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ASSOCIATION OF PTSD SYMPTOMS WITH THE QUALITY OF LIFE IN THE CONFLICT AFFECTED PEOPLE IN NORTH HALMAHERA

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ABSTRACT

Political instability, civil conflict, war, genocide, persecution, and the attendant violations of human rights are increasingly recognized as paramount public health concerns (Marshall et al, 2005). Conflicts in various regions in Indonesia so far has led to its own social problems, such as the buildup of refugees, social cleavage which causes crisis social, poverty, unemployment, and limited access for the poor in resources. According to the United Nations High Commissioner on Refugees, there were approximately 19.2 million refugees, internally displaced persons, and asylum seekers worldwide in 2004 (Marshall et al., 2005). In the Consolidated Inter-Agency Appeal for Indonesia in 2003, noted that the number of people who are very affected by various conflicts since 1999 to reach 3 million people, while the vulnerable groups to reach 40 million people, or one-fifth of the entire population of Indonesia. Exposure to conflict has been associated with lower quality of life (QoL) even after the end of the actual hostilities. The effects of war-related events may persist for many years. Several studies have suggested that trauma is associated with physical as well as mental health problems, especially post-traumatic stress disorder (Krause, 2014). Posttraumatic stress disorder has been found to be associated with decreased quality of life, poorer physical health, and problems with social functioning (Steel et al., 2011). The research design is cross sectional design. This design is best suited to studies aimed at finding out the prevalence of a phenomenon, situation, problem, attitude or issue, by taking a cross-section of the population.

Keywords : PTSD, Quality of Life

Ketidakstabilan politik, konflik sipil, perang, genosida, penganiayaan, dan pelanggaran hak asasi manusia semakin dikenal sebagai masalah kesehatan masyarakat (Marshall et al, 2005). Konflik di berbagai daerah di Indonesia selama ini telah menyebabkan masalah sosialnya sendiri, seperti penumpukan pengungsi, tidak meratanya tingkatan sosial yang menyebabkan krisis sosial, kemiskinan, pengangguran, dan akses masyarakat miskin yang terbatas. Menurut Komisaris Tinggi Perserikatan Bangsa-Bangsa tentang Pengungsi, ada sekitar 19,2 juta pengungsi, orang-orang yang kehilangan tempat tinggal di seluruh dunia pada tahun 2004 (Marshall et al., 2005). Dalam KonsolidasiNegara-Negara Gabungan untuk Indonesia pada tahun 2003, dicatat bahwa jumlah orang yang sangat terpengaruh oleh berbagai konflik sejak tahun 1999 mencapai 3 juta orang, sedangkan kelompok rentan mencapai 40 juta orang atau seperlima dari keseluruhan penduduk Indonesia.Terpapar konflik dikaitkan dengan kualitas hidup yang lebih rendah (QoL) bahkan setelah berakhirnya konflik tersebut. Efek dari peristiwa yang berhubungan dengan perang mungkin bertahan selama bertahun-tahun. Beberapa penelitian menunjukkan bahwa trauma dikaitkan dengan masalah kesehatan fisik dan mental, terutama gangguan stres pasca trauma (Krause, 2014). Gangguan stres posca trauma telah ditemukan terkait dengan penurunan kualitas hidup, kesehatan fisik yang buruk, dan masalah disfungsi sosial (Steel et al., 2011). Desain penelitian adalah desain cross sectional. Desain ini paling sesuai untuk penelitian yang bertujuan untuk mengetahui prevalensi suatu fenomena, situasi, masalah, sikap atau masalah, dengan mengambil bagian lintas populasi.

Kata kunci: PTSD, kualitas hidup

1. Background

Posttraumatic stress disorder (PTSD) is a debilitating psychiatric condition that can be triggered by exposure to extraordinarily traumatic events (Wang et al., 2012). PTSD is one of the important issues in public health, with an average of 8% prevalence in the general population which cost up to 3 billion US dollars per year (Kesler, 2000). Post traumatic stress disorder is a condition that is very common and destructive, but only a small percentage of patients who get treatment and help early (NICE, 2005). PTSD is considered as one part of an anxiety disorder (Benedek & Ursano, 2009).

PTSD has been associated with an increased risk of co morbidity such as depression and anxiety (Spitzer et al., 2008). Most research has been conducted with Holocaust survivors, former prisoners of war and combat veterans, but recent research has identified other types of potentially traumatic events experienced by the elderly such as the death of a loved

one, physical injury, and serious disease (Elklit and O'Connor, 2005; Chung et al., 2008; 2009).

Several studies have suggested that trauma is associated with physical as well as mental health problems, especially post-traumatic stress disorder (Krause, 2014). The traumatic event itself was defined as an event that involved a "recognizable stressor that would evoke significant symptoms of distress in almost everyone" (Leys, 2006). Posttraumatic stress disorder has been found to be associated with decreased quality of life, poorer physical health, and problems with social functioning (Steel et al., 2011).

PTSD is associated with impaired quality of life among both Veterans and non veterans (Schnurr, 2009). There has been a similar rise in recognition of how mental disorders can affect quality of life. Since 2000, there have been no fewer than 6 reviews of quality of life in anxiety disorders (Mendlowicz & Stein, 2000; Mogotsi, Kaminer, & Stein, 2000; Olatunji, Cisler, & Tolin, 2007; Quilty, Van Amerigen, Mancini, Oakman, & Farvolden, 2003; Schneier & Pantol, 2006; Seedat, Lochner, Vythilingum, & Stein, 2006 in Schnurr, 2009).

Health-related quality of life refers to the physical, psychological, social and health, seen as distinct and influenced by one's experiences, beliefs, expectations and perceptions about health (Testa & Simsonson, 1996). Quality of life is a term used to convey a sense of well-being, including aspects of happiness and overall life satisfaction. Health is an important domain of overall quality of life domains such as employment, housing, school and neighborhood. Aspects of culture, values, and spirituality are an important aspect of quality of life that adds complexity of measurement (CDC, 2000). Measurement of quality of life includes 6 domains of quality of life (physical, psychological, independence, social, environmental and spiritual) and 2 general perceptions (perception of quality of life and health). Domain scores showed a positive direction (higher score indicates a higher quality of life) (WHO, 1996). Lost and severity of the disease can have an impact on quality of life (Wiggins et al., 2004).

Exposure to war has been associated with lower quality of life (QoL) even after the end of the actual hostilities. The effects of war-related events may persist for many years. Research has established a high prevalence of mental disorders in war-affected populations, in particular posttraumatic stress disorder (PTSD) and depression. However, wars and armed conflicts also cause lasting changes in social conditions through increased poverty, lack of employment, community violence, inadequate living circumstances and changed social networks (Matanov et al., 2013).

2. Post Traumatic Stress Disorder (PTSD)

Posttraumatic stress disorder (PTSD) can be a debilitating consequence of severe or life-threatening trauma (Breslau et al., 2002). The disorder is associated with a number of symptoms that can broadly interfere with personal functioning and quality of life, including social withdrawal, anger and aggression, and sleep disturbance (Begic & Jokic-Begic, 2001; Carroll et al., 1985; Hoge et al., 2007; Kehle et al., 2011). Furthermore, PTSD is often complicated by other mental health problems (Kehle et al., 2011; Kilpatrick et al., 2003). Given a diagnosis of PTSD, epidemiological studies have documented elevated risk for a broad spectrum of disorders, including depression, anxiety disorder, panic disorder, conduct disorder, personality disorders, and multiple types of substance abuse (Axelrod et al., 2005; Scherrer et al., 2008; Wolf et al., 2010). PTSD can develop after a person experiences a traumatic event.

There are 2 types of trauma, the physical and mental trauma. Physical trauma includes the body's response to injury or serious threat. Mental trauma includes thoughts and feelings are painful and frightening that a response to a serious injury. Mental trauma can produce strong feelings and extreme behavior such as excessive fear, feelings of helplessness, withdrawal, lack of concentration, sleep disturbances, irritability, excessive vigilance, flashbacks and fear reactions that a loved one will get hurt or die (Flannery, 1999).

Symptoms of PTSD can cause substantial distress and interfere with social and educational functioning (National Institute for Health & Clinical Excellence, 2005 in Trickey, et al, 2012). PTSD is an important outcome because it can affect the whole person, impairing psychosocial and occupational functioning and overall well-being (e.g., Kuhn, Blanchard, & Hickling, 2003; Schnurr, Hayes, Lunney, McFall, & Uddo, 2006; Stein, Walker, Hazen, & Forde, 1997 in Schnurr, 2009).

2.1 Quality of Life

Since 1948, when the World Health Organization defined health as being not only the absence of disease and infirmity but also the presence of physical, mental, and social well-being. Quality of life is defined as physical, mental, and social well-being (World Health Organization, 1948 in Schnurr, 2009). Over the past few decades, quality of life has gained recognition as an important component of health (e.g., Gladis et al., 1999; Kaplan, 2003; Katschnig, 2006, in Schnurr, 2009). In contrast with the traditional biomedical model, the outcomes model of healthcare places value not only on increasing life expectancy (or quantity of life), but also helping patients to feel better about the quality of their lives (e.g., Kaplan, 2003; Patrick & Erickson, 1993 in Schnurr, 2009).

Quality-of-life assessment measures changes in physical, functional, mental, and social health in order to evaluate the human and financial costs and benefits of new programs and interventions. The terms

"quality of life" and, more specifically, "health-related quality of life" refer to the physical, psychological, and social domains of health, seen as distinct areas that are influenced by a person's experiences, beliefs, expectations, and perceptions (which we refer to here collectively as "perceptions of health"). Each of these domains can be measured in two dimensions: objective assessments of functioning or health status and more subjective perceptions of health (Testa& Simonson, 1996). Aspects of culture, values and spirituality are also an important aspect of quality of life that adds to the complexity of the measurement (CDC, 2000).

Quality of life is an impact health status consisting of objective and subjective effects. In the specific usage, the term quality of life is an evaluation of a person's existence in his life according to cultural norms and expectations as well as personal concerns that are subjective (Gibney et al., 2008). Quality of life consists of a collection of interaction goals and subjective dimensions, which may change from time to time in response to a state of health, life and experience (Folasire et al., 2012).

In the field of medicine and health care services research, the interest for the health related quality of life (HRQL) has represented a progress respect to the simple investigation of diseases and their symptoms. HRQL represents those parts of quality of life that directly relate to an individual's health so that the quality of life of an individual varies depending on one's state of health as well as on many other factors. A major concern in the debate about the quality of life in medical and health care was the sense and the extent to which judgments on quality of life had to be objective or subjective (Gigantesco & Giuliani, 2011).

2.1.1 Conflict in North Halmahera

Political instability, civil conflict, war, genocide, persecution, and the attendant violations of human rights are increasingly recognized as paramount public health concerns (Marshall et al., 2005). Conflicts in various regions in Indonesia so far has led to its own social problems, such as the buildup of refugees, social cleavage which causes pain in the social, poverty, unemployment, and limited access for the poor in resources. This problem could be a potential conflict in the future if not immediately resolved by political policies and adequate development (Trijono et al., 2004). Refugee problem in Indonesia has reached a critical level (alarming). Due to conflicts in various regions, Indonesia was ranked in the country with the largest number of refugees in Asia.

According to the United Nations High Commissioner on Refugees, there were approximately 19.2 million refugees, internally displaced persons, and asylum seekers worldwide in 2004 (Marshall et al., 2005). In the Consolidated Inter-Agency Appeal for Indonesia in 2003, noted that the number of people who are very affected by various conflicts since 1999 to reach 3 million people, while the vulnerable groups to reach 40 million people, or one-fifth of the entire population of Indonesia. WFP national survey conducted in early 2002 showed that the internally displaced are scattered in various provinces that form a pariah class (underclass) who lived with unemployment, poverty, and poor health. Post-conflict areas in need of development programs that are sensitive to the conflict and the need for sustainable peace and strategic measures of institutional capacity building to overcome the structural tensions that still exist, either caused by unresolved conflicts roots (the roof causes of the conflict) as well as the handling of the problems caused by the conflict (Trijono et al., 2004).

North Maluku conflict originated from ethnic conflicts triggered by Regulation No. 42/1999 on Local Government amalgamation of five villages in the district to the District Kao Malifut. The government's decision has resulted in some people said that the conflict in North Maluku is a pure conflict of interest of the local political elite. When examined, the North Maluku conflict is a continuation of conflict Ambon. North Maluku conflict can be specified into conflict Kao-Malifut, Tobelo and Galela where it claimed the third area more than other areas in the province and that area location in North Halmahera. In Kao-Malifut conflict, the data of victims who died 6 people, 6 people were seriously injured (found), 5 people were slightly injured, 1653 houses burned, 4 damaged church buildings, one school burned, burned 1 health center, 16313 displaced people (Tindage, 2006). The conflict resulted in Tobelo 880 people died, 215 people were seriously injured, 825 houses damaged units, 2 units damaged church buildings, 17 mosques damaged units (North Maluku Provincial Government, Chronology Riots 1999: 4) and other public facilities damaged and residents who fled the area amounted to 20 655 people. Conflict in districts Galela 197 people died, 355 people suffered minor injuries and serious injuries, 19,234 people evacuated. Tobelo is area of refuge for people who target the Christian religion, because Tobelo is one of the largest Christian populations in North Maluku, but when conflict occurs, some Christian citizens to flee Tobelo North Sulawesi and Sorong. Citizens of Muslim majority flee to Ternate and South Morotai (Tindage, 2006). Christian refugees who enter the territory Tobelo, totaling 27,695 people (7,164 households) are derived from the surrounding area were also affected by the conflict Tobelo (Tindage, 2006).

3. Method

The design of this study is descriptive correlation research that aims to reveal correlative relationship between the dependent variable and independent variables using cross sectional approach (Nursalam, 2003). The research design is cross sectional design. This design is best suited to studies aimed at finding out the prevalence of a phenomenon, situation, problem, attitude or issue, by taking a cross-section of the population. They are useful in obtaining an overall "picture" as it stands at the time of the study. They are designed to study some phenomenon by taking a cress-section of it at one time (Kumar, 1999).

The study population is all communities in Kao-Malifut, Tobelo and Galela who exposed directly to the conflict in north Halmahera. The sample is a subset of the population that is actually taken from the sampling frame.

In the study, the sample criteria include criteria for inclusion and exclusion criteria where these criteria can determine whether or not the sample can be used (Hidayat, 2007). Inclusion criteria for the study subjects were men and women in the age range 28-45 years old because when conflict happened they were adolescent or adult, lived in conflict area where conflict happened on 1999-2000, in good health and aware and willing to be a research subjects can be evidenced by a sign of approval.

Data collection techniques used in this study was a questionnaire is a method of data collection or a research on an issue that is generally a lot of public interest (Notoatmodjo, 2010). Questionnaire method is a list of questions to others in order for the person who is willing to provide a response was given in accordance with the request of researchers. All scales used in this study are based on a Likert scale with five categories of possible answers.

Secondary data is data that is obtained by performing document review reports related institutions such as the Central Bureau of Statistics, Social Services and Disaster Management Agency. The data on PTSD symptoms will be collected from The Posttraumatic Stress Disorder Checklist (PCL) that includes 17 items that describe DSM-IV symptoms of PTSD. Data on quality of life will be collected from WHOQOL (Indonesian language version) that include 26 statements.

Validity and reliability is a measure that states the extent to which the measuring instrument can give different results when performed relatively repeated measurements of the same object. Validity means the extent to which the precision and accuracy of a measuring instrument to perform the functions of measurement (Azwar, 2010). To determine the extent to which the precision and accuracy of a measuring instrument in performing its functions, it is necessary to take measurements carefully to the questions. Correlation value of at least 0.30 is valid if it is less than the validity coefficient of 0.30 is usually considered as unsatisfactory (Azwar, 2010). To determine the validity of the measuring instrument researchers used a technique of Pearson product moment correlation.

Level of reliability with Cronbach alpha method is measured by a scale of 0 to 1 alpha (Budi, 2006). Based on test validity by using the Pearson product moment correlation for each item at PCL are valid. Coefficient Cronbach alpha of 17 of valid items was 0,960, for the reliability of PTSD is valid and is in the category can be relied upon to measure the variables because it has a high reliability (> 0.06) (Ghozali, 2009).

Based on test validity by using the Pearson product moment correlation with SPSS for windows version 16.0 for each item at WHOQOL are valid. Coefficient Cronbach alpha of 26 of valid items was 0,959, for the reliability of quality of life is valid and is in the category can be relied upon to measure the variables because it has a high reliability (> 0.06) (Ghozali, 2009).

4. Result and Discussion

Correlation tests performed in this study using the Pearson correlation test for normal distribution of data and scatter diagram shows the linearity met. PTSD symptom correlation results with each domain are as follows: results of PTSD symptom correlation with quality of life domain 1 of - 0.1197 and significant value of 0.2047 (p> 0.05); PTSD symptom correlation with quality of life domain 2 of - 0.0531 and significant value of 0.5746 (p> 0.05); PTSD symptom correlation with quality of life domain 3 of - 0.2734 and significant value of 0.0032 (p <0.05); PTSD symptom correlation with quality of life domain 4 of - 0.0590 and significant value of 0.5331 (p> 0.05). The result of PTSD symptom correlation with quality of life is – 0.1291 and significant value 0.1709 (p>0.05).

A study has a significant relationship if the correlation coefficient $-1 \leq x \leq 1$ (Budi, 2006). On the results of PTSD symptoms and quality of life show that domains 1 shows the degree of relationship between variables is very weak, has a significant negative direction when the symptoms of PTSD is high then low quality of life, and there was no significant correlation (p> 0.05). On the results of PTSD symptom correlation with quality of life domains 2 shows the degree of relationship between variables is very weak and has a negative direction, and there was no significant correlation (p> 0.05). On the results of PTSD symptom correlation with quality of life domains 3 shows the degree of relationship between variables is weak and has a negative direction, the correlation revealed a significant (p <0.05). On the results of PTSD symptom correlation with quality of life domains 4 shows the degree of relationship between variables is very weak and has a negative direction, and there was no significant correlation (p> 0.05). The result of PTSD symptoms with the quality of life shows that relationship

between variables is very weak and there was no significant correlation (p>0.05).

Post traumatic stress disorder (PTSD) is an anxiety disorder that appears to follow psychological stress and traumatic events such as natural disasters, accidents, war or rape. Conflicts in North Halmahera is one traumatic event due to a prolonged and resulted in much loss of property and loss of loved ones and this will affect the quality of life there in the future.

This study aimed to determine the relationship between PTSD symptoms and quality of life in society are never exposed to the conflict in North Halmahera 1999-2000. The results showed symptoms of PTSD are not related quality of life, especially in the domain of physical, psychological, and environmental. Symptoms of PTSD have a weak but significant correlation with social relationships domain.

Individuals with posttraumatic stress disorder (PTSD) experience reduced quality of life. For example, a recent study found that 59% of PTSD patients had severe quality of life impairment, which was comparable to 63% of patients with major depression (Rapaport.,et al 2005 in Schnurr et al, 2006). Furthermore, prospective cohort studies have found that initial PTSD predicts poor life quality at subsequent follow-up intervals. There also is growing evidence that quality of life improves following treatment for PTSD. PTSD symptoms were associated with reduced quality of life before treatment. There were synchronous effects of symptom change on change in quality of life but no significant lagged effects (Schnurr et al, 2006).

Conflict that occurred 14 years ago had an impact on PTSD symptoms and quality of life in the community of North Halmahera. Frequent exposure to the conflict resulted in the issue has become one of culture in social life. Time may be needed in order for immediate improvement in symptoms to affect quality of life. For example, a person whose avoidance and irritability decrease following treatment may not show improvements in social functioning for months afterward because of the time it takes to make and rebuild friendships. The effects of PTSD symptom improvement on physical health might be delayed given the complexity of factors hypothesized to underlie the relationship between PTSD and poor physical health (Schnurr & Green, 2004). Traumatic experience is not always continuing in the form of PTSD. Foa and Rothbaum (1998) suggest that for some, the trauma can be resolved with the passage of time, but others do not.

5. Summary and Recomendation

Post traumatic stress disorder (PTSD) is an anxiety disorder that appears to follow psychological stress and traumatic events such as natural disasters, accidents, war or rape. Conflicts in North Halmahera is one traumatic event due to a prolonged and resulted in much loss of property and loss of loved ones and this will affect the quality of life there in the future. PTSD symptoms are not related quality of life, especially in the domain of physical, psychological, and environmental. Symptoms of PTSD have a weak but significant correlation with social relationships domain. Conflict that occurred 14 years ago had an impact on PTSD symptoms and quality of life in the community of North Halmahera. Frequent exposure to the conflict resulted in the issue has become one of culture in social life. Time may be needed in order for immediate improvement in symptoms to affect quality of life.

Although the symptoms of PTSD do not have a significant relationship with quality of life in society are exposed to the conflict in North Halmahera, we still focus on improving the quality of life by improving the material living conditions, since the goal should be to facilitate overall resilience and to heal the psychological wounds as well. Strategies that help modify the coping strategies are also likely to be of benefit; the focus suggested by our results is to reduce emotion-oriented coping and increase task-oriented coping. Avoidance-oriented coping, instead of emotion-oriented coping, is also likely to be beneficial at least in the shorter time perspective. The subjects are likely to benefit from changes in the organization structure of the shelters that promote the appropriate modification of the coping strategies and also encourage increased social support.

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