THE INFLUENCE OF GROUP SUPPORTIVE THERAPY ON FAMILY ABILITY TO TRAIN"SELF CARE" CHILDREN WITH MULTY DISABLED VISUALLY IMPAIRED (MDVI) IN SLB G RAWINALA JAKARTA

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ABSTRACT

The reactions and perceptions of parents towards their children 's influence affect the way they care for and have an impact on the level of development and self - care of children. The purpose of this study was to determine the effect of supportive group therapy on the ability of parents to train self care for double blind children in SLB G Rawinala East Jakarta. The design used in this study was a quasi experiment pre-post test with control group with 51 respondents, consisting of 26 respondents for the control group. This therapy is mutual support therapy, given in 4 sessions and carried out for 6 weeks. Parental cognitive, affective and psychomotor abilities were analyzed using T test, Chi-Square and simple Linear Regression. The results showed a significant increase in parental ability after being given therapy in the intervention group.

Keywords: parental ability, supportive group therapy, self, care, double blind.

Background

Mental health is something that is needed by everyone to produce quality human beings who are free from mental disorders. According to Stuart & Laraia (2005), mental health is a state of well-being characterized by feelings of happiness, balance, feeling satisfied, self-achievement and optimism.

Law No. 36 of 2009 concerning mental health states that mental health efforts are intended to ensure that everyone can enjoy a healthy mental life, free from fear, pressure and other disorders that can interfere with mental health. These efforts consist of preventive, promotive, curative, rehabilitation of patients with mental disorders and psychosocial problems. Every citizen has the right to get rights in mental health services which include equality of treatment in every aspect of life in various settings in the community.

One community order that has the right to live a healthy life as stated in the Law, is a family that has children with special needs, namely families that have children who are different from normal children in mental characteristics, sensory abilities,

communication skills, social behavior or physical characteristics (Kirk and Gallagher, 1986). Wiliam (in Hallahan & Kauffman, 2006) states that children with special needs are divided into 9 categories, one of which is severe disabilities which in Indonesian is called tunamajemuk or tunaganda.

Based on the National Census data (Susenas) in 2003, people with multiple disabilities according to the type of disability and types of regions, rural and urban, were 5.64%. Persons with multiple disabilities according to the type and causes of disability are as follows, congenital birth 57.47%, accidents / natural disasters / riots 16.13% and because the largest percentage of causes of disability is congenital birth, the psychological burden caused by the presence of children should be anticipated.

Mangunsong, et al. (1998) defines a disabled child as a child who has a combination or combination of two or more physical or mental disorders or disabilities that require educational, psychological, medical, social and vocational services to exceed the services usually available to children with a single disability. intended so that children can develop their abilities optimally as optimal as possible.

In connection with this research, tunaganda is more focused on multiple disabilities and visual impairment (MDVI) or as other double-blind people, ie someone who has "limitations" physically, sensory, mentally or is a combination of their lack of vision, compared to those who have development and also normal education (Tilstone et al, 2004).

Families that have children with special needs, including double-blind children, are also a community mental health problem. Parents and all family members tend to react negatively, such as being shocked, denying, angry, embarrassed, feeling worthless, disappointed, sad, grieving, etc. (Zelalem, 2002). The reaction arises because the response from "loss" of the expectation of the birth of a baby is normal and the reality is not the case.

Reactions that arise for the presence of children with special needs, (Blacher, 2002) divides it into three stages. First, parents are said to experience a period of emotional crisis characterized by shock of regret and distrust. In the second stage, this reaction is followed by a period of

emotional irregularities which includes changes in feelings from anger, guilt, depression, shame, low self-esteem, rejection of children and excessive participation. In the third stage is the stage where they begin to accept their child. This is the phase of loss.

This can be understood, because the condition of children with dual blindness has several characteristics that require more attention, among others, the average of them is slow to learn new skills, difficulties in applying and maintaining new skills learned, communication difficulties, physical and motoric development disorders, ability of independent care (self care) and repetitive behavior that is not appropriate (Heward, 1996).

All reactions experienced by parents have an impact on all children's development. This happens reciprocally, children experience developmental delays because parents, are still in reaction to emotional crises and emotional irregularities. Parents continue to be in that position, because they tend to think that their children will not be able to develop. According to Warren and Trachtenberg, (1987, in Zelalem, 2002), perceptions of parents of their child's special needs influence how to care for and care for their children.

Although double blind children have all their limitations and characteristics, they still need learning opportunities. Every child, both "normal" and has special needs, should have equal opportunities in education and teaching (Carolina, 2006), even the involvement of parents becomes greater in education for their children. This shows that parents play an important role in the process of growth and development of their children, especially in children's independence for daily activities and self care (Miles% Rigio, 1999).

Keterlibatan orangtua dalam membelajarkan dan The involvement of parents in teaching and training their children can be enhanced by the provision of psychotherapy. Some psychotherapy that can be given to families is the Psychotherapy group, the Education Group, Self Help Group (Videbeck, 2006), supportive groups (Rockland, 1993 in Stuart, 2005; Teschinsky, 2000 in Videbeck, 2006), and Multiple Family Therapy (Anderson , et al., 1986 in Bedell et al., 1997). From a variety of psychotherapy that are useful in optimizing family empowerment in

training the self-care abilities of multiple blind children, supportive groups are an alternative therapy option aimed at improving the family's ability to be a support system. Supportive Group is an organized therapy to help members exchange experiences on certain problems in order to improve their coping. Supportive Group is aimed at reducing family burden and increasing family coping and increasing social support (Fadden, 1998, Witux, et al., 2000 in Chien et al., 2006).

General Purpose: It can be obtained an overview of the Effects of Group Supportive Therapy on Family Ability to Train "Self Care" for Children with Dual Blindness

Research Methods

This study was a quasi experimental study with a quantitative method using the design of "Quasi experimental prspost test control group" with supportive therapy intervention groups on May 23 to June 10, 2010. The sampling technique was Concecutive sampling. The study was conducted to analyze the improvement of the family's ability to train child care in comparing groups who got and who did not receive supportive group therapy. Respondents numbered 51 people. The statistical test used was univariate and bivariate with dependent analysis and independent sample t-test and Chi-Square and simple linear regression with display in the form of tables and frequency distributions.

Result

The study was conducted at the Bakti Luhur Jakarta SLB school, of 51 respondents, 26 respondents who received supportive group therapy and 25 respondents who did not receive supportive group therapy, the results of the analysis were as follows:

a. The results of the analysis of family characteristics showed that a total of 51 parents were included in this study with an average age of 40.27 years with the youngest age of 18 years and the oldest 57 years, the most family education was secondary education (graduating junior high and high school) 74.3% the family is working at 83.8% and the level of family income shows that the largest proportion of families shows that the largest proportion is families with income of more than 1 million, 87.6% and under 1 million at 12.2%. The most family relationships with

children are biological parents of 78.4%.

Table 1. Analysis of Group Equality Before Supportive Groups are given

Ability	Group	N	Mean	SD	SE	T	P *Value*
Cognitive (pre Test)	Intervention	26	20,42	1,629	0,139	1,563	0,127
	Control	25	19,24	3,431	0,686		
Affective (pre test)	Intervention	26	52,46	3,361	0,659	1,975	0,555
	Control	25	50,08	5,049	1,010		
Psychomo r (Pre test)	Intervention	26	21,69	5,555	1,089	1,059	0,226
	Control	25	26,36	3,377	0,675		

Table 2. Family Ability Analysis in both groups before supportive group therapy

Group	N	Mean	SD	Median	Min-Maks	95% CI
Intervention	26	20,42	1,629	21,00	16-23	19,77-21,08
Control	25	19,24	3,431	20,00	6-23	17,82-20,66
Intervention	26	52,46	3,361	53,00	46-59	51,10-53,82
Control	25	50,08	5,049	50,00	41-Be59	48,00-52,16
Intervention	26	21,69	5,555	23,50	9-29	19,45-23,94
Control	25	26,36	3,377	28,00	19-30	24,97-27,75

Table 3 Family Capability Analysis before and after therapy for supportive groups in both groups

Ability	**n**	**Mean**	**SD**	**SE**	**T**	***P-Value***
Cognitive						
Pre Test	26	20,42	1,629	0,319	-2,403	0,024
Post Test	26	21,62	2,228	0,437		
Difference		1,20	0,599	0,118		
Affective						
Pre Test	26	52,46	3,361	0,6059	-5,318	0,000
Post Test	26	58,31	4,662	0,914		
Difference		5,85	1,302	0,255		
Psychomotor						
Pre Test	26	21,69	5,555	1,089	-5,590	0,000
Post Test	26	26,69	4,269	0,837		
Difference		5,00	1,286	0,252		
Cognitive						
Pre Test	25	19,24	3,431	0,686	2,000	0,057
Post Test	25	19,04	3,446	0,689		
Difference		-0,20	0,015	0,003		
Affective						
Pre Test	25	50,08	5,049	1,010	-1,365	0,185
Post Test	25	50,20	5,066	1,013		
Difference		0,12	0,017	0,003		
Psychomotor						
Pre Test	25	26,36	3,377	0,675	1,693	0,103
Post Test	25	26,20	3,317	0,663		
Difference		-0,16	0,060	0,012		

b. Equality Test Results of family characteristics, namely age by using independent T-Test and family relations, education, work and income between the intervention group and the control group, using the Chi-Square test were equivalent (p-value> 0.05). In table 1 shows the equality of family abilities in the intervention group and the control group.

The following is the result of an analysis of the family's ability to train self-care of children before supportive group therapy shows an average (1) average cognitive ability of 19.83, standard deviation of 2.025, minimum score of 6 and maximum value of 23, (2) Affective ability is 51.23 standard deviation 4.205, minimum value is 41 and maximum value is 59. For the average psychomotor ability is 24.03, standard deviation is 4.47, minimum value is 9 and maximum value is 30. Minimum value for cognitive ability is 0 and a maximum value of 23 while the minimum value of affective ability is 17 and the maximum value is 68, and for psychomotor abilities the minimum value is 0 and the maximum value is 30. Results can be seen in table 2.

The ability of the family to practice self care for blind blind children, in groups that received TKS and family groups that did not receive TKS, before and after TKS was tested, using dependent paired T-tests, the results are presented in table 3.

The results of the analysis in Table 3 show that before and after giving TKS, family groups that received TKS had a significant increase in cognitive, affective, and psychomotor abilities in training self care for blind blind children. On cognitive abilities increased significantly by 1.2 with p = 0.024 (ὰ = 0.005). This increase has shown the average score of cognitive abilities to be included in the good category (minimum score of good category = 15.5). Affective ability also increased significantly by 5.85 with p = 0.000 (ὰ = 0.05). This increase has shown that the average score of affective ability is included in the good category (minimum score of good category = 46.5). Significant improvement also occurred in psychomotor abilities which was equal to 5.00 with p = 0,000 (ὰ = 0.05). This increase has also made the average score of psychomotor abilities reach the minimum limit of good categories (minimum score of good category = 20.5).

The results of the statistical test can be concluded that at alpha 5%, before and after the TKS, there was a significant increase in the average cognitive, affective, and psychomotor abilities in the family group who received TKS in training self care for blind blind children ($p < \alpha$ 0.05)

Family cognitive and psychomotor abilities in training self care for blind blind children before and after, in a family group that did not get TKS occurred a decrease. Cognitive abilities fell by -0.16 with a decrease of -0.2 with p = 0.057 (α = 0.05). Psychomotor ability has decreased by -0.16 with p = 0.103 (α = 0.05) while the affective ability of the family in training self care for children with dual blindness, before and after, has a nonsignificant increase of 0.12 with p = 0.185 (α = 0.05) is the same as (p-value> 0.05). The results of the statistical test can be concluded that at alpha 5% there was a non-significant increase in family cognitive abilities in training self care for double blind children in the group who did not receive TKS before post-TKS (P <5 0.05) but there was a decrease in cognitive abilities and family psychomotor with (p> α 0.05).

The results of the analysis in Table 3 show that the difference in increase in cognitive, affective and psychomotor abilities in the family group who received TKS was significantly higher compared to the family group who did not get TKS (P <5 0.05).

The difference in the ability of the family to train self-care for dual blind children in the family group who did not receive TKS was carried out using the independent T-Test. The results of the analysis are presented in the following table 5.10:

Table 4 Analysis of family abilities in ATG Self Care training after supportive group therapy in both groups

Group	N	Mean	SD	SE	T	P-Value
Intervention	26	21,61	2,228	0,437	3,158	0,003
control	25	19,04	4,336	0,689		
Difference		4,21	0,447			
Intervention	26	58,31	4,663	0,94	5,940	0,000
control	25	50,20	5,066	1,013		
Difference		3,92	3,125			
Intervention	26	26,69	4,269	1,026	3,287	0,006
control	25	26,20	3,317	0,837		
Difference		14,10	0,336			

The results of the analysis in Table 4 show that there are significantly higher differences in cognitive, affective, and psychomotor abilities, in families who received TKS compared to family groups that did not get TKS (p <5 0.05), that is, respectively (0.003 ; 0,000; 0,006).

Social support given to families through supportive group therapy, is one of the interventions to increase the potential of parents as a source of coping for

individuals and main teachers, for children with special needs (Miles & Regio, 1999). The family is the biggest source of development for children, related to the role of parents to empower children to do selfcare.

Factors that contribute to the ability of the family to train self care for blind blind children, including age, education, employment, income and family relations and supportive group therapy, were analyzed using a simple linear regression correlation test.

The results of the analysis are obtained as follows: a. the contribution to the cognitive ability of the family in training self care for children with multiple visual impairments shows that there is no contribution to family characteristics with (p> ὰ 0.05). Obtained the coefficient of determination (R square) of 0.285, this means that the variable TKS has the opportunity to increase cognitive abilities by 28.5% while the rest by other factors.

As for family affective abilities, results were obtained: there were no family characteristics (age, occupation, income and family relations) that contributed to the affective ability of the family in training self care for blind blind children, with (p> ὰ 0.05) except education (p < ὰ 0.05). The coefficient of determination (R square) is 0.585, this means that the TKS variable has the opportunity to increase affective abilities by 58.8% while the rest is by other factors.

For psychomotor abilities, it shows that there are no family characteristics (age of family relationship, education, employment, and income) that contribute to the family's psychomotor abilities in training self care for children with multiple visual impairments (p> 5 0.05). The value of the coefficient of determination (R square) is 0.459, this means that the TKS variable has the opportunity to increase psychomotor abilities by 45.9% while the rest is by other factors.

Based on the results of the above analysis it can be concluded as follows, that supportive group therapy can be an alternative to overcome the difficulties of parents in caring for and training children. Family characteristic factors, do not affect the ability of the family to train children, this is in line with the opinion of Fontaine (2003), that the main characteristic of the ability of families to care for their children

is the ability to produce productive stress. This means that families need psychosocial ventilation (psychological burden) in training their children, so parents need to gather with other parents who have the same child (Mitchel & Brown, 1991).

According to Seligman & Darling (1997), the ability of parents to educate, teach and collaborate with professional staff is strongly influenced at the stage of parent's denial of their children with special needs. Warren and Trachtenberg, 1987 (in Zelalem, 2002), emphasize that perceptions of parents on their children's specific needs influence how to care for and care for their children. This is because the delay in the development of the child or the independence of the child in doing self care is determined by the stage of parent's acceptance of the child.

(Through supportive group therapy, parents learn from each other together, share experiences, situations and problems so as to reduce the psychological burden and improve individual coping skills to complete unpleasant experiences, ignorance of confusion and stressful situations from each member's condition (Grant Iramu, 1997 in Hunt, 2004).

Based on the above, the researchers argue that the ability of families to train children is not determined by family characteristics (not contributing), but is determined by a sense of comfort in accepting children's limitations, which in turn motivates parents to teach children about self care. Berdasarkan hal tersebut diatas, peneliti berpendapat bahwa kemampuan keluarga melatih anak tidak ditentukan oleh karakteristik keluarga (tidak berkontribusi), tetapi ditentukan oleh rasa nyaman menerima keterbatasan anak, yang selanjutnya memotivasi orangtua untuk membelajarkan anak dalam hal *self care.*

Conclusion

a. Family characteristics that have double blind children on average are 40.3 years old. The family group that received TSK averaged 42.54 years old while the family group that did not receive TSK averaged 38 years.
b. Respondent characteristics for the intervention group and the control group and the ability of parents to provide self care training, before getting group supportive therapy increased significantly. In the intervention group.

c. The effect of group supportive therapy on the ability of parents to provide self care exercises before and after group supportive therapy increased significantly. In the intervention group.
d. The increase in the ability of parents to provide self care training to parents who received supportive group therapy was significantly higher compared to groups that did not receive supportive group therapy significantly higher than those who did not receive supportive group therapy.
e. Supportive group therapy has the opportunity to increase cognitive abilities by 28.5%, and improve affective abilities by 58.5% and psychomotor abilities by 45.9% after being controlled by other factors.
f. The ability of parents to provide self care training is not influenced by family characteristics, namely: age, education, work, income and family relationships.

Suggestions

Related to the conclusions of the research results, there are several suggestions, namely:

a. An organization organization needs to be established that allows the soul nursing service area to expand in the world of education, especially SLB. Follow-up is coordination between the Ministry of National Education (Directory of Special Education) with the Provincial Health Office through SLB education institutions and mental nursing.
b. The Ministry of Health of the Republic of Indonesia sets out a policy to improve health promotion efforts in health promotion groups in healthy groups based on community according to the mental health issue in the world, namely community empowerment. Understanding of community is understood together as a large, formal and informal area.c. Organisasi profesi menetapkan terapi suportif kelompok sebagai salah satu kompetensi dari perawat spesialis keperawatan jiwa.
c. Build networks to collaborate with schools in conducting continuous training to parents and it is hoped that this will become a pilot project for similar schools. It can be started from school insulated with SLB G Rawinala and educational institutions of the Faculty of Nursing.
d. Nursing tertiary education should develop therapy for healthy groups in order to improve family capacity in a

variety of social settings, including the world of education.

e. Evidence based in developing techniques for the provision of mental nursing care for all health service settings in the application of group supportive therapy for families who have children with special needs, maybe even other therapies.

f. The need for further research is carried out on the wider community, for the use of other specialist therapies.

g. Further research is needed for the role of other parents in children with special needs using the same or different methodologies.i. Perlu diteliti lebih lanjut tentang faktor perancu lain, misalnya usia anak karena ada pendapat semakin dini usia anak dilatih, semakin banyak kesempatan mengembangkan potensinya.

h. Need to improve the implementation of therapy; module or evaluation tool.

i. The instruments that have been carried out in this study should be used as a measurement tool and refined for the same therapy.

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