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Comparison of Attitudes Towards Meditation Healing Exercise between the Elderly Living with Chronic Illness in Bangkok and Surabaya

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ABSTRACT

Introduction: Meditation healing exercise (MHE) using the SKT technique is popular in Bangkok, Thailand, while in Surabaya, Indonesia, it is relatively new and unpopular. The attitude towards MHE depends on various internal and external factors. This study aimed to compare the attitude towards MHE between the elderly who are living with hypertension (HT) and/or diabetes mellitus (DM) in Bangkok and Surabaya.

Methods: This was a comparative study involving 96 and 100 elderly individuals with HT and/or DM in the communities of Surabaya and Bangkok respectively. The sample was chosen according to the aforementioned criteria. The sample size was 196. The instrument used was a valid and reliable questionnaire. Descriptive statistics, the Levene test, and an independent sample T test were used for the data analysis.

Results: The majority showed a positive attitude towards MHE; the higher Mean and lower SD was found in Bangkok (19.43 and 2.41). Out of the total, 87.5% and 96.0% elderly had good attitude towards MHE in Surabaya and Bangkok respectively. There was a significant attitude difference in relation to the aspect of preferring to practice MHE between Bangkok and Surabaya ($p=0.004$). Overall, there was no significant attitude difference between Bangkok and Surabaya ($p=0.17$).

Conclusion: The elderly attitude towards MHE was mostly positive and good. The elderly in Bangkok prefer to practice MHE more than in Surabaya. There was no significant attitude difference in the elderly who are living with HT and/or DM between Bangkok and Surabaya. The implementation of MHE using the SKT technique has a high possibility of being accepted personally by the elderly in both sites.

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INTRODUCTION

Non-communicable diseases (NCDs), or chronic diseases, are not passed from person to person. They are of a long duration and have a generally slow progression. The four main types of non-communicable diseases are cardiovascular (e.g. hypertension), cancers, chronic respiratory diseases and diabetes mellitus (DM). 80% of all NCD deaths occur in low- and middle-income countries. Almost three quarters of NCD deaths - 28 million - occur in low- and middle-income countries. 16 million NCD deaths occur before the age of 70; 82% of these "premature" deaths occurred in low- and middle-

income countries. The greatest public health benefits are gained through the prevention of NCD (particularly cardiovascular diseases, cancers, and DM), injuries, and mental health disorders. These benefits can be achieved if the risk factors are identified and mitigated through appropriate interventions. If NCDs and mental illnesses are detected at an early stage and the appropriate controls initiated, then their severity can be significantly reduced (WHO, 2015).

Both Thailand and Indonesia are developing countries that face the threat of economic loss due to the burden of NCD. Efforts to optimise the clinical outcomes and quality of life are necessary to reduce

the health expenditure associated with NCD. One way of doing this is by implementing non-pharmacological interventions, such as meditation practice on a daily basis. Meditation is an umbrella term that encompasses a family of practices that share some distinctive features, but vary in important ways in the context of their purpose and practice. Cardoso, et al. (2004) developed a detailed operational definition of meditation that was broad enough to include traditional belief-based practices and those that have been developed specifically for use in clinical settings. Using a systematic approach based on consensus techniques, they defined any practice as meditation if it (1) utilises a specific and clearly defined technique, (2) involves muscle relaxation somewhere during the process, (3) involves logic relaxation to analyse the possible psychophysical effects, not "to intend" to judge the possible results and not "to intend" to create any type of expectation regarding the process), (4) is a self-induced state, and (5) involves the use of a self-focus skill or "anchor" for attention.

Evidence of meditation healing exercise (MHE) effect on both physiological and neuropsychological aspects has been evaluated in 311 studies. The majority of studies have been conducted in healthy participants. Meta-analysis has revealed that the most consistent and strongest physiological effects from meditation practices in healthy populations occur in the reduction of heart rate, blood pressure, and cholesterol. The strongest neuropsychological effect was an increase in verbal creativity. There was also some evidence in before-and-after studies to support the hypothesis that certain meditation practices decrease visual reaction time, intraocular pressure, and increase breath holding time (Artsanthia & Sari, 2017).

Thailand is famous for its meditation technique. Most of the citizens are Buddhist, and meditation is really close to Buddhist religious practice. One of the meditation experts from Bangkok, S. K. Triamchaisri, proposed eight new techniques for doing MHE named SKT 1-8. Each technique has its own health benefit. For instance, a study of Triamchaisri, et al. (2013) found that after practicing the SKT3 and SKT5 meditation exercises, the function of visual illusions was reduced, hearing problems and posture disorientation was 30% improved, and the quality of life of the patient related to eating, standing, sleeping was improved within one week. The improvement in relation to walking, posturing, hearing, sleeping, memory losing, and walking status was reported after regularly practicing three times a day for one month. 80% of the patient's spatial orientation was met after practicing for one month. There was a 90% level of holistic improvement in the visual and vestibular functions, which improved as per a healthy person within three months of practicing the meditation exercise.

Meditation practice in Indonesia, especially in Surabaya, is relatively new and unpopular in society, especially amongst the elderly who are living with

HT and/or DM in the communities. Most of the citizens in Surabaya are Moslem, and their daily religious practice does not involve any practice related to meditation. MHE is potentially being recognised as a new way of treating diseases. Meditation-related knowledge is potentially low, as well as the attitude towards MHE itself remaining unclear. Although most of Thailand citizens are familiar with meditation in practice, the elderly's attitude towards MHE, especially the SKT technique, remains unclear.

Attitude has always been a subject of interest to many researchers. It is considered exciting and mysterious. Attitude is the positive or negative evaluation or feeling that people have towards other people, objects, issues or events. Attitude includes the general way that people feel towards socially significant objects. Having a certain attitude in life could help people to live in harmony and be better understanding of the things around them. Attitude affects the way that people perceive and act towards other people, as well as the objects or events that they encounter (Abidin, et al, 2011).

This study aims to compare the attitude towards MHE between the elderly who are living with HT and/or DM in Bangkok (familiar with daily meditation practice) and Surabaya (relatively new to daily meditation practice). Our upcoming study aims to analyse the effect of MHE towards a handful of physical and psychological parameters in the elderly who are living with HT and/or DM in Bangkok and Surabaya. This prior study on attitude was important to conduct in order to ensure that there was a positive/good attitude towards MHE in both sites, so then the elderly would accept the study intervention personally and be determined to do meditation practice on a daily basis. This is important to assure that the MHE effects on the physical and psychological parameters are measured properly in the upcoming study. In our upcoming study, we will implement the SKT1 technique as proposed by S. T. Kantharadussadee, which could be useful for managing HT and/or DM with a good outcome, especially related to lowering blood pressure (BP) and blood sugar (BS) level.

MATERIALS AND METHODS

It was a comparative study involving 196 elderly individuals with DM and/or HT in communities around Bangkok and Surabaya. There were 100 and 96 cases compiled from Bangkok and Surabaya respectively. The sample distribution between the two study sites has been presented in Table 1.

Table 1. Sample distribution

Case	Bangkok	Surabaya	Total
DM	30	30	60
HT	35	33	68
DM&HT	35	33	68
Total	100	96	196

The sample was chosen according to a set of criteria, who were then totally included in the study (total sampling). The inclusion criteria consisted of (1) elderly people who are willing to practice MHE using the SKT1 technique, and (2) they are consuming medication from a medical doctor to treat an appropriate disease. The exclusion criteria consisted of (1) elderly people who have heart and/or lung disease, and (2) they cannot communicate using Pasa Thai or Bahasa Indonesia.

The instrument used to measure attitude was developed by the researchers. It consisted of five items in the Likert scale format (1 = disagree until 5 = strongly agree). The attitude questionnaire was proven to be a valid and reliable instrument for measuring attitude towards MHE ($r = 0.437-0.574$; IOC = 0.574; Cronbach's Alpha = 0.880). A positive attitude is evident if the score ≥ 3 , while a negative attitude is evident if the score ≤ 2 in each item. The total score was then categorised into four categories: 5-10 = strongly negative, 11-15 = negative, 16-20 = positive, and 21-25 = strongly positive. These four categories were then merged at the end into two big categories of good and bad attitude. Good attitude was if the total score ≥ 16 , while bad attitude was if the total score ≤ 15 . Descriptive statistics, the Levene test, and an independent sample T test were used for the data analysis ($\alpha = 0.05$). Ethical clearance was issued by the Ethical Committee of Saint Louis College (SLC), Bangkok, Thailand (November, 2016); certificate number: E.038/2559. The attitude data was collected in the beginning of 2017 in the communities around Bangkok and Surabaya, while the pre-experimental study of the effect of MHE using the SKT1 technique on various physical and psychological parameters was conducted for the rest of the year. The principal investigator for our upcoming study is Jintana Artsanthia, from SLC, Bangkok. In Bangkok, there were five communities used as the study sites. In Surabaya, there were three communities used as study sites; RW V, VI, and VII in the district of Mojo.

RESULTS

In total, the study respondents were composed of 15.82% men and 84.18% women. The age range was 60 - 78 years old. The educational background of the sample in Bangkok was mostly primary school level (53%), while in Surabaya, it was mostly secondary school level (64.58%). The income of the sample in Bangkok was 43% at THB 2000-6000 per month, while in Surabaya, it was 53.13% at less than IDR 800 thousand per month. In Bangkok, most of the respondents had relatives who suffered from DM/HT (66%), while in Surabaya, it was the opposite (69.79%). Details of demography characteristic of study respondents are presented in Table 2.

From Table 3, the average of the attitude score in Bangkok and Surabaya was 3.88 and 3.76 respectively, representing a positive attitude in both sites. The highest possible total score of attitude was

25. The results showed that the total score for attitude in Bangkok and Surabaya was 19.43 and 18.77, representing a good attitude in both sites. These results indicate that the study respondents could accept MHE on a personal level. There is a high possibility that the upcoming study respondents will do meditation practice regularly on a daily basis, allowing the MHE effects towards lowering BP and BS level to exist.

From Table 4, we can see that a 0% strongly negative attitude was found in Bangkok. This indicates that the communities in Bangkok were really familiar with meditation practice and the positive value of meditation already exists in the selected society. The most surprising fact was that a 19.79% strongly positive attitude was found in Surabaya. This result was even better than in Bangkok. This indicates that although the Surabaya communities are not really familiar with meditation practice and that the knowledge related to it is potentially low, the study respondents were optimistic towards meditation's benefit for their health.

From Table 5, we can see that even in Bangkok, most of the citizens are familiar with meditation practice. However, 4% of the study respondents had a bad attitude. It was not surprising that we found a higher result in Surabaya (12.5%), because meditation practice is relatively new and unpopular in society. The relieving fact is that 62.24% respondents had a good attitude towards MHE in both sites. There was a high possibility that the upcoming study respondents will do meditation practice regularly on a daily basis, so that the MHE effect of lowering BP and BS level could exist.

From Table 6, we can see that the attitude in Bangkok was better than that in Surabaya because of the higher Mean and lower SD. This result indicates that the respondents in Bangkok had a good attitude towards MHE, in which the positive value was not really different between the focused societies.

All of the attitude data was normally distributed ($p > \alpha$). There was significant attitude difference in the aspect of preferring to practice MHE (item 4) between Bangkok and Surabaya ($p = .004$). This result indicates that the respondents from Bangkok like to practice meditation more than Surabaya's respondents. Based on the total score of attitude, overall, there was no significant attitude difference in the elderly who are living with HT and/or DM between Bangkok and Surabaya ($p = .17$)

DISCUSSION

Attitudes have long been considered to be a central concept of social psychology. The concept of attitudes has changed over the years. The initial definitions were broad and encompassed cognitive, affective, motivational, and behavioral components. The current conception of attitude does not adequately distinguish between attitudes and factual beliefs on the one hand, or between attitudes and

Table 4. Level of the elderly attitude towards MHE based on the total score

Total score	Bangkok (n=100)			Surabaya (n=96)		Meaning
	Σ	%	Σ	%		
5-10	-	-	5	5.21	Strongly Negative	
11-15	4	4	7	7.29	Negative	
16-20	82	82	65	67.71	Positive	
21-25	14	14	19	19.79	Strongly Positive	
Total	100	100	96	100		

Table 5. Category of the elderly attitude towards MHE based on the level of attitude

Category	Bangkok		Surabaya		Total	%
	Σ	%	Σ	%		
Good attitude (positive + strongly positive)	96	96	84	87.5	122	62.24
Bad attitude (negative + strongly negative)	4	4	12	12.5	74	37.76
Total	100	100	96	100	196	100

Table 6. Descriptive statistics of the elderly attitude towards MHE

Attitude in site	Σ	Mean	Std. Deviation
Attitude in Bangkok	100	19.43	2.41
Attitude in Surabaya	96	18.77	4.15
Total - average	196	19.10	3.55

Table 7. Statistical test results on the elderly attitude differences towards MHE

Attitude	Levene's Test for Equality of Variances		Independent t-test for Equality of Means							
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% CI		
								Lower	Upper	
item1	19.440	.000	-1.398	194	.164	-.16167	.11567	-.38981	.06647	
			-1.384	151.724	.169	-.16167	.11685	-.39253	.06919	
item2	2.294	.132	-2.268	194	.789	-.02958	.11053	-.24757	.18841	
			-2.266	178.868	.790	-.02958	.11110	-.24882	.18965	
item3	14.773	.000	-1.226	194	.222	-.13875	.11320	-.36202	.08452	
			-1.213	150.653	.227	-.13875	.11437	-.36473	.08723	
item4	23.456	.000	-2.917	194	.004	-.33792	.11585	-.56640	-.10943	
			-2.892	159.911	.004	-.33792	.11686	-.56871	-.10712	
item5	7.823	.006	.248	194	.804	.02958	.11912	-.20535	.26452	
			.246	156.197	.806	.02958	.12024	-.20792	.26708	
total	9.165	.003	-1.365	194	.174	-.65917	.48308	-1.61193	.29360	
			-1.351	151.459	.179	-.65917	.48800	-1.62334	.30500	

6 'authentic values', reveal themselves to be either (a) factual beliefs about aesthetic properties or about human motivation respectively, (b) preferences, or (c) moral attitudes as defined (Maze, 2008).

5 Conceptualisations of the attitude construct advances the possibility that attitudes can form in multiple ways. The three key means of attitude formation implicates cognitive, affective, or behavioral processes. An attitude is formed on the

basis of cognitions when one comes to believe either that the attitude-object possesses (un)desired outcomes. The expectancy-value model argues that an attitude toward a given object is the sum of the expected value of the attributes of the object. An overall attitude toward the object is reached by taking the sum of the expected values of all of the attributes that an attitude object is thought to have. They claim that all attitudes are based on beliefs about the attitude object, and that all attitudes are formed via the summation of its subjective probabilities and values (Wigfield & Cambria, 2010).

Most people seem to agree that an attitude involves at least three things: an attitude object which is defined by the attitude holder, a set of beliefs towards the object, and a tendency to behave in a certain way. Other underlying dimensions of attitude are knowledge level and strength or resistance to change. If the attitude intensity is high, then strength is also apt to be high. Strength may be high if one has lots of knowledge. There are also times when attitude seems to be change resistant despite a lack of knowledge. There is a reason to believe that an attitude that is high in intensity, strength, and knowledge is apt to be a good predictor of behavior; but attitude alone does not determine behavior (Hulleman, et al, 2010).

Based on Table 2, we can see that all of the respondents possessed a relatively low knowledge level based on their educational background (84.18% in total). From Table 3, we can see that regarding the 5 items in the attitude questionnaire, most of the respondents tend to choose a higher score (3/ 4/ 5) for each item. It is expected then that the respondents will practice MHE regularly, because 1) they intensely feel about MHE, 2) enough information was given prior to the study period, and 3) the high attitude intensity has made it change resistant.

Other than cognition, attitude forms from the effect that stems from an emotional reaction to the attitude object. One can be said to have an affectively-cased attitude when either positive or negative feelings are evoked when considering the attitude object. As seen in Table 3, 4 and 5, most of the respondents have a positive/good attitude toward MHE (91.84% in total). Although most of the bad attitude was found to be in Surabaya (12%), the overall attitude was mostly positive/good. There are three primary ways in which attitudes might be formed on the basis of affect: operant conditioning, classical conditioning, and mere exposure. Without clear feelings or beliefs about a potential attitude object, one may still have had past experiences with it. The past behavior can be used to infer the attitude toward an object through self-perception (Nagengast, et al, 2011).

One of the reasons that attitudes are practically and theoretically important is because they have predictable and very powerful effects on behavior (Nagengast, et al, 2011). People care passionately about some attitudes and consider them to be deeply

important, and therefore accord no particular significance to other attitudes. Determining which attitudes most accurately predict which behavior under what circumstances has turned out to be a highly complex enterprise. Some research has revealed that some kinds of individuals are more likely than others to act on their held attitudes (Singh, et al, 2012). In addition, some kinds of situation are more likely than others to promote attitude-congruent behaviors (Tang, et al, 2014). In addition to differences across people and across situations, there are also marked differences across types of attitude – some kinds of attitude are more likely than others to motivate and guide behavior (Eaton & Vissers, 2008).

It is generally understood that a person's attitude has a primary influence on behavior. Banaji & Eiphetz (2002) stated that if attitude is a predisposition to act favorably or unfavorably, then the attitude that one has should predict one's behavior. From the 1930s on, however, studies have shown the weak prediction of behavior from attitude (Abidin, et al, 2011); there are situational factors whose influence is stronger than mere attitude. People's expressed attitudes hardly predict their varying behavior (Wicker, 2010). Behavior and expressed attitude differs because both are subject to other influences. On any occasion, it's not only inner attitudes that guide us, but also the situation that we are face with.

The attitude model suggests that how you feel about some person, object, or idea will influence your behavior toward that object. However, it is not uncommon for people to have feelings one way and to behave differently. This difference may lead one to raise question about the relationship between attitude and behavior. It is apparent that there are intervening factors influencing the attitude – behavior relationship: habit, social norms, and the expected consequences of behavior. Habits are automatic ways of behaving in appropriate situations with minimum thinking. Social norms include the role expectations of a certain behavior that members of a group, community, or society share. The expected consequences of a behavior produce an apparent inconsistency between what a person says and what a person does. Therefore, attitude is not always a good predictor of behavior (Tesser & Schwarz, 2001).

The information that a person has about an object will influence the attitude that the person holds about that object. Many beliefs may underlie a given attitude. Individuals also use attitudes to express their basic values and to portray to others the sort of persons that they are. Generally, people maintain a consistent relationship between their beliefs, values, and attitudes. Attitudes are also influenced by personal needs, such as the need for reward, defending the ego, and understanding the environment. These three basic personal needs which attitudes serve are very important. Often, a set of beliefs and values are used to provide reasonable justification for an attitude. However, the real

motivation for the attitude in question may be basic personal needs (Prasad, et al, 2011).

The attitude towards MHE in the elderly who are living with NCD, especially HT and/or DM, in Bangkok and Surabaya, was mostly positive/good and insignificantly different overall. Both Thailand and Indonesia are located in the South East Asia region, which is relatively similar regarding culture, habits, customs, and daily life. The beliefs, values, social norms, personal needs and expected consequences of behaviour are also relatively similar in the study context. By way of this positive/good attitude regarding MHE expressed through the five items in the attitude questionnaire, the upcoming respondents are expected to practice MHE regularly on a daily basis so then its benefits for health can be assured

Almost half (47.8%) of caregivers' knowledge before and after physical disability children's self-care training is good, and the knowledge increased in the majority (69.6%) of caregivers after training. The caregivers' knowledge is good because some (30.43%) of them had already obtained information about self-care on physically disabled children from school and other sources. Based on research by Tristani et al. (2017), 70% of parents have sought to find sources of information about physical activity for children with physical disability through websites using common sources to increase their knowledge.

In a UNICEF study (2014), among 247 mothers, 65% of mothers had completed their primary education and 81% of parents with high school education levels had the knowledge and readiness for education of their children at home increased. This is in accordance with research result which finds that the highest education level of caregivers (56.51%) is Senior High School.

The older the person's age, the better the mental development process, but, at a certain age, the increase in mental development process is not as fast as in their teens. In addition, a person's memory is affected by age. Therefore, the age of a person can affect the acquisition of obtained knowledge, but, at certain ages, the ability to accept or remember will be reduced. The knowledge of 40-year-olds will be different from the current knowledge of 60-year-olds (Notoatmodjo, 2007). The increase in the caregivers' knowledge is less significant because the average age of caregivers is 41.43 years, where 47.83% are aged 31-40 years.

The decrease of correct answers to some questions on knowledge was also due to the fact that most caregivers (47.83%) are aged 31-40 years, at which point there is difficulty in the process of remembering. According to Aizpurua, et al. (2009), the brain is particularly vulnerable in long-term memory processes as age grows. In this study, post-test was conducted two weeks after training and there was no intervention in the form of recall about the materials, but the training equipped caregivers with the module.

The questions that the caregivers found difficult to answer were more about theories, such as the definition of self-care and the bath stages and what is taught during toileting. In the choice of answers, they used words that were less familiar and also ambiguous because they related to caregiver habits. Information will be easy to remember if using the traits or characteristics typical of the stimulus (Bhinetty, 2008). There is no distinctive form of training module, so the parents were less interested to read back on the modules that were being given.

Before the training, over half (56.5%) of the caregivers already had a positive attitude and this increased after the training. Parental awareness in guiding children with physical disability and preparing them to be able to engage in activities independently could form a positive attitude in the parents (Dziubanek, et al, 2013).

This is evident from the enthusiasm of caregivers in training indicated by their involvement in following the training process. The response of the training process becomes very important to determine the success in transferring a material so that participants are able to understand, determine their attitude, be responsible in applying it and be able to make someone become more creative (Campbell, 2010 cited in McMahan and Archer, 2010).

Caregivers participated in the training because they saw that the training was very useful for their lives, as illustrated by the questionnaire result where the benefits of the training became the best judgment in that more than half of (60.9%) the caregivers responded very good to the benefits of training aspect. In line with Fickert and Ross, (2012), activities that have direct implications on a person are likely to be the reason to join the education program. This indicates the appeal of training because the respondents felt that the training materials were what they needed in daily life to teach children how to take care of themselves. In line with Huebner and Milgrom's research results (2014), the benefits of intervention in their lives became the motivation of parents in joining the training program.

Before training, almost half (43.5%) of the caregivers' skills were good and, after training, about 95.7% of the caregivers' skills in teaching self-care to children with physical disability became good. In caring for children, mothers have more ability than the father. The mother's ability to provide support and action on the development of children is better. Mothers simply use their experience and cultural values in caring for the child (Unicef, 2014). Mother dominates in this study and the increase of skill to become good is because most of the respondents are mothers (78.26%).

The parenting skills that changed considerably after the training were in the activities of teaching to regulate the temperature of the water, cleaning the closet, putting clothes in the closet, buttoning clothes, zipper closing, wearing socks, wearing shoes

and tidying clothes. After training, all self-care activities were taught to children with physical disability.

The challenge of physically disabled children in dressing activities is how they manage positions to perform these activities. Difficulties that are often experienced include wearing underwear, wearing socks and shoes. The clothes difficult for children with a physical disability to wear are skirts, underwear and uniforms (Kabel, et al., 2017).

Kling, et al. (2010) showed the most difficult routine for children with a physical disability is bathtime. Based on information, parents still find difficulty to find a washing tool for the child's hair, vibrating toothbrush, and a special chair to change the position of the body when the child is in the bathroom.

Difficulties often experienced in toileting activities by children with physical disability is the difficulty of moving and positioning themselves in the closet, needing a special seat for them to move. The difficulties that are often experienced by children having incontinence are in opening underwear before toileting, difficulty in cleaning after toileting and difficulty closing zippers (Noble, 2014).

Self-care training for caregivers of children with physical disability does not have a significant effect on knowledge where the p value is 0.225. It can be seen from the mean value, that there less significant increase from before and after training, i.e. 13.17 to 14.00, where the difference test shows a difference mean of 0.826 with value t count 1.249, smaller than t table, 2.0739, which means that the training does not have a significant influence on knowledge.

Less knowledge is increased due to the giving of materials done in the classroom where the information is given by the trainer to some people in front of the class. According to Vahdaniya, et al. (2015), giving the material in the class is less likely to increase knowledge compared with telling stories.

The study of the instruments of knowledge assessment has become a concern as a result of caregiver knowledge being insignificant. According to Nunally (1978 cited in Widhiarso, 2005), instruments that have a reliability value <0.7 are less adequate as a measuring tool. In this research, the reliability of the knowledge instrument questionnaire is 0.673, which means that the instrument is less consistent to be used as a measuring tool; this happens because it is difficult to find the subjects for a validity and reliability test. Testing the validity of reliability was only followed by 34 people out of 30 question items with only 18 valid questions. Of the 18 questions, there were three (16.7%) questions that experienced a decrease in mean value after self-care training, namely, the question of the definition of self-care, bath steps and toileting tools. There was one question that did not change after the training, which was about equipment for bathing.

Self-care training improves the attitude of caregivers for children with physical disability.

Based on the result of the paired sample t test, p value of 0.038 and t value 2.213 were greater than t table; this means self-care training had an effect on the attitude of the caregivers. In the Kling, et al. (2010) study, after training on supportive technology for children with physical disability, there was increase in attitude of caregivers and they were able to choose a solution to their problem with the appropriate support tools.

After the training, caregivers' skills increased significantly based on the results of the paired sample t test and obtained p 0.002, which means the skills of parents were better after the training. Training can improve parenting skills more compared to those who only seek information from the literature (Kling, et al., 2010).

The success of the training in this study is based on the evaluation obtained from the caregivers, as it assessed for both the media training (52.2%), speaker (60.9%) and time and training facilities (78.3%). The improvement of caregiver skills was supported by an audiovisual learning media where parents were given the opportunity to see videos on how to teach children with physical disabilities. In addition, caregivers were given the opportunity to practice firsthand the materials that had been given by involving the child in the training activities of bathing, toileting, eating and dressing.

In a study conducted by Lehna, et al. (2013), which aimed to compare educational methods of classroom meetings, DVDs, home visits, leaflets, telephone contacts, pamphlets, and short messages on research subjects with parents with physically disabled children, visual disturbances and control groups showed the most effective method of education on such parent groups is classroom meetings, DVDs and home visits. Based on the theory of learning outcome, training is effective in improving skills. According to Bandura (1971), a person's behavior is formed from the process of observation (attentional phase), retention phase, reproduction phase and motivation to do something (motivation phase). The phases are done by parents in the training process where they observe through audiovisual and demonstration, being given the material, imitating through practice activities and then practice at home.

CONCLUSION

The elderly attitude towards MHE was mostly positive/good in both sites. The elderly in Bangkok prefer to practice MHE more than in Surabaya. Overall, there was no significant attitude difference towards MHE between the elderly who are living with HT and/or DM in Bangkok or Surabaya. The implementation of MHE, especially using the SKT1 technique, in the elderly communities of Bangkok and Surabaya has the high possibility of being accepted on a personal level. Its effects on the

various physical and psychological parameters involved in HT and DM management also possibly exist.

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