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Research Article

FAMILIAL, DEMOGRAPHIC, AND MEDICAL PATTERNS OF CONFLICT-INDUCED VIOLENCE AMONG INJURED HOSPITALIZED PATIENTS

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ABSTRACT
The present study examined familial, demographic, and medical patterns of conflict-induced violence among injured hospitalized patients. The population under study included injured patients at Rajaii Hospital in Shiraz; of whom 200 injured patients were selected using availability sampling as the respondents in the research sample. The respondents were asked to fill out the Familial, Demographic, and Medical Patterns of Conflict-Induced Violence Scale (Rouhezamin, 2013). According to the results, a majority of the respondents were male (87.5%). In addition, 62% of the respondents were single, 63.5% employed, 90.6% self-employed, 40% had an education level lower than high school diploma, and 35.5% of them had parents whose education was at an elementary level or they were illiterate (34%). In addition, in most cases, the conflict site was in street (56%) and at home (25.5%). Most conflicts involved the use of fist, kicking, and stick (45.5%) and knives (43.5%). on the other hand, most damages injuries included open wounds (64.5%) in the head (67%) and arms and hands (32%).

Keywords: *Conflict-induced Violence, Family Structure, Demographic Patterns, Battery*

INTRODUCTION
Violence can be considered one of the most serious problems in the world throughout human history (Sahin *et al.,* 2010) such that approximately 3.5 million persons worldwide are victims of violence (Chen *et al.,* 2005). Violence is defined as a behavior by which a person imposes his will on others using physical or nonphysical force (Dehkhoda Dictionary, 1968). In other words, violence refers to the intentional use of physical force and power to threat or a person or group of people with the most likely consequence of beatings, death, psychological harm, inappropriate development, or deprivation (Krug *et al.,* 2002).

In its first global report on violence and health, WHO defines violence as intentional use of physical force or power in a threatening or actual way against oneself, another person, group, or society; causing physical injury, death, psychological harm, delayed growth or exclusion, or in a way that it increases the likelihood of these events. According to statistics released by WHO, approximately 106 million lives worldwide is lost each year due to violence. For example, in 2000, over 165,800 deaths have been reported as a result of violence; accounting for 3% of all deaths. It has been reported that valance is the leading causes of deaths among 15-44 year-old people in the world (WHO, 2001). As was mentioned, conflict-induced violence is known as a kind of violence. Statistics show that the cost of this type of violence in the US totals $ 300 billion a year. In addition, the cost for victims of conflict-induced violence has been estimated to be over S 500000 per year which is equivalent to 10% of the US GDP (WHO, 2004). These statistics point to the significance of conducting a comprehensive investigation of this kind of violence. Of course, there are no exact statistics available in Iran concerning this type of violence. Conflict-induced violence is a harm that is intentionally applied by individual or small group of individuals. This type of harm as a serious problem will threaten the public health in many countries (Wagner *et al.,* 2000; cited in Karbkhsh *et al.,* 2004). Battery refers to impairments resulting from the impact of external factors on the body without apparent disruption of body's tissues and blood flow such as bruising and swelling (Dadnameh Website, 2012).

Injury, on the other hand, refers to damage to the body caused by external factors which is associated with the disruption of the body's tissues and is often accompanied by bleeding such as abrasions and lacerations (Dadnameh Website, 2012). Despite previous research, it should be noted that very little research has examined the relationship between family, demographic, and medical factors and battery among patients. In addition, previous study have failed to reach a conclusion concerning violence-related statistics so that different sources of information in various statistical reports provided different and sometimes inconsistent figures with regard to the level of conflict-induced violence or familial, demographic, and medical patterns of this kind of violence among assaulted patients. Accordingly, the present study is going to provide more accurate statistics of conflict-induced violence through an investigation of opinions of victims of violence as an awareness of actual statistics of the people refer to hospitals a result of violence can help use to determine the impact of familial, demographic, and medical factors related to conflict-induced violence. In addition, the recognition of the impact of each of these factors can pave the way for preventing the recurrence of such violence.

Literature Review

Parekh *et al.*, (2012) studied investigate the prevalence of partner violence among patients affected by injuries and found that 8% of patients suffer from injuries caused by their family partners. In addition 81.6% of women and 18.4% of men revealed injuries and harms made by their partners. Bodaghabadi (2007) examined the prevalence of violence and its related factors among pregnant women at Shahid Mobini Hospital in Sabzevar, Khorasan Province. The results showed that 14.5% of pregnant women were exposed to physical violence by their husbands.

Razzaghi *et al.*, (2010) examined domestic violence and factors affecting it among women referring to medical centers in Sabzevar (2008) and found that the most common psychological violence against women were psychological violence (29.2%), sexual violence (28%), and physical violence (10.8%). Cusimano *et al.*, (2010) studied injury patterns of urban violence and found locations of violence and places where people are injured are closely related. They are also associated with the number bars, housing units, and shelters for homeless people, and household low income. Karbkhsh *et al.*, (2004) examined conflict-induced violence leading to the hospitalization of victims in six emergency centers in Tehran. The results showed that the most vulnerable group in conflict-induced violence is young men. Kelly *et al.*, (2010) conducted a case study of the combined effect of drug treatment by parents and their anger against their children at home and concluded that there is a significant relationship between the use of medications by parents and the exercise of anger toward their children. Gould *et al.*, (2008) conducted a study on drugs and anger in the U.S. and concluded that drug use may increase anger-related behavior.

MATERIALS AND METHODS

Method

The research population included all assaulted patients admitted to hospitals in Shiraz. In addition, 200 assaulted patients at Shahid Rajaii Hospital in Shiraz were selected using availability sampling as the respondents in the research sample.

Instruments

The instrument used in this study was the Familial, Demographic, and Medical Patterns of Conflict-Induced Violence Scale (Rouhezamin, 2013). The scale contained 29 items and three subscales: Family Patterns (6 items), Demographic Patterns (13 items), and Medical Patterns (10 items). Assaulted patients at Shahid Rajaii Hospital were used to develop the scale. Rouhezamin (2013) used content validity to check for the validity of the instrument. To do so, the scale was reviewed by three psychologists and medical experts and they were asked to tell their opinions about the scale items. Then, the items with most favorable opinions were included in the revised version of the scale. Scoring of the scale items varies in different models.

Data Analysis

Descriptive statistics including means and standard deviations were employed in this study to analyze the collected data.

REULTS AND DISCUSSION

Results

Table 1: Descriptive statistics for respondents' age

Standard deviation	Average	Maximum	At least	Count	Variable
8/99	28/92	65	15	186	Age

Table 2: Respondents' demographics in terms of gender

Percent	Abundance	Variable
11/5	23	Woman
87/5	175	Man

Table 3: Respondents' demographics in terms of place of conflict

Percent	Abundance	Variable
56	112	Street
/5	1	School
25/5	51	Home
2/5	5	Recreational sites
13	26	Public place
1	2	Celebration

Table 4: Respondents' demographics in terms of party to conflict

Percent	Abundance	Variable
14	29	Family feud
7	14	Spouse
/5	1	Father-in-law
62/5	125	Anonymous
15/5	31	Neighbor-colleague

Table 5: Respondents' demographics in terms of devices used in conflict

Percent	Abundance	Variable
2	4	Shotguns
1	2	Colt
2	4	Glass
43/5	87	Knife
45/5	91	Punching and kicking, Rod
2	4	Glass and knife

Table 6: Respondents' demographics in terms of hospitalization mode

Percent	Abundance	Variable
68	136	Emergency
27/5	55	Patient
/5	1	Cop
/5	1	Emergency and police

Table 7: Respondents' demographics in terms of types of wound

Percent	Abundance	Variable
64/5	129	Open wound
33/5	67	Wound closure
2	4	Wound open and closed

Table 8: Respondents' demographics in terms of body area wounded

Percent	Abundance	Variable
67	134	Head
6	12	Neck
21	42	Chest
/5	1	Chest and abdomen
10	20	Abdomen
15/5	31	Back
1	2	Genital
/5	1	Leg
12/5	25	Foot
4	8	Hand (from shoulder to fingertip)
1/5	3	Arm (forearm)
32	64	Hand
1	2	Palms

Table 9: Respondents' demographics in terms of number of hospitalization days

Percent	Abundance	Variable
47/5	149	No admission
14/5	29	A day
5	10	Two days
1/5	3	Three days
1/5	3	Four Days
/5	1	Six days
/5	1	Seven days
/5	1	Eight days
/5	1	Ten Days
/5	1	Eleven days

Table 10: Respondents' demographics in terms of types of wound

Percent	Abundance	Variable
39	78	Without Surgery
55/5	111	Surgery
3/5	7	Both cases

Table 11: Respondents' demographics in terms of number of wounds

Percent	Abundance	Variable
37/5	75	A wound
58	116	Multiple wounds

Discussion and Conclusion

Demographic findings of the study concerning the respondents' gender differences indicated that the majority of the respondents (the injured patients) were men accounting for 87.5% of the sample under study. According to international and national statistics, most cases of violence including family, street,

sport, and job violence or violence against women have been committed by men. Different studies about men's involvement in violence have reported various factors such as low education, unemployment, and psychological disorders. Research also shows that men with lower education are more likely to engage in more violent behaviors (Naved & Person, 2005; Pop, 2003). Other studies point to men's unemployment as a factor affecting their violent behavior (Thompson & Kingree, 2004; Walker *et al.,* 2002; Lundeberg, 2004). In addition, Kantor *et al.,* (1994) argue that men with ideas which support the adoption of physical violence 2.17 times are more likely to commit physical violence than men with no such ideas. This is in line with findings of the previous research (e.g., Ole & Annie, 1998; Rand, 1994; Straus, 1993; Asai & Olson, 2004; Karbkhsh *et al.,* 2004). Our findings also indicated that most of the respondents involved in violence (62%) were single. Due to lower age and lower skills, single people are more involved and reckless in conflict. Nouraei and Seidi (2010) found that there is a significant difference between single and married people in terms of their willingness to commit crime and violence in the sense that single people are more willing to commit violence than married people.

The results of the present study showed that most conflicts have occurred in street (56%) and then at home (21.5%). One possible explanation is that conflicts at places such as school and home often occur between people who are familiar with each other beforehand so they are less likely to take legal action or to refer to hospital. On the other hand, in street fights which often happen between unfamiliar people, parties to conflict are more likely to take legal action or to refer to hospital. It was also noted that most conflicts involved the use of fist, kicking, and stick (45.5%) and knives (43.5%). The higher rate of using fist, kicking, stick, and knife can be attributed to the fact there is no legal guarantee against prohibition of carrying and using such devices. For instance, lots of men especially those with lower sociocultural positions in the society carry sticks or knives under the pretext of self-defense (Karbkhsh *et al.,* 2004). Some studies found that sometime people carry knives as they think it will increase their masculinity and power and use them in violent conflicts (Wright & Correa, 1997). This is consistent with other studies (Strauss, 1986; Gelles, 1986; Karbakhsh *et al.,* 2004; Pournaghash, 2005). In addition, this study found that most injuries occur in the victim's head (67%) followed by his hands (32%). This can be contributed to attackers' and victims' intentions as in most cases violent actions is taken to harm the victim rather than to kill him and thus the victim's head is a part this is most likely to be affected. Besides, the victim tries to protect his head against the attacker's blows by buffering his hands (Karbakhsh *et al.,* 2004). This is supported by other researchers (Shepard & Shepland, 1990; Eli & Annie, 1990; Wright & Correa, 1997; Pyne-James & Dean, 1994; Karbakhsh *et al.,* 2004). The results of the present study showed that most injuries were open wounds. One reason is that people with injuries other than open wounds are less likely to refer to hospital as indicated by Buchart and Brown (1991) and Karbkhsh *et al.,* (2004).

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