SAFE Questions: Overcoming Barriers to the Detection of Domestic Violence

BRENDA NEUFELD, M.D., San Xavier Health Center, Tucson, Arizona

Although domestic violence is an important public health problem in this country, several barriers tend to hinder its detection by physicians. Physicians may lack knowledge about the subject, harbor attitudes that hinder detection or lack the necessary skills to address patients who are victims of domestic violence. The SAFE questions—which address the areas of safety, abuse, friends' and family's knowledge and emergency plans—can be used to identify affected patients. In addition, these questions provide the physician with a logical framework for counseling and intervention.

Physical and sexual violence against women are increasingly being recognized by the medical and mental health communities as major public health problems. Conservative estimates put the number of women assaulted by their partners at 2 to 4 million per year.[1] Recent research suggests that domestic violence results in more injuries requiring medical treatment than rape, auto accidents and muggings combined; it may be the most common source of serious injury to women.[2] In response, the American College of Obstetrics and Gynecology and the American Medical Association (AMA) have launched campaigns to educate practitioners about the problem, and the American Academy of Family Physicians is working to implement recommendations made in a recent White Paper.[3-5]

Until recently, issues of domestic violence were rarely addressed by the health care profession. Many physicians still lack basic knowledge of the prevalence of domestic violence and its mental and physical costs. Education about domestic violence continues to be sparse in medical school and residency curricula.[6-9] Practicing physicians demonstrate low rates of inquiry about domestic violence with their patients.[10]

Thus, despite an increased focus on domestic violence, there continue to be deficiencies in physician identification and treatment of victims of the problem. These deficiencies occur in the areas of knowledge, attitudes and skills. This article discusses the epidemiology of domestic violence and the clinical presentations of its victims, reviews practitioner attitudes that may be barriers to the identification and treatment of victims and, finally, presents an introduction to the SAFE questions as a tool for detecting domestic violence in an office setting, as well as a framework for intervention strategies.

Epidemiology of Domestic Violence

Domestic violence can be defined as a pattern of coercion or assault used by an adult or adolescent to force a partner or spouse to comply with his or her wishes. This control can take many forms, including physical, psychologic and sexual abuse. Although data on domestic violence vary, it is clear that women are more likely to be victims of assault, rape or murder by a male partner (current or former) than by all other types of assailants combined.[11] In a recent study[12] of emergency department patients, the cumulative lifetime exposure to domestic violence was 54 percent. Even

in women without current partners, 5 percent had experienced domestic violence within the previous 30 days. In one study,[13] however, only 5 percent of 107 victims of domestic violence seen in a metropolitan emergency department were identified as such in the physician's note. A survey[10] of adult female patients in a family practice clinic found that 22.7 percent had been physically assaulted by their partners within the past year.

There is great variation in the profiles of patients affected by domestic violence. Neither demographic factors nor psychologic problems have been found to be consistent predictors of victimization or violence.[14] Domestic violence cuts across all racial, socioeconomic, religious and ethnic lines.[15] The only consistent risk factor for being the victim of domestic violence is being female, and actions perpetrated by men against female partners tend to be more aggressive, more numerous and more severe than actions by women against men.[11]

Just as victims have no common set of traits, no consistent predictive personality factors have been found in men who commit domestic violence.[2] Although alcohol and drug use can worsen violence, no causal relationship has been established between alcohol or drugs and domestic abuse.[16] The high use of alcohol by batterers seems to represent an association of one common social phenomenon with another common problem, rather than a cause and effect connection.[17]

Clinical Presentation

Victims of domestic violence can present to a clinician in many different ways. Injuries can be of any type, but are commonly to the head, neck and torso.[1] Patients may have common primary care complaints, such as chronic pain, sleep disturbances, frequent headaches, and abdominal and gynecologic problems.[18,19] Psychologic symptoms resulting from abuse include depression, anxiety, suicide attempts, and alcohol or drug abuse.[20] Most outpatient visits by battered women involve stress-related illnesses, rather than recent physical trauma.[19] Abuse may begin or escalate during pregnancy and has been associated with a variety of pregnancy complications, such as miscarriage, stillbirth and preterm labor.[19]

Physician Attitudes

Because victims of abuse can present with many common complaints and may not spontaneously disclose violence, physician screening has been recommended.[14] However, physicians knowledgeable about domestic violence may still fail to inquire about battering.[21] Sugg and Inui[22] explored the attitudes of primary care physicians toward domestic violence; repeatedly, physicians cited the image of "opening Pandora's box" as a barrier to detection of domestic violence. This metaphor suggests a reluctance to discuss domestic violence because doing so will require the physician to deal with difficult and time-consuming personal and social issues. In one physician's words, "You just don't ask a question that you know is going to open a Pandora's box. Even if it crosses your mind, you don't ask."

In this and other studies, several attitudes emerge as potential barriers to physician queries about domestic violence (*Table 1*).[22,23] These attitudes include fear of

TABLE 1

Physician Attitudes that Hinder Detection of Domestic Violence

Fear of offending their patients
A belief that one's patients are not at risk
Feeling a need to establish the facts of abuse unequivocally
Lack of knowledge about domestic violence
Feelings of failure if the patient's problem is not quickly resolved

Derived from references 22 and 23.

offending patients; physicians may feel uncomfortable addressing an area culturally defined as private. Physicians may think that their patients are not at risk. Some feel the need to establish unequivocally that violence indeed occurred before verbally suggesting the possibility to their patients. Physicians may feel powerless to respond to patients suspected of being victims of domestic violence because of a lack of training in intervention. Because many patients do not immediately leave their partners after being given advice or referral, physicians may think that questioning and intervention are not worthwhile.

Detection

Because of its public health importance, many experts now think that screening for violence should be incorporated into routine medical interviews in various settings. The "Diagnostic and Treatment Guidelines on Domestic Violence" put out by the AMA in 1992 include the following statement: "Domestic violence is sufficiently prevalent to justify screening of all women in medical and mental health settings."[1]

In fact, experts who study domestic violence consistently say that the single most important service physicians can provide to victims is to ask about abuse.[24] Many battered women do not spontaneously disclose information about violence. By opening the discussion, health care providers communicate the message that the problem is important, which is in itself therapeutic.[25] Failure to diagnose abuse, especially if injuries are present, can increase a woman's feelings of isolation and discourage her efforts to leave the relationship. When the questions are made routine, physicians become more comfortable with discussions of domestic violence.

Physicians should always question their patients about domestic violence privately and keep the answers confidential, unless the circumstances make reporting to law enforcement mandatory. Although the abusing partner may insist on being present during the interview, this is not advisable. Discussing violence with a patient while a batterer or potential batterer is present can put the patient at increased risk for further violence. Any descriptions of violence by the patient should, however, be carefully documented in the record. If injuries are present, they should be diagrammed on a body map or, with the patient's written permission, photographed.[26]

TABLE 2

SAFE Questions

Stress/Safety
What stress do you experience in your relationships?
Do you feel safe in your relationships (marriage)?
Should I be concerned for your safety?
Afraid/Abused
Are there situations in your relationships where you have felt afraid?
Has your partner ever threatened or abused you or your children?
Have you been physically hurt or threatened by your partner?
Has your partner forced you to have sexual intercourse that you did not want?
Friends/Family
If you have been hurt, are your friends or family aware of it?
Do you think you could tell them if it did happen?
Would they be able to give you support?
Emergency plan
Do you have a safe place to go and the resources you (and your children) need in an emergency situation?
If you are in danger now, would you like help in locating a shelter?
Would you like to talk with a social worker, a counselor or me to develop an emergency plan?

Derived from reference 28.

SAFE QUESTIONS

A number of screening tools can help physicians identify victims of domestic violence.[27] Although not yet tested and validated in research studies, the SAFE questions have been recommended as a framework for screening (*Table 2*).[28] These questions have the advantages of simplicity and a focus on the safety and empowerment of the victim. The SAFE questions address the following four areas: stress/

safety, *a*fraid/*a*bused, *f*riends/*f*amily, and *e*mergency plan.

Stress/Safety. Questions about stress and safety can be phrased in the following ways: "What stress do you experience in your relationships?" "Do you feel safe in your relationships (or marriage)?" "Should I be concerned for your safety?" Beginning the interview with questions about stress and safety is less threatening to most patients than an immediate inquiry about abuse.

Afraid/Abused. The next area of questioning is about being afraid or abused. Suggested questions include the following: "Are there situations in your relationships where you have felt afraid?" "Has your partner ever threatened or abused you or your children?"

When focusing on abuse, it is important to know how to use a variety of questions. Many victims are reluctant to identify themselves as being abused but will talk about violence if questioned in other ways. One alternate way to phrase a question about abuse is this: "Have you been physically hurt or threatened by your partner?" Recent studies have shown that rape by husbands or boyfriends is a common manifestation of domestic violence, so it may also be important to ask, "Has your partner forced you to engage in sexual intercourse that you did not want?"[11,29]

Yet another question that may lead patients to disclose abuse is "What happens when you and your partner disagree?"

The Author

BRENDA NEUFELD, M.D.
is a family physician with the Indian Health Service at the San Xavier Health Center, Tucson, Ariz. She is also clinical assistant professor in the Department of Family and Community Medicine at the University of Arizona College of Medicine, Tucson. She graduated from the University of Kansas School of Medicine, Kansas City, and completed a residency at the Medical University of South Carolina, Charleston.

Address correspondence to Brenda Neufeld, M.D., San Xavier Health Center, Indian Health Service, 7900 S.J. Stock Rd., Tucson, AZ 85746.

Friends/Family. Questions about friends and family can help the provider assess the patient's degree of social isolation. The physician might ask "If you have been hurt, are your friends or family aware of it?" If the patient denies violence, the provider can still ask, "Do you think you could tell your friends or your family if violence did happen to you, and do you think they would be able to give you support?"

Emergency Plan. The fourth area of questioning pertains to an emergency plan. The patient can be asked, "Do you have a safe place to go and the resources you (and your children) need in an emergency?" "If you are in danger now, would you like help in locating a shelter?" "Would you like to talk with a social worker, a counselor or me to develop an emergency plan?" These questions lead directly into the intervention process.

Intervention

The following intervention strategies are part of an approach to the management of abused patients that can be adopted by most physicians. Although most states do not have mandatory reporting for partner violence, physicians should be familiar with the specific reporting laws of their state. Physicians are legally obligated to report violence to children.[23] Reporting may also be required if the abused partner is an older person.

Patients who have experienced violence but do not want to leave their partners should be offered counseling about emergency plans. That is, the patient should have in mind a way to extricate herself from a violent situation that may arise in the future. Such a plan should be individualized to the patient but will often include the availability of vital documents, an extra set of keys, emergency money, emergency telephone numbers and a packed suitcase.[30] In some cases, it may be unsafe for the woman to have emergency telephone numbers if her partner is likely to find them.[31] When it is safe, the woman should

be given telephone numbers for shelters or battered women's hotlines.

Emergency planning should provide an opportunity for further risk assessment. Physicians should know that the presence of a gun in the home, use of drugs or alcohol by the partner, sexual abuse, increased frequency or severity of battering, and a history of threats of suicide or homicide are potential risk factors for homicide (*Table 3*).[31] Follow-up should be scheduled for ongoing assessment of women who have elected not to leave their partners. Follow-up should also be scheduled if abuse is denied but the provider strongly suspects that it is occurring.

If a woman does want to leave her partner, she should be asked whether she would like to be referred to a battered women's shelter. The National Domestic Violence Hotline (800-799-7233) has a computer database of emergency shelters and other services. An opportunity to file a police report should be provided, and information on filing for court protection should be given.[32] If the woman elects to stay elsewhere or if shelter beds are full, she should be given telephone numbers for services such as battered women's support groups. Ongoing medical follow-up should be arranged.

Patients who have experienced past or present domestic violence should be offered group or individual counseling. Women suffering from associated psychiatric disorders should be treated for these conditions by the primary care physician or referred to appropriate mental health professionals.

Final Comment

As a public health problem of epidemic proportions, domestic violence can no longer be viewed as a private matter. Physicians first need to know about the problem. They then need to examine their attitudes about the issue and determine where barriers to identification of patient victims may exist. Finally, they need the skill to identify and treat victims, with the focus always being on the safety and empowerment of the patient. The SAFE questions provide a simple and logical framework for identification of these patients.

TABLE 3

Factors That Increase the Risk of Homicide in Cases of Domestic Violence

Presence of a firearm in the home
Use of drugs or alcohol by the abuser
Increasing frequency of battering
Increasing severity of injuries
Sexual abuse
Threats of homicide or suicide

Derived from reference 31.

A patient information handout on domestic violence is provided on page 2582.

The author thanks Theresa Cullen, M.D., Barry Weiss, M.D., Frank Hale, Ph.D., and James Ratliff, Ph.D., for assistance in the preparation of this manuscript.

REFERENCES

1. American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence. Arch Fam Med 1992;1:39-47 [Published erratum appears in Arch Fam Med 1992;1:287].
2. Stark E, Flitcraft A. Violence among intimates: an epidemiological review. In: Van Hasselt VB, et al., eds. Handbook of family violence. New York: Plenum, 1988:293-317.
3. American College of Obstetricians and Gynecologists. Domestic violence. ACOG technical bulletin no. 209. Washington, D.C.: American College of Obstetricians and Gynecologists, 1995.
4. Randall T. AMA, joint commission urge physicians to become part of solution to family violence epidemic. JAMA 1991;266:2524,2527.
5. Family violence: an AAFP white paper. AAFP Commission on Special Issues and Clinical Interests. Am Fam Physician 1994;50:1636-40,1644-6.
6. Education about adult domestic violence in U.S. and Canadian medical schools, 1987-88. MMWR Morb Mortal Wkly Rep 1989;38:17-9.
7. Chambliss LR, Bay RC, Jones RF 3d. Domestic violence: an educational imperative? Am J Obstet Gynecol 1995;172:1035-8.

Domestic Violence

8. Hendricks-Matthews MK. A survey on violence education: a report of the STFM Violence Education Task Force. Fam Med 1991;23:194-7.
9. Randall T. ACOG renews domestic violence campaign, calls for changes in medical school curricula. JAMA 1992;267:3131.
10. Hamberger LK, Saunders DG, Hovey M. Prevalence of domestic violence in community practice and rate of physician inquiry. Fam Med 1992; 24:283-7 [Published erratum appears in Fam Med 1992;24:568].
11. Violence against women. Relevance for medical practitioners. Council on Scientific Affairs, American Medical Association. JAMA 1992;267: 3184-9.
12. Abbott J, Johnson R, Koziol-McLain J, Lowenstein SR. Domestic violence against women. Incidence and prevalence in an emergency department population. JAMA 1995;273:1763-7.
13. Goldberg WG, Tomlanovich MC. Domestic violence victims in the emergency department. JAMA 1984;251:3259-64.
14. Saunders DG, Hamberger K, Hovey M. Indicators of woman abuse based on a chart review at a family practice center. Arch Fam Med 1993;2:537-43.
15. Hotaling GT, Sugarman DB. An analysis of risk markers in husband to wife violence: the current state of knowledge. Violence Vict 1986;1:101-24.
16. Straus MA, Gelles RJ. The drunken bum theory of wife beating. In: Straus MA, Gelles RJ, Smith C, eds. Physical violence in American families. New Brunswick, N.J.: Transaction Publishers, 1990:203-24.
17. Sassetti MR. Domestic violence. Prim Care 1993; 20:289-305.
18. Hendricks-Matthews MK. Survivors of abuse. Health care issues. Prim Care 1993;20:391-406.
19. Koss MP, Heslet L. Somatic consequences of violence against women. Arch Fam Med 1992;1:53-9.
20. Carmen EH, Rieker PP, Mills T. Victims of violence and psychiatric illness. Am J Psychiatry 1984;141: 378-83.
21. McLeer SV, Anwar RA, Herman S, Maquiling K. Education is not enough: a systems failure in protecting battered women. Ann Emerg Med 1989; 18:651-3.
22. Sugg NK, Inui T. Primary care physicians' response to domestic violence. Opening Pandora's box. JAMA 1992;267:3157-60.
23. Physicians and domestic violence. Ethical considerations. Council on Ethical and Judicial Affairs, American Medical Association. JAMA 1992;267: 3190-3.
24. Burge SK. Violence against women as a health care issue. Fam Med 1989;21:368-73.
25. Randall T. Domestic violence intervention calls for more than treating injuries. JAMA 1990;264:939-40.
26. Mehta P, Dandrea LA. The battered woman. Am Fam Physician 1988;37(1):193-9.
27. Domestic violence: a directory of protocols for health care providers. Children's Safety Network. Newton, Mass.: Education Development Center, 1993.
28. Ashur ML. Asking about domestic violence: SAFE questions [Letter]. JAMA 1993;269:2367.
29. Russell DE. Rape in marriage. New York: MacMillan, 1982.
30. Campbell JC, Sheridan DJ. Emergency nursing interventions with battered women. J Emerg Nurs 1989;15;12-7.
31. Campbell JC. Nursing assessment for risk of homicide with battered women. Adv Nurs Sci 1986;8:36-51.
32. Keilitz SL. Civil protection orders: a viable justice system tool for deterring domestic violence. Violence Vict 1994;9:79-84.