This article reviews an attempt to use a tape recording of step-by-step directions to improve a distractible, retarded individual’s face-washing performance. A review of the research published 1979 to 1984 disclosed no similar procedure. Although articles in occupational therapy and physical therapy journals have discussed self-care (Klein & Bell, 1982; Shillam, Beeman, & Loskin, 1983; Vickery et al., 1983) and audiovisual equipment (Kelly, 1983; Vasudevan, Lynch, Donnell, & Murphy, 1983), no article has associated these topics.

The patient was a 55-year-old white male who had lived in a state hospital for 14 years and then in a nursing home for 13 years. He had congenital hydrocephaly and mental retardation and was referred to occupational therapy.

Initial occupational therapy evaluation revealed that the patient had functional hearing (he could follow simple verbal commands appropriately) and an intact body scheme (he could name body parts and their relationships to each other, which suggested he could respond to directions concerning what part of the body to wash or dress). The patient’s attention span was 5 minutes long, as measured by a pegboard task, and he could perform self-care activities (washing, dressing, and upper extremity hygiene, which includes washing hands, face, and underarms, applying deodorant, and putting on shirt) if given one- and two-step directions, assistance with setup, and 20 minutes of direct personal supervision. This information, as well as observations made during preliminary treatment, indicated that the patient was a good candidate for skill training using a tape recording, tape recorder, and headphones. The skill selected for training was face washing.

Training

The training schedule was as follows: 1 week of baseline data collection, 4 weeks of treatment, 1 week of data collection, and 3 weeks of treatment. During training, environmental stimuli were controlled by closing privacy curtains and the door, turning off the television, and applying headphones. During training, the patient heard the tape once a day, 5 times a week.

The initial baseline data were collected during five consecutive mornings. The patient was seated in bed with a tray across the rails. The nurse’s aide set up the resident’s soap, water, washcloth, and towel and then instructed him to wash his face and left the room. Meanwhile the therapist was out of sight behind a curtain in order to observe performance. The performance proved to be erratic. The resident never completed the task correctly: sometimes he washed, rinsed, and dried some parts of the face and not others; other times he performed only one of the...
these steps; on some occasions he performed the steps out of sequence.

In the first treatment period, an audiotape consisting of step-by-step face-washing instructions was introduced. Each instruction was followed by a 5-second pause. Setup and observation procedures were the same as in the data collection week. Observation showed problem areas in some aspects of face washing and a need to allow more or less time on the tape for the resident to respond to the instructions. But pauses were adjusted only minimally (to 4 or 6 seconds from the original 5). New tapes were made weekly in response to the changes dictated by the observations.

During the second week of data collection, the resident’s face-washing skills were assessed. Observation showed that the training had produced no apparent changes in skills.

During the second treatment period, a new audiotape was introduced (see Table 1). In addition to the step-by-step instructions, it included prompts (e.g., “Hold up the wash cloth; don’t let it get in the water;” or “Open up the towel; Dry your whole face.”), and pauses between instructions were readjusted to match the resident’s speed of performance (some pauses were increased and others were decreased). The resident’s final performance at the end of this 4-week treatment period showed improvement in washing, rinsing, and drying as evaluated by the therapist’s observation and as measured by a rating scale developed for this project and completed by five nurse’s aides selected at random.

### Discussion

This method of training proved cost-effective because it demanded little or no time of the therapist once the tape was made and required only setup assistance by the nurse’s aides. Further, the improved skill increased the independence of the resident, and increased independence may lead to increased self-esteem (Hopkins & Smith, 1978).

Recorded instructions may also be useful for training in other self-care skills, such as shaving, dressing, brushing dentures, and self-feeding. The difficulty of audiotapes can be adjusted as necessary.

Recorded instruction may have potential for self-administered, step-by-step treatment using a reel-to-reel tape that the patient can switch on and advance by pushing a button. If a task is not completed and the patient does not push the button, the tape would switch back to repeat the instruction.

### Conclusion

The patient was a good candidate for training with a tape because he had functional hearing, an intact body scheme, and an attention span of 5 minutes, and he could perform self-care activities with supervision. His face-washing skills improved with the use of the tape-recorded instructions.

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### References


