Screening for intimate partner violence: Understanding SAFE

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abstract

We introduce the SAFE screening tool to help guide students through taking a medical history in the setting of Intimate Partner Violence. Intimate Partner Violence is one of the most common forms of violence experienced in Canada and, more poignantly, we see a much higher incidence of violence among marginalized populations including refugees, persons of varying abilities, and Aboriginal women. In particular, greater than 50% of Aboriginal populations across Canada experience incidents of violence in their lifetime. This article is dedicated to Intimate Partner Violence survivors and their communities and families and strives to enable medical students to take part in the movement toward change.

In the first term of medical school, students are taught to use the acronym FIFE (feelings, ideas, functions, and expectations) while taking a history. As a result, the acronym and its letters help us engage in meaningful history-taking and understand the patient's perspective. Acronyms are powerful memory tools and can be incredibly useful when taking a patient history in the context of violence where many medical students may at times feel uncomfortable. When a patient has unexplained bruises, a black eye, or more subtle signs such as difficulty keeping appointments, what should one do? This article aims to enable change by presenting a straightforward memory tool to help navigate history-taking tasks in the setting of Intimate Partner Violence—are you 'SAFE'?[1]

We bring attention to the SAFE tool within the context of the current social climate in which students practice medicine. In Canada, Intimate Partner Violence is one of the most prevalent forms of violence experienced, making up over one quarter of violent crime reported to the police, and is defined by the Center for Disease Control as:

"Physical, sexual, or psychological harm by a current or former partner or spouse. Regardless of sexual orientation, Intimate Partner Violence can take place in any relationship and does not require sexual intimacy."[3]

Troublingly, we see a much higher incidence of violence among marginalized populations such as refugees, people of varying abilities, and Aboriginal women than in the general population. In British Columbia, the reported rate of all Intimate Partner Violence among Canadian women is 22.2% in their lifetime.[1] Notably, the reported rate of all Intimate Partner Violence among B.C.'s Aboriginal women is 42.1%, almost double the reported rate in non-Aboriginal–identifying populations.[1] Even more concerning is that Aboriginal women experiencing Intimate Partner Violence are more likely to experience extreme and life-threatening violence, such that these populations are reported to be eight times more likely to be killed by their partner as a result of escalating intimate partner violence.[1] It should be noted that while other acronyms are also available, SAFE was chosen by the authors from several presented by the Society of Obstetricians and Gynecologists' (SOGC) Report on Intimate Partner Violence as a Health-Canada recommended screening tool that is gender-neutral, of average length, and simple for interviewers to recall.[1] Most importantly, the SOGC poignantly reminds healthcare providers that while several validated questionnaires exist for Intimate Partner Violence screening, the nature of the patient-physician relationship, and how questions are phrased, is more important than the choice of screening tool.[1] A further discussion around Intimate Partner Violence screening is available in the closing of this article.

So what can be done to create change?

Ask if the patient is 'SAFE'.

S - Spouse. How would you describe your spouse?
A - Arguments. What happens when you argue?
F - Fights. Do you fight? Are you ever slapped, kicked or punched?
E - Emergency Plan. Do you have an escape plan in case of emergency?

The SAFE Acronym begins with an S for "spouse", prompting the interviewer to begin an open and non-judgemental line of questioning that starts with learning more about a patient's partner. One might ask, "How would you describe your relationship with your spouse?" or have the patient characterize their relationship. This is followed by asking if they feel safe, supported, if they tend to be in agreement or disagreement when communicating with their partner, and if they feel loved. Follow the patient's lead to help develop rapport. Being empathetic is more important than phrasing one's questions perfectly. Open ended questions and a safe space for the patient are key to understanding the full context of the patient history.[1]

The next letter, A, stands for arguments. Start by asking "What happens when you and your partner argue?" Then, have the

patient describe how often they fight, who is present in the home when this happens, and if police have ever been called before. You should also ask what the last argument was about. It is essential to phrase questions in a non-judgemental manner to ensure the patient does not feel faulted while sharing information.[1] If children are at risk, engage in further assessment—disclosure may be required by law.[1]

Next, detail fights and what happens when they arise as the F section of the acronym SAFE. Begin with questions such as, "Do you fight? If so, do you ever get hit, punched, slapped, or kicked?" Evidence demonstrates the importance of using descriptive terms such as hit, punched, and kicked to be as clear as possible since terms such as "abuse" or "domestic violence" can be misunderstood, are overly academic, or do not have meaning for patients.[1] Be explicit when asking questions such as: When did the violence start? Has it increased in severity? Are there weapons in the home? Have your children been harmed?

Lastly, the letter E involves completing a safety screen and explicitly eliciting information around a patient's emergency plan. Explain that, much like a fire drill, the patient may want to consider having safety checks in place should the situation necessitate that they leave the home quickly. Leaving an abusive partner is the most dangerous time for women and their children.[1] A safety plan may include an emergency shelter or resource phone numbers, important travel documents such as passports and driver's license, money, and a code word to alert family and friends to the situation. The last detail is especially important if communication lines are being monitored by an abusive partner.

It is fundamental that healthcare providers become comfortable with routinely asking the questions that the SAFE acronym generates. Most recently, the 2013 Canadian Task Force on Preventative Health Care acknowledged that there is not enough evidence within the Canadian population to recommend the regular Intimate Partner Violence screening of women of childbearing age that is encouraged by the United States guidelines on Intimate Partner Violence.[4] However, remember that women do not routinely disclose for many reasons such as "shame and embarrassment, fear of discussing violence, guilt or self-blame, fear professionals will not believe them, and fear of government involvement or disruption to family".[5] For Indigenous women, in particular, the barriers to disclosure may include "fear of stereotypical attitudes and stigmatization, impact of residential schools including mistrust of institutions, threat of apprehension of… children by social service agencies and lack of service or support in remote or rural communities".[5]

While assessment of the effectiveness of Intimate Partner Violence screening tools is fraught with statistical and research limitations,[6,7] and can cite sensitivities as broad as 35-71%,[8] the SAFE acronym is presented here as an easy-to-remember, gender-neutral acronym of moderate length that is notable for being one of the few screening tools integrating open-ended questions.[1] These factors help establish rapport and create a comfortable environment for a survivor of Intimate Partner Violence which the writers feel is necessary for any successful interview. Further screening tools are available from the CDC [9] but it is important to note that emphasis should be placed on the way in which questions are asked more than the type of screening tool utilized.[1] When evaluating further screening tool options, be aware that the sensitivity and specificity of Intimate Partner Violence screening tools is difficult to establish, since the tests need to be compared against a gold standard exam which does not exist in the case of Intimate Partner Violence.[6] Unlike the exemplary screens for hypertension and resultant identification and treatment of a patient, there is no consensus on appropriate action following disclosure in the setting of violence.[1]

In conclusion, simply having conversations around SAFE categories in an empathetic manner, regardless of the formal screening tool used, will help create a safe space for conversation that can help empower the survivors of Intimate Partner Violence. Focus on empowering patients, reinforcing how common domestic violence and interpersonal violence is, and keeping children safe. Together we can work toward eradicating violence in our homes and communities.

This article is dedicated to all communities enduring violence.

disclosures

The authors do not have any conflicts of interest to disclose.

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