

# The therapeutic use of doll therapy in dementia

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It is estimated that the annual cost of dementia in the UK is £8.2 billion, with the anticipated increase in those suffering from dementia set to rise from 750 000 to 1.5 million in the next 30 years (Department of Health (DH), 2009a; 2009b; 2010). In light of the increasing population experiencing dementia, it is not surprising that researchers and practitioners are increasingly interested in therapeutic ways to improve the quality of lives of people with dementia and their carers. There are a number of distressing symptoms that can occur in some individuals with dementia. Distress is acknowledged as being a common feature, and it is estimated that around 60–90% of people with dementia will exhibit some level of distress when living with their condition (James et al, 2008a; 2008b).

The manifestations of distress can take a variety of forms, which can include anxiety, anger, depression, fear and suspicion (Gataric et al, 2010). Distress as a form of psychological hardship has historically been treated through pharmacological interventions, such as risperidone and olanzapine (Sink et al, 2005). More recently, however, in an attempt to implement a truly holistic model of care informed by policy guidance (DH, 2001; 2010), health professionals have been encouraged to limit the use of psychotropic medications and to explore the greater use of nonpharmacological and therapeutic interventions.

The call for a reduction in the use of psychotropic medicines in dementia is associated with questions related to their biological efficacy and also the complications associated with medication use in this population, which can include accelerated cognitive decline, increased risk of falls and tardive dyskinesia (James et al, 2008a). The nonpharmacological treatment of dementia is difficult to define, given the large number of treatments highlighted in the literature. For the purpose of this paper, nonpharmacological treatment is defined as an approach to care that seeks to improve the wellbeing of a person with dementia without the use of medications.

Nonpharmacological treatments vary not only in their approaches but also in the extent to which they have been researched for use in clinical practice. For example, reality orientation, reminiscence therapy, aromatherapy and music therapy have proved to be successful interventions in dementia (Holt et al, 2009; Vink et al, 2011; Woods et al, 2012). While there are a number of alternative interventions available to assist the health professional with nonpharmacological treatment in dementia, not all of these appear to be as rigorously researched as the examples above.

The use of therapeutic dolls for people with dementia

## Abstract

Over the next 15 years, the number of people with dementia in the UK will increase significantly. There are clear limitations associated with the sole use of pharmacological interventions to address the cognitive decline and related problems that people with dementia and their carers will experience. As a result, health professionals, including nurses, need to consider the development and use of nonpharmacological therapies to help resolve the distress and decline in social function that people with dementia can experience. The use of doll therapy in dementia care appears to be increasing, even though there is limited empirical evidence to support its use and therapeutic effectiveness. It is suggested by advocates of doll therapy that its use can alleviate distress and promote comfort in some people with dementia. Despite these encouraging claims, the theoretical basis for the use of doll therapy in dementia is poorly understood and morally questionable. The purpose of this article is to provide healthcare professionals with a succinct overview of the theory behind the therapeutic use of dolls for people with dementia, a presentation and appraisal of the available empirical evidence and an appreciation of the potential ethical dilemmas that are involved.

**Key words:** Doll therapy ■ Dementia ■ Ethical dilemmas ■ Nonpharmacological treatments ■ Holistic care

is one such therapy that has limited empirical evidence, but is appearing to be increasingly used in clinical practice (Stephens et al, 2012). As there is limited empirical evidence to support the use of doll therapy, and there are obvious ethical considerations associated with the use of this therapy, its effectiveness needs to be closely monitored and evaluated before widespread implementation with people who have dementia.

## The origins of doll therapy

The therapeutic use of doll therapy is best understood at a theoretical level from the work of the eminent psychologist John Bowlby. Bowlby's (1969) work on attachment theory is

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often cited as a rationale for the use of this therapy (Bisiani and Angus, 2012; Higgins, 2010; Moore, 2001; Stephens et al, 2012). While Bowlby (1969) undoubtedly influenced the use of doll therapy in dementia, it is important to highlight that this conceptual work was originally focused on child attachment with limited reference to older people with dementia.

After Bowlby's death, his theoretical explanation for attachment was subsequently thought helpful to apply and use in people with dementia. Miesen (1993) drew parallels with Bowlby's attachment theory by suggesting parent fixation, or the way in which some people with dementia often search for their parents, is an expression of an attachment need. This searching behaviour was considered to be important by Miesen, as it signalled that the person was insecure and was seeking to be reunited with or attached to a familiar figure in order to find safety. Stephens et al (2012) appear to agree, stating that experiences of loss, separation and insecurity are all themes of attachment theory that are likely to be experienced to some degree by people with dementia. Notably, attachment theory can extend beyond early life, as evidenced by Winnicott (1953), who claimed that a 'transitional object' is sometimes used by children when separating from their primary caregiver *en route* to adulthood. Winnicott stated that blankets, soft toys or repetitive words and phrases were some of the transitional objects frequently used by children.

This concept of the transitional object and its application to care in dementia has received limited empirical study; however it is suggested that it has the potential to act as an 'anchor' for people with dementia in a period of uncertainty (Loboprabhu et al, 2007). The endorsement of doll therapy therefore appears to be grounded in a complex network of theories and concepts developed by Winnicott (1953), Bowlby (1969) and Miesen (1993). While these authors suggest that attachment theory is mainly applicable to child populations, Miesen (1993) supports the application of attachment theory to people with dementia. Clearly, people with dementia are not children; however, Bowlby (1969) did acknowledge that attachment concepts, including transitional objects, could be used in adulthood.

The influential work of Tom Kitwood is an important starting point for those wishing to understand effective dementia care. His work emphasized the importance of person-centred care and its relationship to improved well-being (Kitwood, 1990; Kitwood and Benson, 1995; Kitwood and Bredin, 1992). To some extent, Kitwood is viewed as a pioneer in the field of dementia care and much of his theoretical work continues to pervade dementia research and dementia-related public policy. The philosophy of patient-centred care advanced by Kitwood has the potential to conflict with the goals associated with doll therapy, which is perceived by some observers as the infantilization of people with dementia. Kitwood (1997) did assert, however, that: 'if a need is not met, a person is likely to decline and retreat. When the need is met, a person may be able to expand again.' Supporters of doll therapy argue that the person with dementia 'transforms'. This transformation is advocated because of the debilitating effect of dementia, which can



**Figure 1.** Transitional objects, such as this empathy doll, can act as an anchor for people with dementia, reducing challenging behaviour

make it difficult for the person to articulate his or her needs and can lead to a deterioration in mood and ability. People who support doll therapy suggest that the use of a therapeutic doll can assist the person to express unmet needs, for example, the action of cuddling and kissing the doll is said to be an expression of safety and nurturing or, as Bisiani and Angus (2012) conclude, that 'embracing a transitional object may be considered a representation of the personal support that they [persons with dementia] yearn for'.

While doll therapy appears to generate some positive outcomes for some people with dementia and there is some theoretical support for its use in clinical practice, there are also those who question its use, believing it to be inappropriate. Boas (1998) criticised the use of doll therapy because it appears to treat the individual with dementia in a 'child-like' manner. Boas (1998) suggests that the use of doll therapy can be detrimental to the person with dementia, as it generates what Kitwood (1997) described as, malignant social psychology. Cayton (2001) suggested that enabling those with dementia to engage with dolls is a form of deceit and breach of trust and Salari (2002) argues that old age should not be used as a second childhood, as becoming a person with dementia is not like becoming a child again.

### Empirical evidence

There is some—mainly anecdotal—evidence that supports the positive therapeutic impact of doll therapy in dementia care (Gibson, 2005; Lash, 2005; Moore, 2001; Verity, 2006). Moore (2001) noted that there was a 'reduction in agitation, aggression and wandering' in patients with dementia at

Merevale House following the introduction of doll therapy. Verity (2006) stressed the social and behavioural benefits of doll therapy use and concluded that: 'if the person with dementia smiles, claps their hands ... shows delight ... when they have a doll in their arms ... how can I allow myself to say the activity is not acceptable?' Lash (2005) at about this time suggested when patients are permitted to carry a teddy bear this helped to reduce aggression and challenging behaviour. There are a number of limitations to all of these small, mainly exploratory, studies. They tend to be subjective narrative accounts of success and their findings are not supported by validated outcome measures or rigorous narrative interview procedures. These early studies aimed at exploring the benefits of doll therapy have been helpful in paving the way for more rigorous empirical research directed at determining the therapeutic gains of this therapy.

The Newcastle Challenging Behaviour Service was responsible for the first empirical studies in the UK that considered the therapeutic use of doll therapy. Ellingford et al (2007), James et al (2006a) and Mackenzie et al (2006) all sought to determine the therapeutic gains associated with the use of doll therapy in dementia. First, as a therapeutic intervention for people with dementia, James et al (2006) provided 30 toys (15 dolls and 15 teddy bears) to be introduced in a care home. They used a mixed methods design to help collect observational data from staff caring for patients with dementia. The mixed methods approach used in this study consisted of a Likert scale, used to measure levels of activity, agitation and happiness in the population. A number of open-type questions were also used to provide a qualitative dimension to the study. 'Interestingly, in 93% of the cases, residents who were given a choice of either doll or teddy bear preferred dolls. Also, the majority of the 14 residents who participated in this study generally appeared to be 'much less anxious ... [s/he] uses it to interact with everyone ... [is] more content ... more active'. Similar findings are reported in a replicated study by Ellingford et al (2007), who used similar data collection methods in 4 dementia care homes in Newcastle upon Tyne.

Ellingford et al (2007) examined the case notes of 66 residents (34 of which used dolls and 32 of which did not) over a period of 6 months (3 months prior to introduction of dolls and 3 months after doll therapy had been implemented). The authors reported that following the introduction of doll therapy, the population who had participated in the therapy demonstrated significant improvements in 'positive behaviour'. There are limitations in both of these 2 studies, mainly because they were conducted with the same study population in the same geographical area, which raises generalisability concerns. While the results of this study are interesting, it would have been helpful to have additional information regarding the development and testing of the measures used for data collection.

Minshull (2009) reports similar doll therapy benefits after using the recognised Bradford Dementia Group Wellbeing Profiling tool as a means of data collection. In this study, Minshull clearly articulates not only the appearance of the doll but also purchasing details, which is helpful for those who would hope to replicate this study. Minshull reported that the majority of people with dementia who participated

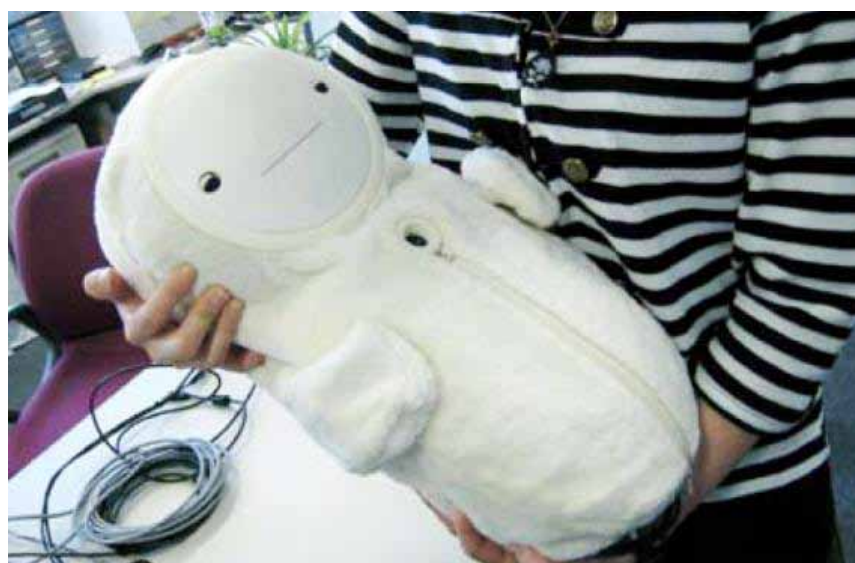


Figure 2. 'Babyloid' dolls have eyelids and mouths that move and can display feelings that simulate those of a real baby. The babyloid is currently undergoing development in Japan, but has shown some favourable results in dementia patients to date

in the study experienced some increase in wellbeing, reflected in reduced agitation, mood improvement, increased appetite and a reduction in wandering.

The final empirical study from the triad of studies completed within the Newcastle Challenging Behaviour Service was completed by Mackenzie et al (2006). The authors administered questionnaires to 46 care staff following a 3-week trial providing 14 dolls for use among 37 residents in 2 dementia care homes. Of these 46 care staff, 32 reported that the life of residents who engaged with doll therapy was 'much better', while the other 14 carers concluded that the resident was only 'a little better'. The authors do not elaborate on what constituted 'a little' or 'much' better, or even whether there was an option for a participant to respond 'no better'. While it appears that all carers believed that doll therapy had a positive effect on residents (in the form of reduced wandering, decrease in aggression or increased well-being), Mackenzie et al (2006) highlight several methodological issues within the study. The authors indicate that '13% of carers recorded misgivings with the study ... [some thought it was] demeaning ... patronising ... babyish'. It is also worth noting that 35% of carers reported that there had been some problems in establishing the ownership of certain dolls, with a few arguments between residents occurring. Despite these

Figure 3. More life-like dolls were better received in one Japanese study



**Table 1. Variability of 'doll' used for people with dementia**

Study	Description of dolls used in practice
Nakajima et al (2001)	Three animal-shaped toys: a gorilla, a tiger and a dog
Gibson (2005)	'Baby is a cute battery-operated doll purchased in the toy department of a local store'
Lash (2005)	Teddy bear
Ellingford et al (2007)	'Dolls ... were all plastic ... had eyes that opened and closed ... had different faces and clothes ... no auditory functions, such as crying'
Mackenzie et al (2007)	Empathy dolls ( <i>Figure 1</i> )
Minshull (2009)	'The doll we chose is from an American company ... it is weighed to feel like a baby'
Scott (2011)	Scott (2011) notes that the 'babyloid' ( <i>Figure 2</i> ) is being developed in Japan at present, but there have been favourable results in patients with dementia. The babyloid 'looks a bit like a baby seal ... it has the ability to make certain human emotions via a moving mouth ... eyelids ... can emote happiness and sadness ... even crying'
Stephens et al (2012)	'Henry was regularly seen with a Popeye doll ... Ruby ... carried a knitted doll'
Bisiani and Angus (2012)	'The face was anatomically correct, female and the expression was one of peace and tranquillity' ( <i>Figure 3</i> )

difficulties, all 46 care staff reported some degree of patient benefit with the use of doll therapy.

Fraser and James (2008), like Mackenzie (2006a), also considered the views of carers on the use of doll therapy. Mackenzie (2006a) notes participants in this study as 'carers' and does not elaborate whether they occupy a formal or informal role. Fraser and James (2008) provide more explicit information regarding study participants, which included psychologists, nurses and a psychiatrist. They explored the use of doll therapy using a qualitative research method that is frequently favoured in this type of study, exploring concepts from the individuals' perspectives when little is known of the concept under investigation (Polit and Beck, 2009). Following data analysis, Fraser and James identified a number of themes that reflected the benefits of doll therapy: attachment, comfort and activity among others.

In the empirical papers from the UK included in this review, there are perceived problems linked to research rigour in data collection, analysis and verification. In the studies by James et al (2006a), Ellingford et al (2007) and Minshull (2009), data collection appears to rely on the personal experiences of the authors, with little discussion on study limitations. Despite the limitations, empirical data concur with previously published anecdotal data that often assert doll therapy's potential to provide benefits in practice.

The phenomenon of doll therapy in dementia care is not exclusive to the UK. Tamura et al (2001) conducted a study examining the benefits of doll therapy in Japan. The authors observed how 13 people with dementia engaged in doll therapy over a period of 60 minutes. They used 3 different doll types and found that the more life-like dolls were much better received by the study population. They concluded that there are therapeutic gains associated with the use of doll therapy for people with 'severe dementia' and that its

use helped to reduce a range of behaviour that challenges, such as 'anxiety, aggression and wandering'. Nakajima et al (2001) engaged in a similar study in Japan using animal-shaped toys instead of dolls. However, the authors state that they carried out this study in response to the practical difficulties of assessing the use of pet therapy in dementia and do not provide any theoretical underpinnings to their study, despite the results appearing favourable. Finally, in Australia Bisiani and Angus (2012) examined the therapeutic value of doll therapy using a case-study approach. While this study included the relevant conceptual theory and reported favourable findings (reduction of panic, improvement of dining experience, improved social interaction and improved ability to communicate), it is difficult to generalise these findings to other populations, as the study population was so limited.

## Discussion

According to Andrew (2006), a doll should be presented to the person with dementia in a way that allows that person to establish whether it is a baby or a toy doll. Interestingly, Andrew advises that if the doll is indeed perceived as a baby then the person with dementia should not be corrected on this perception. Minshull (2009) eloquently phrases this as 'an avoidance of an unnecessary truth, rather than a lie'. This issue of truth-telling in dementia care is not a new or innovative concept. Schermer (2007) states that 'even if lying is *prima facie* wrong, it can be justified in some circumstances, for an example with an appeal to the wellbeing of the one lied to'. James et al (2006b) have even published ethical guidelines for when it might be appropriate to lie to people with dementia. One of the draft guidelines states that: 'Once a lie has been agreed it must be used consistently across people and settings' (Elvish et al, 2010). An example of an everyday lie that is told by care staff is that their deceased spouse would come to visit them in a short time.

Despite these justifications, it should be noted that Kitwood (1990) claims that 'treachery', such as telling lies, is a threat to the personhood of someone with dementia and can pollute existing and future relations with people. With regards to the Nursing and Midwifery Council code of professional conduct (Nursing and Midwifery Council, 2008), there are no special grounds for any level of deception. Brooker (2003) lists the primary component of person-centred care as 'valuing people with dementia'. In relation to doll therapy, empirical and anecdotal studies have largely shown that the person engaging with the doll perceives it to be a baby. By endorsing its use, advocates are potentially deceiving the people they care for. Kitwood (1997) suggests that a person with dementia 'is still an agent, one who can make things happen in the world ... to be a person is to have a certain status, to be worthy of respect'.

With regards to the practical aspects of doll therapy, *Table 1* and *Figures 1–3* provide examples of dolls used in clinical practice. The range and types of dolls that can be used in therapy can make it potentially confusing for those who may wish to evaluate the use of doll therapy in clinical practice settings, as they may not be aware of the doll type that may be the most appropriate or effective. To add to these



complexities, doll therapy has not been acknowledged in UK dementia care policy or clinical guidelines. Mackenzie et al (2007), as part of the Newcastle Challenging Behaviour Service, provide two pages of guidance for the public, but these are based on the research this group carried out alone. Furthermore, Mackenzie et al do not commit to a particular type of doll, stating that 'various types of doll are effective'. They also support the views of Andrew (2006), maintaining that 'if they [the person with dementia] refer to it as a doll, staff should do likewise'.

As a footnote to this notion of deception, Mackenzie et al also advise that 'blankets, hats, shoes and socks should be made available, as some doll users can appear puzzled by the coldness of the plastic feet/head/hands'.

The term 'validation' has been endorsed in the field of dementia and it serves as a way of stepping into the reality of a person with dementia (Feil and Altman, 2004). Andrew (2006) argues that a person who is told their baby is a doll is likely to become upset, either because someone is telling them something that they feel is obviously wrong, or alternatively that the person is right and they feel saddened as they are aware of their cognitive misconception of reality. Validation is closely linked to the concept of dignity, in that a person with dementia should be supported in whatever time or location they are in (Feil and Altman, 2004). Despite this logic, validation does not synergise with doll therapy. This is because, according to Mackenzie et al's guidelines (2007), the doll is strategically placed for the person to access; *vis-à-vis* healthcare professionals are purposely manipulating an environment with the intent of potentially distorting a person's reality.

## Conclusion

There appears to be a place for doll therapy to be used therapeutically with people who have dementia, and to conclude otherwise would be erroneous, given the anecdotal and empirical evidence on offer. In a time when clinical practice is driven by evidence-based research, scrutinised by audit and governance frameworks, however, it appears perplexing that doll therapy is so widely practised within the UK. This is because of the limited knowledge base and a variety of contentious ethical issues.

Any therapeutic avenue that does not involve debilitating pharmacology and improves the wellbeing of the person with dementia is of great value and importance to clinical practice. The practice of doll therapy, however, requires close scrutiny and its use should be approached with some caution. This is due to the fact that its use in people with dementia is in its infancy and must evolve and be critically evaluated before being routinely used in practice settings.

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Conflict of interest: none

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## KEY POINTS

- Nonpharmacological treatments are increasingly advocated in the treatment of challenging behaviour in people with dementia; while there are numerous nonpharmacological treatments available to health professionals, one treatment that has shown favourable results is that of doll therapy.
- Doll therapy is understood on a theoretical level from the work of Winnicott, Bowlby and Miesen and is believed to be helpful for some people with dementia, as its use can facilitate an expression of need.
- There have been limited empirical studies conducted assessing the use of doll therapy in people with dementia.
- Despite the limited data, some favourable results have emerged from the studies that show people with dementia to be less anxious and happier when in receipt of doll therapy.
- Doll therapy remains a contentious issue when consideration is given to Kitwood's definition of malignant social psychology; it can be perceived as infantile, undignified and degrading to the person with dementia.
- If doll therapy is to be advocated as good clinical practice, there is a pressing need for more research studies that assess its value. The absence of legislative clinical guidelines in this area is also important for clinicians interested in its use.

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