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Meta-analysis

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Improving Clothing Skills and Self-Esteem in Mentally Retarded Children with Self-Modelling Videos in Gondangrejo Karanganyar District: A Case Report

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ABSTRACT

Background: Children with mental retardation have below-average cognitive functions that can affect the overall level of intelligence, such as cognitive, motor, language, and social abilities. Improving skills in daily life, especially the use of clothing, is one of the important things that needs to be done. This case report aims to discuss how dressing skills and self-esteem in children with retardation with self-modeling videos.
Subjects and Method: An 8-year-old child with moderate mental retardation has a learning disability with mild criteria, Initial complaints are known that the child has a dependence on parental assistance in terms of performing the skill of wearing clothes. Initial examination found that there was poor mental development which was characterized by low skills during the development period which affected cognitive ability, the patient also had a history of low self-esteem with a score of 12.
Results: We reported the case of an 8-year-old child with moderate mental retardation who was given a self-modelling video to improve clothing and self-esteem skills. Patients were given modeling with videos that were assessed in 3 phases, namely the initial phase, the intervention phase, and the maintenance phase, the results showed an improvement curve in the ability to wear clothes and skills in patients.
Conclusion: Self-modeling videos or Video Self Mondelin (VSM) is one of the effective and relatively simple interventions for children with mental retardation.

Keywords: self-esteem, video, self-modelling, mental retardation.

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BACKGROUND

Children with mental retardation have below-average cognitive function which can affect their growth and development. Mental retardation is defined as a mental development problem that is often encoun-

tered in children, characterized by disturbances during development that will affect the overall level of intelligence, such as cognitive, motor, language, and social abilities (Pratiwi et al., 2017). Below-average intellectual function conditions that cause adaptive behavior disorders will manifest during the developmental period (Kurnia et al., 2019). These health problems have been found all over the world, including in Indonesia.

Based on data from the World Health Organization (WHO) in 2019, it is estimated that more than 450 million children experience mental disorders or mental retardation in the world. Mental retardation accounted for about 12% in 2019 and is expected to increase by 15% in 2020 of the world's population (World Health Organization, 2019). The results of Riskesdas (2018) show that as many as 3.3% of parents in Indonesia give birth to children with disabilities, one of which is mental retardation. Based on the Center for Data and Information Technology, Ministry of Education and Culture in 2020, the number of children in public and private SLBs in Surakarta in 2019/2020 was 2,290 children (Ministry of Education and Culture, 2020).

The learning techniques used can use giving examples or providing modeling, role play and practice or repetition (rehealing). Modeling is learning through observation and is not only imitating but is a cognitive process and can use the media of actual objects, including sounds, images and humans. A technique that involves demonstrating the desired behavior through video is called video modeling, which involves both individuals to see a demonstration of a recorded video and then the individual can imitate the behavior of the model in the video.

According to (Kathleen & Emily, 2007) modeling videos that can be used include adults, peers, groups, siblings, and themselves as models (Video Self Modelling/VSM). For the sake of increasing, Dorwick (2011) revealed that VSM is a specific application of video modeling that allows children to imitate targeted behavior by observing themselves in performing-certain behaviors. VSM can also be interpreted as an effective modeling to-modify children's behavior in improving their pilgrim crab (Hitchcock et al., 2003). This case report aimed to discuss how the perpetratorswear clothes and self-esteem in children with retardation with self-modeling videos.

CASE PRESENTATION

Ms. C, 8 years old, is a child with mental retardation and has a learning disability with mild criteria, Initial complaints are known that the child has a dependence on parental assistance in terms of doing the best in wearing clothes.

During the process of wearing clothes, patients are often accompanied by their mothers and cannot carry out these activities independently. Patients are always facilitated and assisted by their parents if they experience difficulties and are given the right example, however, this method does not alleviate the patient's difficulties in carrying out these activities.

In the patient, it was found that there was incomplete mental development which was characterized by low skills during the development period which affected cognitive ability, the patient also had a history of low self-esteem with a score of 12 at the time of the initial examination, this data was obtained from observations made 3 times by observers.

RESULTS

Baseline data was collected after parents signed a consent sheet to be a respondent.

This baseline data is taken to obtain basic data or preliminary data on the ability of res-ponden in the skill of wearing clothes. The data collection began with the observation of the children wearing clothes documented in the matan sheet. This observation began equally for all three respondents. The length of baseline data is three data points. Penga-matan is related to the assessment of the child's ability to independently perform tasks in the task analysis sheet that has been prepared. Children are asked to wear clothes without being given assistance and direction, observe which tasks children can and cannot do.

Table 1. Baseline phase

Session	Steps to be taken independently	Percentage (%)
1	7/16	81.25
2	9/16	75.0
3	12/16	81.25

Table 1 explains that the length of the baseline condition is as many as three data points, the results show that the patient is able to perform about 7 to 12 tasks out of 16 tasks in the data collection sheet. The data also appears to vary, but is not much different.

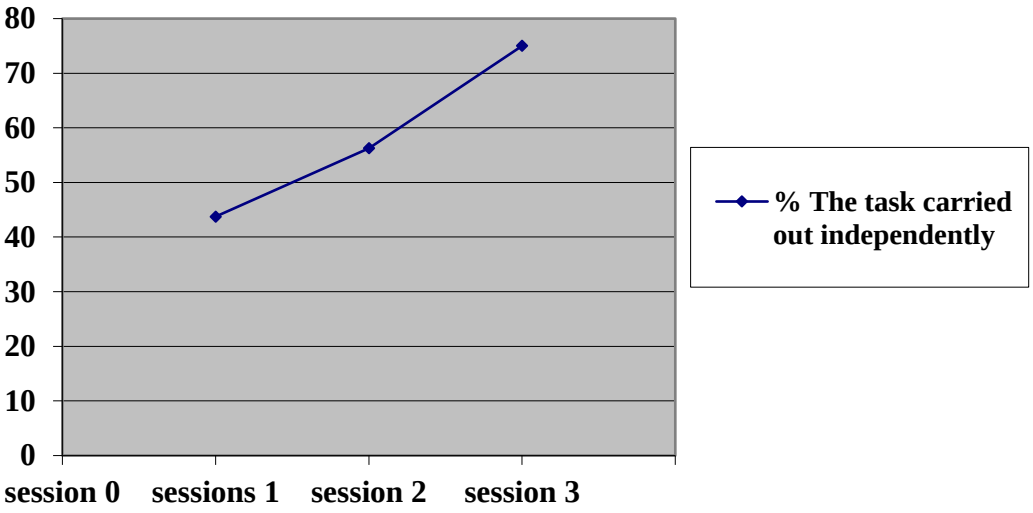

Figure 1. Baseline phase graph

Figure 1 explains the data points (scores), which are as many as three data points in three observation sessions. From the three data points, it appears that the data is stable. The level of stability can be seen from the small range of data and the low level of variation. If the mean of all data is 54.17%, then the difference between the data and the mean ranges from 10.42% below the mean, 8.33% above the mean. In general, if all data is still at 15% above and below the mean, then the data is said to be stable.

At the level change level, it can show how much data changes occur in a condition. This can be calculated by determining the size of the first and last point data in this baseline phase. The differenceis to subtract large data from small data so

that it can be determined whether the difference indicates an improving direction.

Figure 1 also explains that the first score is 43.75, while the last score is 56.25, so the difference is 12 in accordance with the purpose of the intervention.

The trend (trend/slope) of the chart from session to session needs to be assessed to provide an overview of the behavior of the subject being studied. From Andra's baseline data, it appears that the data varies, to determinethe trend is carried out by the freehand method, which is to observe directly from the data points on a condition. Using this method,Andra's baseline data showed that the level of direction of the crane increased, which meant that the behavior of the subjects studied showed an increase in the tendency of the crane. With stable data conditions, a good level change directionand an increasing trend of direction, after obtaining three data points, it was decided to proceed to the intervention phase.

Table 2. Intervention phase

Session	Steps to be taken independently	Percentage (%)
4	13/16	43.75
5	12/16	56.25
6	13/16	75.0

Table 2 is an intervention condition of three data points, the resultsshow that Andra's child is able to performabout 12 to 13 tasks out of 16 tasks in the data collection sheet. The data also seems to vary, but is not much different. A total of 12 tasks out of 16 tasks can be done independently in 5 sessions and 13 tasks independently in 4 sessions and 6 sessions. A total of 12 tasks and 13 tasks were also able to be carried out independently in 3 sessions.

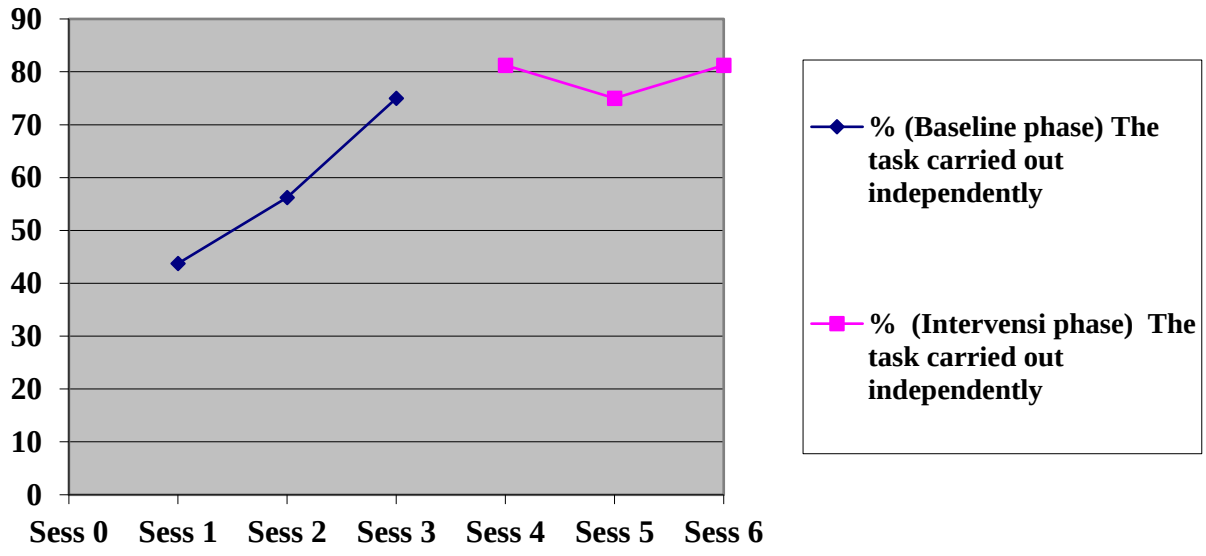

Figure 2. Intervention phase graph

Figure 2 is a graph of the intervention phase, it is illustrated that the number of data points (scores) of the intervention phase is five data points in five training sessions. From the five data points, it-appears that the data is stable. The level of-

stability can be seen from a small range of data anda low level of variation. If the mean of all data is calculated to be 79.2%, then the difference between the data and the mean is around 4.2% at the bawah mean and 2.1% above the mean. Ingeneral, if all data is still at 15% above and below the mean, then the data is said to be stable.

From the level change in the intervention condition of the child, the first score is 81%, while the last score is 75% as well, so the difference is -6%. The largest score is 81%, the smallest score is 75%, if subtracted, the result is 6%. When comparing the results from -6% to 6%, it shows an improvement (therapeutic) direction in the phase or condition of the intervention.

Table 3. Maintenance phase

Session	Steps to be taken independently	Percentage (%)
7	13/16	81.25
8	15/16	93.75

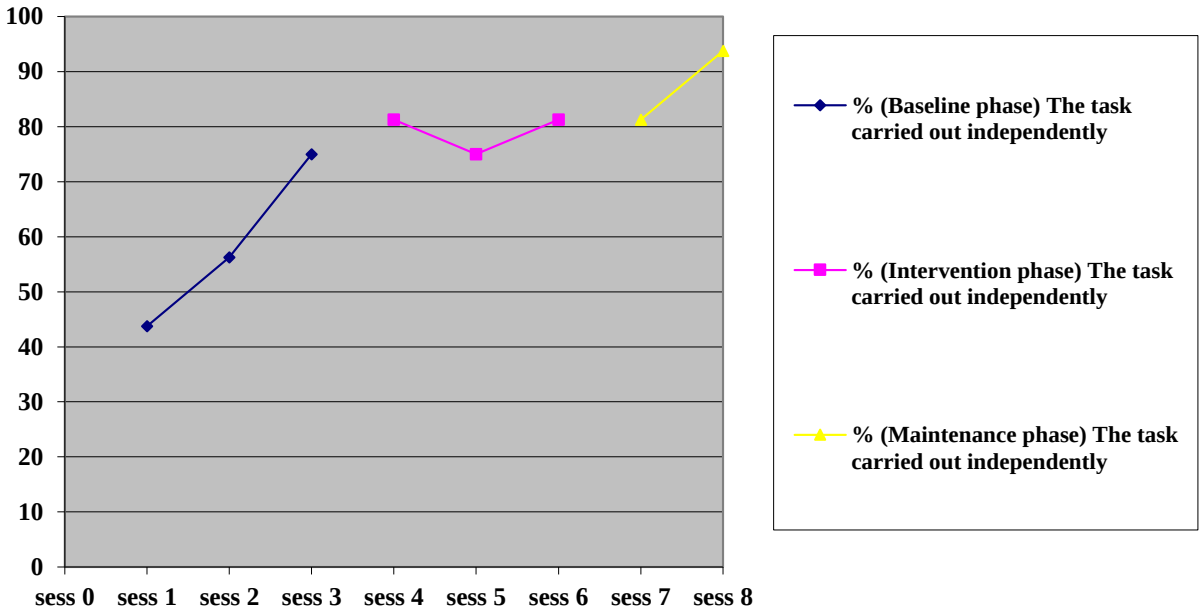

Figure 3. Maintenance phase graph

Table 3 shows the maintenance conditions of two data points, the results show that Cantika children are able to perform tasks independently as many as 13 tasks out of 16 tasks in the first observation session and as many as 15 tasks out of 16 tasks are able to be carried out independently in the second observation session.

Figure 3 explains the graph of the patient's main tenance phase, the number of data points (scores) of the intervention phase is five data points in five observation sessions. From the five data points, there is asense of data stability. The level of stability can be seen from the small range of data and the low level of variation. If the mean of the entire data is 88%, then the difference between the data with the mean ranges from 6% below the mean and 6% above the mean. In general, if the overall data is still at 15% above and below the mean, then the data is said to be stable.

The trend (trend/slope) of the graph from the intervention phase to the maintenance phase needs to be assessed to provide an overview of the behavior of the

subject being studied. To determine the trend, the split-middle method is used, which is to determine the trend of the direction of the chart based on the median data of the points that have a greater value. If analyzed, the direction of the inter intervention phase and the maintenance phase also increases.

DISCUSSION

Mental retardation is a disorder¬with a lack of intelligence. Mental retardation children, in addition to having intelligence skills, also have skills in self-care so they need support from their families to achieve accurate matches (Arfandi et al., 2014). In Indonesia, mental retardation is also referred to by various terms including tuna grahita, which is an individual who experiences mental development obstacles including intellectual, social and mental functions (Nevid et al., 2003)

Self-care is a behavior that is carried out or done by individuals or their guardians personally to improve their health, health, and welfare. Self-care is greatly influenced by family experiences in problem management, family education, culture, knowledge, growth and development and parenting (Meleis, 2007).

The results of the study showed that self-modeling videos were effectively used to improve clothing skills and self-esteem in children with moderate mental retardation, this was proven through careful analysis of graphs and¬ calculations of data obtained in the field. Based on the graph, it can be seen that the students' ability to wear clothes and do several other skills can be seen.

People with moderate mental retardation who are not able to carry out daily activities or independence in their own life are not solely due to their lack of income but because of a less supportive environment, so they need guidance, both from the family and the community, which is expected to be a person with moderate mental retardationThe ability to take care of oneself, if this ability is really mastered, it will give confidence to the person with moderate menstrual retardation. Family participation to improve the ability of self-care in children with mental retardation can be facilitated by providing motivation or support, and providing stimulation to support the child's development (Kasih, 2019).

Self-care is one of the basic human abilities in realizing their needs in order to maintain their lives, health and well-being in-accordance with their health conditions, clients are declared to be disturbed if they cannot take care of themselves. The ability to take care of oneself will make¬mentally retarded children able to adapt to the environment and achieve independence. In doing self-discipline for mentally retarded children still experience difficulties, so they need to be taught and need a long time, more training and assistance, and repeated teaching.

Video modeling is a technique that involves demonstrating the desired behavior through video representation of -behavior. Video modeling will involve-individu to watch videos of demon-strangulation and then imitate the behavior of the model (Buggey, 2005). Modeling interventions with video will involve classmates, siblings, or adults as models. This modeling is considered effective because children are more likely to follow models similar to the ones they see (Mechling et al., 2005).

Self-modeling videos can be a motivating procedure to teach new tasks to students. With this method, participants watch video recordings, especially in the skill of using clothes. Videos that are shown repeatedly with a rather loud sound will make the child record the activity in his memory

(Graves et al., 2005). Videos can also provide a permanent model for mentally retarded children that can improve skills and self-care (Bellini & Akullian, 2007).

The therapeutic process in the form of video modeling will help or influence and strengthen weak behavior, and will facilitate the response, this media will provide stimulus to hearing and vision (Rusdiana et al., 2016), so that the expected results are more optimal in improving children's abilities, namely children become aware of how to use the correct clothes, then children can apply them.

AUTHOR CONTRIBUTION

Rita Benya Adriani is the main author who select research topics, search for articles, process articles, and create publication manuscripts.

FUNDING AND SPONSORSHIP

There is no funding or sponsorship, this study is self-funded.

CONFLICT OF INTEREST

The researcher dclared that there is no conflict of interest in this study.

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