University of Nebraska Medical Center
Nebraska Medicine

Graduate Medical Education Research Journal

Volume 4 | Issue 1 Article 6

July 2022

Intimate Partner Violence in Plastic Surgery Practice: Perceptions and Preparedness Amongst Practicing Plastic Surgeons

Sophie L. Cemaj
University of Nebraska Medical Center

Collin J. MacDonald
University of Nebraska Medical Center

Bria R. Meyer
University of Nebraska Medical Center

Erin M. Shriver
University of Iowa Hospitals and Clinics

Sean Figy
University of Nebraska Medical Center

Intimate Partner Violence in Plastic Surgery Practice: Perceptions and Preparedness Amongst Practicing Plastic Surgeons

Abstract

INTRODUCTION

It is estimated that 4 of 10 women in the United States have experienced one or more forms of intimate partner violence (IPV) in their lifetime. The US Preventative Service Task Force recommends that clinicians screen women of reproductive age for IPV and refer women who screen positive to ongoing support services (B recommendation). We aim to identify the perceptions, attitudes, and preparedness of plastic surgeons regarding intimate partner violence

METHODS

An IRB approved survey was sent to members of the American Society of Plastic Surgeons. The survey contained three sections: (1) surgeon and practice demographics, (2) surgeon experience with intimate partner violence and preparedness of using protocols to screen for intimate partner violence, and (3) surgeon attitudes and perception of those experiencing and inflicting intimate partner violence. Four follow-up emails were sent to enhance response rate.

RESULTS

A total of 107 of 2,535 plastic surgeons responded (4.22% response rate), and 81 (75.7%) of them were men. Most surgeons, 57 (64.0%) respondents, estimate that intimate partner violence is rare (year) in their practice while 22 (24.7%) surgeons were unsure of the prevalence. Only 17 (37.8%) surgeons responded that they feel comfortable screening for intimate partner violence while 41 (43.2%) believe that screening protocols are likely to capture patients' experiences. Most surgeons (71.6%) state they have no established protocol if a patient discloses intimate partner violence.

CONCLUSIONS

The prevalence of IPV is well understood, but educational efforts and adequate screening protocols are needed within the plastic surgery community to identify and treat patients experiencing intimate partner violence.

Keywords

IPV, plastic surgery, intimate partner violence, screening

Intimate Partner Violence in Plastic Surgery Practice: Perceptions and Preparedness Amongst Practicing Plastic Surgeons

Sophie L. Cemaj[1], Collin J. MacDonald[1], Bria R. Meyer[2], Erin M. Shriver[3], Sean C. Figy[2]

[1]University of Nebraska Medical Center, College of Medicine
[2]University of Nebraska Medical Center, College of Medicine, Department of Surgery, Division of Plastic and Reconstructive Surgery
[3]University of Iowa Hospitals and Clinics, Department of Ophthalmology and Visual Sciences

https://doi.org/10.32873/unmc.dc.gmerj.4.1.001

Abstract

Introduction: It is estimated that 4 of 10 women in the United States have experienced one or more forms of intimate partner violence (IPV) in their lifetime. The US Preventative Service Task Force recommends that clinicians screen women of reproductive age for IPV and refer women who screen positive to ongoing support services. We aim to identify the perceptions, attitudes, and preparedness of plastic surgeons regarding intimate partner violence.

Methods: An IRB approved survey was sent to members of the American Society of Plastic Surgeons. The survey contained three sections: (1) surgeon and practice demographics, (2) surgeon experience with IPV and preparedness of using protocols to screen for IPV, and (3) surgeon attitudes and perception of those experiencing and inflicting IPV. Four follow-up emails were sent to enhance response rate.

Results: A total of 107 of 2,535 plastic surgeons responded (4.22% response rate), and 81 (75.7%) of them were men. Most surgeons, 57 (64.0%) respondents, estimate that intimate partner violence is rare (<1 time per year) in their practice while 22 (24.7%) surgeons were unsure of the prevalence. Only 17 (37.8%) surgeons responded that they feel comfortable screening for intimate partner violence while 41 (43.2%) believe that screening protocols are likely to capture patients' experiences. Most surgeons (71.6%) state they have no established protocol if a patient discloses intimate partner violence.

Conclusions: The prevalence of IPV is well understood, but educational efforts and adequate screening protocols are needed within the plastic surgery community to identify and treat patients experiencing intimate partner violence.

Keywords: IPV, plastic surgery, intimate partner violence, screening

Introduction

According to the Center for Disease Control and Prevention, intimate partner violence (IPV) is defined as physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse.[1] Over 4 of 10 women in the United States have experienced one or more forms of violence in their lifetimes, including child abuse (17.8%), physical assault (19.1%), rape (20.4%), and intimate partner violence (34.6%).[2] Acknowledging the high rates of IPV is important considering medical professionals often underestimate the prevalence of IPV in their patient populations. [3,4]

IPV is associated with several adverse medical and psychological conditions. In comparison to women with no history of IPV, patients with IPV are 5.89 times more likely to suffer from a substance use disorder, 4.96 times more likely to have family and social problems, are 3 times more likely of being diagnosed with a sexually transmitted disease, and 2.36 times more likely to have depression..[5] Factors associated with IPV including history of depression, anxiety, and motivation for receiving plastic surgery based on relationship issues are associated with poor psychological outcomes after cosmetic surgery.[6]

Although IPV is prevalent, it may be hard to recognize due to a variety of factors. Patients believe that physicians should screen for IPV, but patients who experienced IPV may not be ready to disclose or even recognize that they are victims of IPV.[7] Sensitivity and specificity can vary widely between IPV screening tools and no single tool has well established psychometric properties.[8] Although identifying IPV may be difficult, many specialties have taken on the initiative to recognize and offer assistance to patients who have experienced IPV. Oculoplastic literature indicates that the third leading cause of orbital floor fractures in women is IPV (7.6%) and have called for increased awareness of IPV as a leading mechanism of injury in patients who present with orbital floor fractures.[9]

Due to the high prevalence and the types of injuries associated with IPV, patients experiencing IPV are presenting to plastic surgery clinics. Soft tissue injury is the most common manifestation of physical IPV, accounting for 61% of cases, and 88-94% of female patients who experience IPV have trauma to the head and neck region.[10–12] To our knowledge, there is little understanding of the rates of patients experiencing IPV presenting to plastic surgery clinics and there is minimal research on plastic surgeons' awareness and screening protocols for IPV. The rates of IPV are underestimated or unknown within the plastic surgery community, which leads to lack of adequate screening and treatment options for this patient population. The purpose of this study is to identify the perceptions, attitudes, and preparedness of plastic surgeons regarding IPV. .

Methods

The subject pool for this study included all 2,535 active members of the American Society of Plastic Surgeons (ASPS). ASPS was chosen as it represents 93% of all board-certified plastic surgeons in the U.S.[13] Requests for participation were sent via the organization's electronic mailing list a total of four times between September to November of 2020.

The survey was approved by the IRB at the University of Nebraska Medical Center and adhered to ethical principles stated in the Declaration of Helsinki. The survey was comprised of 27 questions and was administered through SurveyMonkey (SurveyMonkey Inc, San Mateo, California). Participants could elect to not answer some or all of the questions, while still being able to submit the survey. Participant anonymity was maintained, and no personal identifiers were recorded. Questions within the survey focused on surgeon demographics, perception and attitudes towards issues relating to IPV, and current IPV screening protocols. Questions regarding IPV perceptions, attitudes, and screening protocols were minimally modified from a previously validated study which surveyed orthopedic surgeons.[3,14] The survey instrument is available as Supplement 1.

Results

The survey was sent to 2,535 active members of ASPS and was completed by 107 individuals (4.22% response rate). Provider and practice demographics are summarized in Table 1. In total, 81 (75.7%) respondents were male, while 26 (24.3%) respondents

Table 1.
Provider and Practice Demographics

	No. (%) of Respondents
What is your gender? **(n=107)**	
Male	81 (75.7%)
Female	26 (24.3%)
What is your age? (n=107)	
<35	4 (3.7%)
35-44	19 (17.8%)
45-54	33 (30.8%)
55-64	29 (27.1%)
65+	22 (20.6%)
What best describes your practice type? **(n=107)**	
Solo Practice	48 (44.9%)
Solo Practice-shared facility	7 (6.5%)
Small group practice (2-5 plastic surgeons)	21 (19.6%)
Large group practice (6+ plastic surgeons)	2 (1.9%)
Medium multi-specialty practice (6-20 physicians)	1 (0.9%)
Large multi-specialty practice (20+ physicians)	4 (3.7%)
Academic practice	12 (11.2%)
Academic practice (salaried with private practice)	4 (3.7%)
Employed Physician	7 (6.5%)
Military	1 (0.9%)
Describe practice in terms of time spent: **(n=107)**	
100% Reconstructive	14 (13.1%)
25% Cosmetic 75% Reconstructive	19 (17.8%)
50% Cosmetic 50% Reconstructive	21 (19.6%)
75% Cosmetic 25% Reconstructive	29 (27.1%)
100% Cosmetic	24 (22.4%)
Do you cover facial trauma call? **(n=107)**	
Yes	46 (43.0%)
No	61 (57.0%)

were female. The respondents were most commonly in solo practice, [48 (44.9%)], or within a small group practice, with 21(19.6%) in a group consisting of 2-5 surgeons. A total of 12 (11.2%) surgeons were in academic practice while 4 (3.7%) surgeons were in academic practice and salaried with private practice. Most surgeons' practices were mixed between cosmetic and reconstructive work, with 14 (13.1%) surgeons solely performing reconstructive procedures and 24 (22.4%) surgeons solely performing cosmetic procedures. A majority of those who responded, 61 (57.0%) surgeons, do not cover facial trauma call.

A majority of surgeon, 57 (64.0%) respondents, estimate that IPV is rare (<1 time per year) in their practice, while 22 (24.7%) surgeons were unsure of the prevalence. Plastic surgeons believe that IPV is more prevalent in the community with 24 (26.7%) respondents estimating it is fairly common (quarterly), yet, most surgeons, 47 (52.2%) respondents, are unsure about the prevalence of IPV in their own community. When asked about implementing universal screening for IPV, most surgeons were unsure, [32 (35.6%) respondents], or believe that it should not be implemented, [33 (36.7%) respondents]. Conversely, over half of surgeons surveyed, [53 (59.6%) respondents], believe that targeted screening for IPV should

Table 2.
Attitudes of Plastic Surgeons Toward Issues Relating to IPV

	No. (%) of Respondents
How prevalent is IPV in your practice? **(n=89)**	
Rare (<1 time per year)	57 (64.0%)
Fairly Common (Quarterly)	7 (7.9%)
Very Common (Monthly)	3 (3.4%)
Unsure	22 (24.7%)
How prevalent is IPV in your community? **(n=90)**	
Rare (<1 time per year)	17 (18.9%)
Fairly Common (Quarterly)	24 (26.7%)
Very Common (Monthly)	2 (2.2%)
Unsure	47 (52.2%)
Do you believe universal screening for IPV should be implemented? **(n=90)**	
Yes	25 (27.8%)
No	33 (36.7%)
Unsure	32 (35.6%)
Do you believe targeted screening for IPV should be implemented? **(n=89)**	
Yes	53 (59.6%)
No	6 (6.7%)
Unsure	30 (33.7%)
Do you believe inquiring about personal relationships is an invasion of privacy? **(n=90)**	
Yes	23 (25.6%)
No	44 (48.9%)
Unsure	23 (25.6%)

	No. (%) of Respondents
Do you worry about how patients might react to screening for IPV? **(n=90)**	
Yes	40 (44.4%)
No	29 (32.2%)
Unsure	21 (23.3%)
Who bears the responsibility for Intimate Partner Violence? (select all that apply) **(n=90)**	
The perpetrator	83 (92.2%)
The person experiencing IPV	22 (24.4%)
Society	41 (45.6%)
Do you believe some patients are more likely than others to experience IPV? **(n=90)**	
Yes	65 (72.2%)
No	6 (6.7%)
Unsure	19 (21.1%)
Are you afraid of offending a patient by asking about IPV? **(n=90)**	
Yes	29 (32.2%)
No	47 (52.2%)
Unsure	14 (15.6%)

be implemented. While most surgeons, [83 (92.2%) respondents], believe the perpetrator bears the responsibility for IPV, 22 (24.4%) surgeons also believe the person experiencing IPV bears the responsibility. Attitudes of plastic surgeons toward issues relating to IPV are summarized in Table 2.

Very few surgeons (8.9%) felt "very uncomfortable" addressing issues related to IPV and 17.8% felt "very uncomfortable" discussing appropriate resources and responses to patients disclosing IPV. Interestingly, the majority of surgeons were unsure (21.1%) or did not have developed mechanisms (55.6%) for asking about IPV without putting themselves at risk. Preparedness of plastic surgeons toward issues relating to IPV are summarized in Table 3.

Current provider and practice efforts to identify IPV are summarized in Table 4. While 44 (43.1%) surgeons state that their emergency departments have IPV screening protocols, only 11 (10.6%) surgeons' clinics and 2 (2.0%) surgeons' med spas report having IPV screening protocols. While 41 (43.2%) believe that screening protocols are likely to capture patients experiencing IPV only 17 (37.8%) surgeons responded that they feel comfortable screening and 68 (71.6%) surgeons state they have no established protocol if a patient discloses IPV.

Most surgeons, 62 respondents (65.3%), have not had a patient disclose experiencing IPV and 66 respondents (69.5%) have never personally screened patients for IPV. While 71 (77.2%) surgeons have never received training in IPV, 42 (45.2%) surgeons state that plastic surgeons should receive training. Surgeon experience with IPV is summarized in Table 5.

Discussion

The purpose of this study is to assess the level of knowledge plastic surgeons have with issues relating to IPV and the current protocols the plastic surgery community is using to screen for IPV. The rates of IPV in the community are underestimated or unknown by plastic surgeons which has resulted in a lack of adequate protocols to screen for IPV and lack of preparation for how to handle patients who disclose experiencing IPV. This study aims to bring awareness to the plastic surgery community regarding the rates of IPV and encourages screening protocols to be implemented within a plastic surgery practice setting.

Table 3.
Preparedness of Plastic Surgeons Toward Issues Relating to IPV

	No. (%) of Respondents
How comfortable do you feel addressing issues related to IPV? **(n=90)**	
Very comfortable	14 (15.6%)
Somewhat comfortable	27 (30.0%)
Neutral	18 (20.0%)
Somewhat uncomfortable	23 (25.6%)
Very uncomfortable	8 (8.9%)
How informed do you feel regarding appropriate responses and resources for individuals experiencing IPV? **(n=90)**	
Very comfortable	8 (8.9%)
Somewhat comfortable	17 (18.9%)
Neutral	22 (24.4%)
Somewhat uncomfortable	27 (30.0%)
Very uncomfortable	16 (17.8%)
Have you developed ways of asking about IPV without putting yourself at risk? **(n=90)**	
Yes	21 (23.3%)
No	50 (55.6%)
Unsure	19 (21.1%)

Table 4.
Provider and Practice Efforts to Identify IPV

	No. (%) of Respondents
Do you have IPV screening protocols in**:**	
Clinic (n=104)	
Yes	11 (10.6%)
No	78 (75%)
Not Applicable	15 (14.4%)
Emergency Department (n=102)	
Yes	44 (43.1%)
No	23 (22.6%)
Not Applicable	35 (34.3%)
Med Spas (n=101)	
Yes	2 (2.0%)
No	53 (52.5%)
Not Applicable	46 (45.5%)
Do you feel comfortable screening for IPV using the protocol? **(n=45)**	
Yes	17 (37.8%)
No	8 (17.8%)
Unsure	20 (44.4%)
Do you believe having screening protocols are likely to capture patients experiencing IPV? **(n=95)**	
Yes	41 (43.2%)
No	15 (15.8%)
Unsure	39 (41.0%)
If a patient discloses an experience with IPV, do you have established protocol for further management and referral? **(n=95)**	
Yes	27 (28.4%)
No	68 (71.6%)
If a patient disclosed experiencing IPV, please select the service(s) you would contact or refer to (select all that apply)**: (n=94)**	
Social work	55 (58.5%)
Police	55 (58.5%)
Family	6 (6.4%)
Domestic violence hotline	53 (56.4%)
No referral	3 (3.2%)
Other	8 (8.5%)

Table 5.
Provider Experience with IPV

	No. (%) of Respondents
Have you ever had a patient disclose experiencing IPV? **(n=95)**	
Yes	33 (34.7%)
No	62 (65.3%)
Have you ever personally screened a patient for IPV? **(n=95)**	
Yes	29 (30.5%)
No	66 (69.5%)
For all encounters where a patient has disclosed experiencing IPV, indicate the number of times this has occurred**: (n=31)**	
Fracture or injury related to IPV	29 (93.6%)
Non-IPV-related injury	22 (71.0%)
Cosmetic procedure	24 (77.4%)
Toxin/Filler	23 (74.2%)
Other	13 (42.0%)
Have you ever received training on identifying or managing IPV? **(n=92)**	
Yes	21 (22.8%)
No	71 (77.2%)
Do you believe all plastic surgeons should receive IPV training? **(n=93)**	
Yes	42 (45.2%)
No	21 (22.6%)
Unsure	30 (32.3%)

Plastic surgeons underestimate or are unaware of the rates of IPV within their community and practice. It has been estimated that over 4 out of 10 women have experienced one or more forms of IPV in the United States.[2] Furthermore, in a study conducted by Breiding et al, an overall lifetime prevalence of physical violence and/or unwanted sex was estimated to be 26.4% for women and 15.9% for men.[15] This did not include psychological abuse in its data set. The rates of IPV have consistently been within this range or have risen. A study conducted by the National Violence Against Women Survey (NVAWS), a decade before the Breiding et al study was published, showed 25% of surveyed women and 7.6% of surveyed men reported IPV.[16] Our study demonstrates that over half of surgeons believe IPV is rare within their practice and a quarter are unaware of the prevalence. While a quarter of surgeons believe that IPV is fairly common within their community, almost one quarter believe a majority believe that IPV is rare or are unaware of the rates within their community. Perceiving that IPV is rare or being unaware of the rates of IPV within the clinical and community setting demonstrates a lack of medical training efforts to help providers appreciate the high prevalence of IPV.

One of the most alarming results of this study is the perception of plastic surgeons towards who bears responsibility for IPV. While almost all surgeons believe the perpetrator bears the responsibility for IPV, a quarter of surgeons believe the person experiencing IPV bears the responsibility and around half of surgeons believe society bears responsibility. Perpetrator's perception towards who bears responsibility of IPV in offender intervention programs is a central factor for minimizing the risk of re-offense and increasing the responsibility of assumption.[17–20] Furthermore, victim-blaming attributions are frequently used by offenders to justify their own violent actions and impede a positive change in behavior by intervention programs.[21] While most plastic surgeons attribute the responsibility of IPV to the perpetrator, placing blame on the victim is dangerous by permitting perpetrators to not take responsibility for their violent actions and obstructs a change in behavior by the offender and the recovery process of the victim. Additionally, placing blame on the victim may result in the patient not feeling safe or trusting of the physician, may lead to inadequate patient care due to negative perceptions inflicted on the patient, and could possibly impede patients from receiving needed resources and assistance.

There is a discrepancy between stated comfort level and surgeon preparedness with issues relating towards IPV. While very few surgeons stated they were very uncomfortable addressing issues related to IPV and less than a quarter of surgeons state they are very uncomfortable regarding offering appropriate resources and responses for individuals experiencing IPV, most surgeons were unsure or had no protocol in assessing and reporting IPV. Three-quarters of respondents were unsure or had no developed ways of asking about IPV without putting themselves at risk. A lack of protocol and low rates of screening are not exclusive to plastic surgery. Although the US Preventative Service Task Force recommends that clinicians screen women of reproductive age and refer women who screen positive to ongoing support services (B recommendation), Universal screening remains to be controversial amongst the IPV community and screening for IPV in the healthcare setting remains low.[22,23] Top barriers identified that prevent clinicians from screening for IPV include lack of education regarding IPV, lack of time, and lack of effective interventions.[23] This further emphasizes the need for education with issues related to IPV and standardized and effective protocols for screening and referring patients.

Similar studies exist in other medical specialties. A survey of the Canadian Orthopaedic Association (COA) found the majority of orthopedic surgeons, (80% of 186 surveyed surgeons), believed IPV prevalence in their practice was <1% and 95% of those surveyed believed community prevalence was <10%.[24] Nearly *one third* of surveyed physicians felt personal discomfort discussing IPV, while almost *half* felt they lacked knowledge of appropriate response to IPV. In another study, of 1000 randomly selected physicians from specialties pre-identified as most likely to care for women at the point of initial IPV disclosure (family practice, obstetrics and gynecology, emergency care, maternal/newborn care, and public health), only 42% routinely initiated the topic of IPV in practice with inadequate preparedness cited as a key barrier to routine inquiry.[25] Similarly, obstetricians and gynecologists reported lack of education as the most common barrier to physician inquiry into IPV.[26] A common theme of inadequate training and education about IPV exists among these studies, often accompanied by misperceptions regarding its prevalence.

This study is not without its limitations. The low response rate of 4.22% could be indicative of a non-response bias. In particular, a majority of respondents worked in a solo practice, did not cover facial trauma call, with 50% or more of their procedures being cosmetic. These attributes could result in a lower likelihood of encountering a patient's initial disclosure of IPV.

Conclusions

The plastic surgery field needs further education on issues associated with IPV and protocols should be developed for the

different practices settings to assess patients who may be experiencing IPV. The rates of IPV within the patient population are higher than perceived by plastic surgeons and there is currently no standardized protocol for screening patients for IPV. Further studies and efforts are needed to educate the plastic surgery community on how to best help patients experiencing IPV and an evidence-based standardized screening protocol can be considered for implementation in the plastic surgery setting. ■

References

1 Intimate Partner Violence |Violence Prevention|Injury Center|CDC. Published December 17, 2019. Accessed June 2, 2020. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

2 Plichta SB, Falik M. Prevalence of violence and its implications for women's health. *Womens Health Issues Off Publ Jacobs Inst Womens Health*. 2001;11(3):244-258. doi:10.1016/s1049-3867(01)00085-8

3 Bhandari M, Sprague S, Tornetta P, et al. (Mis) perceptions about intimate partner violence in women presenting for orthopaedic care: a survey of Canadian orthopaedic surgeons. *J Bone Joint Surg Am*. 2008;90(7):1590-1597. doi:10.2106/JBJS.G.01188

4 Sprague S, Kaloty R, Madden K, Dosanjh S, Mathews DJ, Bhandari M. Perceptions of Intimate Partner Violence: a cross sectional survey of surgical residents and medical students. *J Inj Violence Res*. 2013;5(1):1-10. doi:10.5249/jivr.v5i1.147

5 Bonomi AE, Anderson ML, Reid RJ, Rivara FP, Carrell D, Thompson RS. Medical and Psychosocial Diagnoses in Women With a History of Intimate Partner Violence. *Arch Intern Med*. 2009;169(18):1692-1697. doi:10.1001/archinternmed.2009.292

6 Honigman RJ, Phillips KA, Castle DJ. A Review of Psychosocial Outcomes for Patients Seeking Cosmetic Surgery. *Plast Reconstr Surg*. 2004;113(4):1229-1237. doi:10.1097/01.PRS.0000110214.88868.CA

7 Zink T, Elder N, Jacobson J, Klostermann B. Medical Management of Intimate Partner Violence Considering the Stages of Change: Precontemplation and Contemplation. *Ann Fam Med*. 2004;2(3):231-239. doi:10.1370/afm.74

8 Rabin RF, Jennings JM, Campbell JC, Bair-Merritt MH. Intimate partner violence screening tools: a systematic review. *Am J Prev Med*. 2009;36(5):439-445.e4. doi:10.1016/j.amepre.2009.01.024

9 Clark TJ, Renner LM, Sobel RK, et al. Intimate partner violence: an underappreciated etiology of orbital floor fractures. *Ophthal Plast Reconstr Surg*. 2014;30(6):508-511. doi:10.1097/IOP.0000000000000165

10 Saddki N, Suhaimi AA, Daud R. Maxillofacial injuries associated with intimate partner violence in women. *BMC Public Health*. 2010;10(1):268. doi:10.1186/1471-2458-10-268

11 Shepherd JP, Gayford JJ, Leslie IJ, Scully C. Female victims of assault: A study of hospital attenders. *J Cranio-Maxillofac Surg*. 1988;16:233-237. doi:10.1016/S1010-5182(88)80053-2

12 Greene D, Maas CS, Carvalho G, Raven R. Epidemiology of facial injury in female blunt assault trauma cases. *Arch Facial Plast Surg*. 1999;1(4):288-291. doi:10.1001/archfaci.1.4.288

13 About ASPS. American Society of Plastic Surgeons. Accessed December 17, 2020. https://www.plasticsurgery.org/about-asps

14 Maiuro RD, Vitaliano PP, Sugg NK, Thompson DC, Rivara FP, Thompson RS. Development of a health care provider survey for domestic violence: psychometric properties. *Am J Prev Med*. 2000;19(4):245-252. doi:10.1016/s0749-3797(00)00230-0

15 Prevalence and Risk Factors of Intimate Partner Violence in Eighteen U.S. States/Territories, 2005. *Am J Prev Med*. 2008;34(2):112-118. doi:10.1016/j.amepre.2007.10.001

16 Tjaden P, Thoennes N, US Department of Justice: Office ot Justice Programs: National Institute of Justice. Extent, nature, and consequences of intimate partner violence: (300342003-001). Published online 2000. doi:10.1037/e300342003-001

17 Standards for Batterer Programs: A Review and Analysis - JULIET B. AUSTIN, JUERGEN DANKWORT, 1999. Accessed December 17, 2020. https://journals.sagepub.com/doi/10.1177/088626099014002004

18 Lila M, Oliver A, Catalá-Miñana A, Galiana L, Gracia E. The Intimate Partner Violence Responsibility Attribution Scale (IPVRAS). *Eur J Psychol Appl Leg Context*. 2014;6:29-36. doi:10.5093/ejpalc2014a4

19 E. Pence, Paymar M. Education Groups for Men Who Batter: The Duluth Model. *Springer Publ Co*. Published online 1993.

20 Denial, Minimization, Partner Blaming, and Intimate Aggression in Dating Partners - Katreena Scott, Murray Straus, 2007. Accessed December 17, 2020. https://journals.sagepub.com/doi/10.1177/0886260507301227

21 Lila M, Gracia E, Murgui S. Psychological adjustment and victim-blaming among intimate partner violence offenders: The role of social support and stressful life events. *Eur J Psychol Appl Leg Context*. 2013;5(2):147-153. doi:10.5093/ejpalc2013a4

22 U.S. Preventive Services Task Force. Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: US Preventive Services Task Force Final Recommendation Statement. *JAMA*. 2018;320(16):1678-1687. doi:10.1001/jama.2018.14741

23 Waalen J, Goodwin MM, Spitz AM, Petersen R, Saltzman LE. Screening for intimate partner violence by health care providers: Barriers and interventions. *Am J Prev Med*. 2000;19(4):230-237. doi:10.1016/S0749-3797(00)00229-4

24 Della Rocca GJ, Sprague S, Dosanjh S, Schemitsch EH, Bhandari M. Orthopaedic surgeons' knowledge and misconceptions in the identification of intimate partner violence against women. *Clin Orthop*. 2013;471(4):1074-1080. doi:10.1007/s11999-012-2749-x

25 Gutmanis I, Beynon C, Tutty L, Wathen CN, MacMillan HL. Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health*. 2007;7:12. doi:10.1186/1471-2458-7-12

26 Parsons LH, Zaccaro D, Wells B, Stovall TG. Methods of and attitudes toward screening obstetrics and gynecology patients for domestic violence. *Am J Obstet Gynecol*. 1995;173(2):381-387. doi:10.1016/0002-9378(95)90256-2