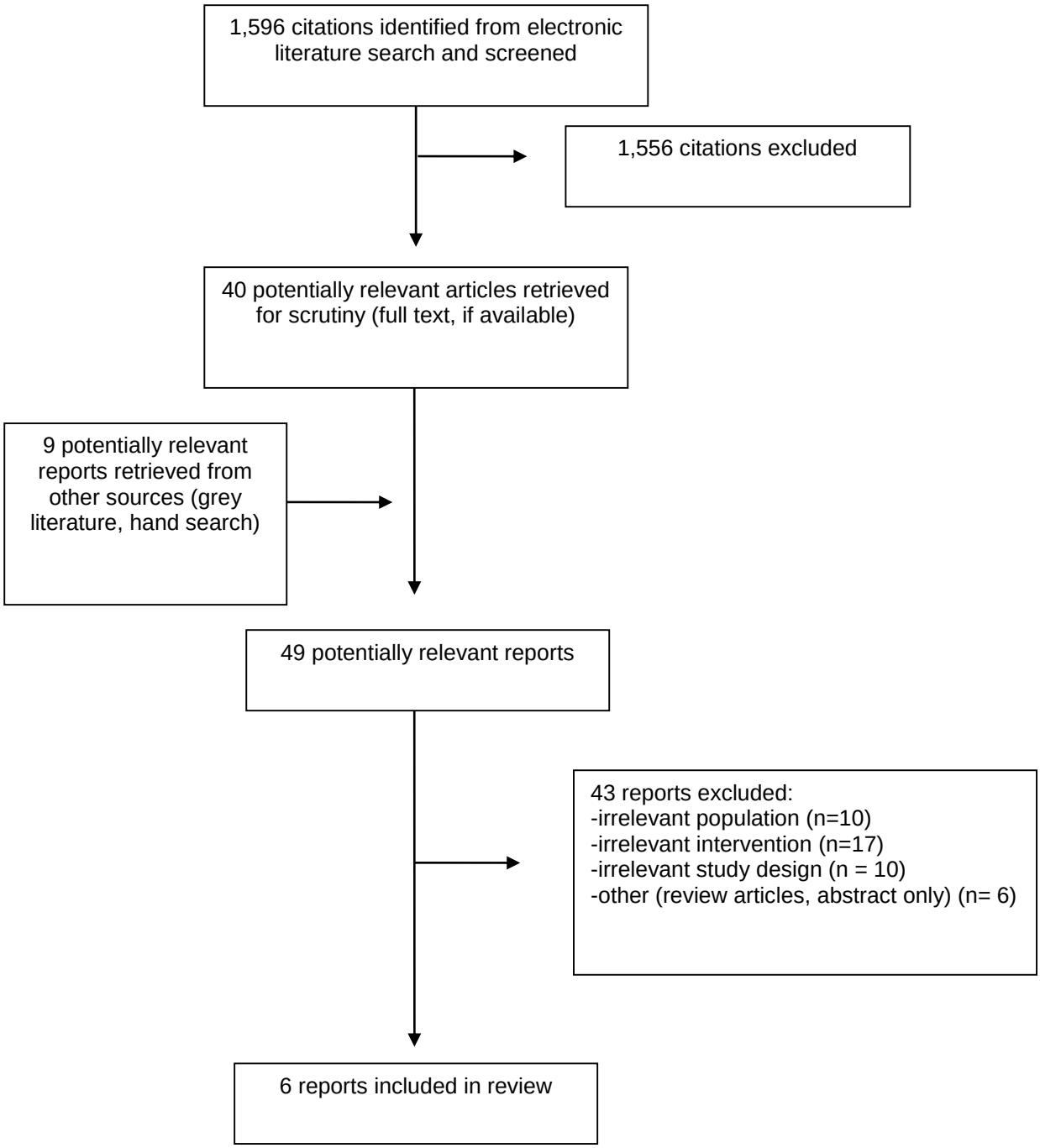
Appendix 1: Selection of Included Studies



Appendix 2: Characteristics of Included Publications

Table 2: Characteristics of Included Studies

First Author, Publication Year, Country, Funding Source	Study Design	Study Objectives	Sample Size	Inclusion Criteria	Data Collection (type, sampling method)
Literature Synthesis					
Reeves, 2015, USA, Not Reported[19]	Synthesis of the literature using the matrix method	To examine existing research on trauma-informed physical health care for survivors of physical and sexual abuse and to generate implications for practice, research, and policy that support the implementation of trauma-informed physical health care	16 primary studies 10 theoretical studies	Included studies needed to focus on survivors of child or adult sexual or physical abuse, pertain to physical health care settings, and discuss trauma informed practice	Where empirical and theoretical studies presented similar findings, empirical studies were chosen for inclusion
Primary Studies					
Conn, 2018, USA, NIH T32 training grant[15]	Thematic Framework	To understand the views of parents in primary pediatric care settings regarding screening for ACEs	15 parents	Parents 18 years or older to children younger than 6 years who were fluent in English	Interviews and purposive sampling
Purkey, 2018, Canada, None Reported[18]	Directed content analysis	To understand the primary care experiences of women who have a history of childhood trauma and chronic disease	26 participants	Women 21 years or older with two or more non-psychiatric diagnoses as recorded in ICD-9 codes in their electronic medical records with an ACE score ≥4	Interviews with analysis continuing until data saturation
Robinson, 2008, USA, None Reported[16]	Content based analysis	To examine service members' and spouses' perceptions regarding the inclusion of ACE domains in active military health surveillance	28 military personnel 13 non-military spouses	Individuals self-reporting an ACEs score ≥1	Interviews within a purposive sample

First Author, Publication Year, Country, Funding Source	Study Design	Study Objectives	Sample Size	Inclusion Criteria	Data Collection (type, sampling method)
Shannon, 2012, USA, grant from the Park Nicollet Foundation[9]	Content analysis and constant comparison method	Exploring refugees' perspectives regarding the nature of communication barriers that impeded the exploration of trauma histories in primary care	50 refugees	Refugees 18 years or older	Interviews within a convenience sample
White, 2016, USA, Substance Abuse and Mental Health Services Administration[17]	Not reported, but appears to mimic thematic analysis	Exploring abuse survivors' perspectives on optimal physician approaches to trauma inquiry in prenatal care	6 participants	Females 18 years or older who were not pregnant, English speaking, history of at least one live birth, history of remote trauma that included physical or sexual abuses, and willingness/ease discussing trauma-related issues without emotional distress	Focus group made up of a targeted sample of six adult female volunteers

ACE = Adverse Childhood Experience

Appendix 3: Characteristics of Study Participants

Table 3: Characteristics of Study Participants

First Author, Publication Year, Country	Sample Size	Sex (% male)	Age range in years	Forms of History Taking and of Trauma
Literature Synthesis				
Reeves, 2018,[19]	16 empirical publications 10 theoretical publications	Not Reported	Not Reported	Not Applicable Studies of individuals who self-reported having experienced sexual or physical abuse
Primary Studies				
Conn, 2018,[15] USA	15 parents	7%	18-44	ACEs Questionnaire ACEs Questionnaire score ≥3
Purkey, 2018,[18] Canada	26 participants	0%	Not Reported	ACEs Questionnaire ACEs Questionnaire score ≥4
Robinson, 2008,[16] USA	28 military personnel 13 non-military spouses	39%	Not Reported	ACEs Questionnaire ACEs score ≥1
Shannon, 2012,[9] USA	50 refugees	36%	Not Reported	Physician inquiry or patient disclosure during primary care War trauma
White, 2016,[17] USA	6 participants	0%	18-45	Development of a trauma inquiry for physicians to use in routine prenatal care Self-identified sexual trauma

ACEs = Adverse Childhood Experiences

Appendix 4: Quality Appraisal of Included Qualitative Studies

Table 4: Quality Appraisal

Is the study credible?	Is the study trustworthy (dependable and confirmable)?	Is the study relevant (transferable)?
Conn, 2018[15]		
Yes. Choices for specified methods generally well explained and supported by literature.	Partially. The use of a deductive approach could structure how researchers engage with data or participants. While not inherently wrong, this should be acknowledged and reflexively engaged with. The study authors also note in the discussion section that this study was completed with "high-risk parents," although this is the first point readers have been introduced to that terminology. No description is provided of what makes the included participants "high-risk," what they are at high-risk of, or how that is defined.	Yes. As this was a deductive, thematic framework approach that used previous literature to develop topic areas in which to fit participant responses, findings are reflective of other included studies.
Purkey 2018[18]		
Partially. Methods generally well described and choices for their use explained. However, while most exclusion criteria are explained, the option of the primary researcher not wanting to invite an individual to participate was left unexplained. This practice in and of itself does not discredit the study, but it calls into question connections between participant sampling and study findings. Perhaps this decision was a component of the study being a "directed" content analysis which is much more deductive than inductive in its approach.	Partially. High-level and thin analysis. As researchers restricted themselves to the confines of an interview script that was established a priori, possible avenues of exploration important to the participants may have been excluded. A priori scripts are not inappropriate, but a reflexive engagement with what this might do to findings is warranted. Otherwise, the links between data and findings are well supported throughout.	Partially. As this was a deductive, directed content analysis approach that used previous literature to develop topic areas in which to fit participant responses, findings are reflective of other included studies. However, as this study was not specifically focused on history taking, there are aspects that veer from the purpose of this report.
Robinson, 2008[16]		
Yes. Content-based analysis of semi-structured, open-ended interviews briefly, and well described.	Partially. The study findings are limited and largely representative of the data itself (i.e., sentence setting up explanation of quotes, then quote). Similarly, the connections between data and analysis can feel tenuous at times. As such, while the data are considered trustworthy, the analysis is less so due to its undeveloped and unsupported nature.	Partially. While this study takes place within the US military (an already highly surveilled space), acknowledgement of this context helps to make sense of participant responses. Similarly, well-articulated methodological choices help to make sense of this study in light of others.

Is the study credible?	Is the study trustworthy (dependable and confirmable)?	Is the study relevant (transferable)?
Shannon, 2012[9]		
No. Described as a content analysis (of in-person interviews) following the constant comparison method. No indication whether the interview questions were open-ended. No recording device used, thus content available for analysis derived from "detailed notes." While all participants noted as refugees, no indication as to how long participants had resided in North America which could impact things like comfort with healthcare system or relationship with care provider. No sense of reflexive engagement with how aspects of study design may impact findings (i.e., short length of interviews, location within primary care rather than walk-in clinic).	Partially. Raw data is used to buffer analytical findings, but the connections between the two can seem tenuous or forced at times. Similarly, analytical findings seem superficial and more oriented toward aggregative yes/no responses. While there was no reflexive engagement regarding normative assumptions of trauma (e.g., importance of disclosure), the researchers' decision to interview three Liberian healthcare professionals as a way of providing validation and explanation for findings indicates some reflexive thought regarding normative assumptions of care. Similarly, while the discussion section notes the importance of educating refugees on the collaborative nature of doctor-patient relationships, no indication that collaboration would include anything other than care provider changing wording around trauma.	Yes. As the only study exploring the perspectives of refugees in the context of North American primary care clinics, this study adds to our knowledge of the history taking experiences of marginalized populations. That being said, as both credibility and trustworthiness are either tenuous, transferability should be understood at a very high level.
White, 2016[17]		
Partially. While most methodological steps were noted, there was no reflexive engagement with why these steps were chosen and how they best addressed research question. For example, it is unclear why the researchers chose to recruit this particular targeted sample. Also, no mention of analytic method, although seems like thematic analysis. However, choice of focus group over individual interviews is well explained and supported by the literature.	Partially. Findings are high-level and thin analysis. Impossible to know how well findings reflect the data as only minimal supporting data is offered.	Partially. Considered alongside the whole body of evidence, some data presented in this report support other observations, and should be interpreted in light of other analyses.
Reeves, 2015[19]		
Yes. As a literature synthesis, the methodological steps are well noted and the reasoning behind them described.	Yes. Findings are well-articulated and supported. Clear indication there was reflexive thought on how these findings emerged from within the literature.	Partially. While the overall synthesis is methodologically well-articulated, there is a bit of confusion on where included studies lay in terms of study and population characteristics. The characteristics of eight of the included 26 studies were detailed which makes it

Is the study credible?	Is the study trustworthy (dependable and confirmable)?	Is the study relevant (transferable)?
		difficult to know how populations or other characteristics compare across studies.