

## **DOLL THERAPY IN DEMENTIA CARE: A REVIEW OF CURRENT LITERATURE**

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### **ABSTRACT**

Older people within the UK who suffer from dementia are a growing service user group. Despite this a lack of knowledge and research into effective methods of intervention persists. One relatively new approach is doll therapy. Empirical research within this field has thus far delivered promising results, across the UK (primarily England), and in a global context within Australia and the USA. The intervention is based on findings related to earlier research into toy therapy, and has groundings in key theories relating to older age.

Doll therapy (DT) is the process of utilising baby-like dolls in therapeutic encounters to create positive outcomes for the older person with dementia. Thus far, researchers have identified four main needs-based outcomes through the use of dolls: to initiate and encourage interaction, to fulfill attachment needs, to act as a transitional object and to provide sensory stimulation through activity. These themes and the theories that underpin them will be explored and evaluated individually to give an overall view of the value DT can bring within social care practice.

Overall the review found that although most results are positive there are potential difficulties and limitations in the use of dolls. Similarly individuals, families and professionals may have negative perceptions of DT, its effectiveness and its appropriateness. Throughout examination there is a clear link to DT's relevance within community care practice.

**Keywords:** Dementia, doll therapy, attachment, transitional objects, challenging behaviour, communication, reminiscence, carers, older people, social work, activity, pharmacological.

### **INTRODUCTION**

In recent years dementia has become a focus for research. This has now led to a common understanding regarding the effects of dementia within older people. The National Health Service (NHS) states that those with dementia may "become apathetic or uninterested in their usual activities, and have problems controlling their emotions. They may also find social situations challenging, lose interest in socializing, and aspects of their personality may change" (NHS 2013).

The Alzheimer's Society (2013) and the NHS (2013) share statistics which show that in 2012, there were approximately 800,000 people with dementia within the UK - expected to rise to 1million by 2021. Two thirds of dementia sufferers are women, and only one third of dementia sufferers reside within care settings. 60-90% of those with dementia are considered to display challenging behaviours (Robert et.al 2005). James

et al. (2008) indicate that these behaviours are typically addressed through the use of pharmacological treatments and highlight that further consideration towards therapeutic approaches is needed to reduce the use of potentially harmful drugs.

Collectively increased awareness of dementia has led to reappraisal of interventions used to support people with dementia to enjoy the final stage in their lives. One such intervention is Doll Therapy, which aims to address a variety of needs as experienced by older people, but more so those experienced by older people with dementia.

DT has originated from toy therapy, dating back to the 1980s within the USA and Australia. The most prevalent of these were studies conducted by Milton and MacPhail (1985), and Mayers and Griffin (1990). These are considered to be the initial studies into toy therapy, and were particularly influential in discovering DT. The studies found that the use of toys and objects allowed for increased communication and positive feelings of attachment and security in older people with dementia, with decreasing negative and aggressive behaviours. Historically, Ehrenfeld (2003 p.292) states that there has been no clear introduction of DT from a needs-led, therapeutic perspective, and suggests that "it is most likely that patients who were exposed by chance to dolls adopted them". One of the initial moves from toy therapy to DT was explored in the USA by Bailey, Gilbert and Herweyer (1992). Their results suggested that DT had great potential for older people with dementia. Other studies provided similar results, however DT was not researched within the UK until Mackenzie et al. (2006). This research continues.

DT has been defined by a key researcher as "wise and mindful use of dolls for their symbolic significance to help improve the wellbeing of people with dementia" (Verity 2006 p.27). Although the current research base around DT is limited, it is expanding positively on a global scale. Thus far researchers have identified four main outcomes and uses of DT for Older people with dementia:

- ❖ to initiate and encourage interaction and communication
- ❖ to fulfill attachment and nurturing needs
- ❖ to act as a transitional object
- ❖ and to provide sensory stimulation through activity

(Mackenzie, Wood-Mitchell and James 2007).

As there is limited research surrounding DT, this piece will discuss the outcomes and findings to date, with reference to British research and consideration to the global perspective. As will be shown, DT is still a new and controversial therapeutic approach to dementia care, but one which deserves recognition and further empirical research – a fact highlighted within most studies. It is important throughout to be mindful of the

opinions of older people with dementia families and friends in relation to DT as these can be very influential to its success.

## **Review of Literature**

### **Introduction**

There is very limited understanding around DT at present and therefore it is important to identify why DT is used with older people with dementia and establish guidelines for implementation and use. Scott (2011) observes that older people with dementia display fundamental needs including attachment, identity, comfort, occupation, inclusion and above all, love, and that DT can fulfil these needs if the individual responds positively to it. James (2011 p.157) emphasises that throughout this process "it is paramount that the doll use is guided by the person" themselves to meet their own personal needs. Walker (2005) and James and Mackenzie (2005) agree, encouraging a needs-led approach. Bisiani and Angus (2012 p.448) state that for people living with dementia "their present reality [is] strongly linked to past memories" and that these impact the needs individuals express and address through DT. Fernandez, Arthur and Flemming (2013) believe that DT addresses attachment behaviours including parental fixation and seeking people who are no longer living or in contact. These behaviours are believed to lead to challenging behaviours. James et al. (2005) argue that DT can reduce challenging behaviours and address social and emotional withdrawal. Ehrenfeld (2003 p.296) states that DT works with older people with dementia as "play comes naturally to patients in a regressive state of mind". She emphasises the basic human needs for physical contact and touch, stating that these often increase in older people with dementia and require a therapeutic approach such as DT. Wylie (2001) and Walker (2005) agree, recognising play as an innate part of the human experience which is easily experienced/exhibited by older people with dementia through lack of social inhibitions.

Alander, Prescott and James (2013), and Ellingford et al. (2007) state that despite cultural expectations, both men and women engage with DT. Ellingford et al. (2007) refer to a study by James, Mackenzie and Mukautova-Ladinska (2006 p.37) and state that "being female and having a diagnosis of dementia are associated with choosing a doll" but that DT is not limited to this client group.

Mackenzie, Wood-Mitchell and James (2007) provide guidelines for DT implementation. They advise that when introducing DT, dolls should have:

- soft bodies
- eyes which open and close to avoid distress over the doll being asleep/dead
- different faces and clothes to avoid confusion over ownership.

Other factors such as clothing and skin colour should be considered for gender/ethnic suitability. Blankets and additional clothing should be

supplied to distract from the cold feeling of the doll and these should be kept clean. The authors discourage dolls which make noises as this can upset and confuse older people with dementia and the feeling of batteries within the doll is distracting, confusing and unrealistic. These guidelines support findings by other researchers (Moore 2001), however Gibson (2005) highlights that user preferences and responses vary. These should therefore be considered as a basic set of guidelines.

Ellingford et al. (2007) add that dolls should be introduced indirectly by leaving dolls in communal areas and on chairs, to allow for free interaction. The authors also encourage staff to implement DT as a therapeutic alternative to pharmacological interventions. To use the above guidance effectively staff should also be given appropriate training and families should be advised about DT. Mackenzie, Wood-Mitchell and James (2007) state that staff, families and visitors should be aware of DT before implementation as a positive attitude is required by all involved, for DT to be effective for older people with dementia.

Mackenzie, Wood-Mitchell and James (2006) found prediction of DT use and success very difficult. Between professionals and families, only 55% of predictions for use and 80% of predictions against use were correct. They also state that families and carers have a great influence over DT use and success. They state that in some cases the older person with dementia may really want to engage, but families may not approve, and will discourage it. Families should therefore be encouraged to engage with DT and in this way the above guidelines should be used to allow free access to dolls. Those involved should also ensure dolls are not removed without permission, a valid reason/explanation and reassurance that it will be returned. They also stress that DT should be used along side activities within the home, not instead of it, and encourage people to be creative with DT and use dolls to "promote joint activity between staff and residents" (Mackenzie, Wood-Mitchell and James 2006 p.27).

Kitwood (1997) suggests that within person-centred dementia care it is the role of the worker to engage with and respect the individual's potentially multiple realities, to fully understand their needs. Mackenzie, Wood-Mitchell and James (2006) encourage carers to reassure older people with dementia by using the same term/name for the doll as the older person with dementia (e.g. a doll or baby). Andrew (2006 p.419) agrees, as "it is up to the person with dementia to decide whether it is a baby or a doll and it is the staffs' responsibility to reinforce whatever the person decides". Moore (2001 p.20) agrees also, stating that "an acceptance by staff of the resident's beliefs about their doll had clearly been beneficial". Therefore, DT must maintain the older person dignity at all times, and with clear therapeutic intentions for use.

### **Facilitating and encouraging interaction and communication.**

"Many participants felt that the central purpose of doll therapy was to facilitate and allow (the individual) to confide in a doll without feeling criticized" (Alander, Prescott and James 2013 p.7). Doll users were enabled to create dialogues with their dolls, providing the responses they wanted to hear. This initial communication can evolve to include staff,

other residents and family, as the doll provides a conversation focus to allow sharing of similar experiences. Staff also found that some users communicated their needs through the doll, by saying the doll was tired/hungry and this allowed a greater understanding of the needs of older people with dementia.

Similarly, Lash (2005) discusses a client who created conversations with her bear. Initially, the client acted out disagreements/arguments with the bear, and gradually formed fuller, more positive conversations. The woman communicated pain and resolved family conflicts by discussing these with the bear. The woman expressed love and affection towards the bear and showed a strong and genuine attachment. Gibson (2005 p.22) recalls how her mother's doll would "initiate the conversations", and adds that her mother expressed happiness through imagined conversation and responding to the 'dolls laughter'. Moore (2001) notes that older people with dementia "will often transfer their emotional state onto the doll", and feels that this can be a powerful way of communicating with staff and caregivers. This is due to "the doll's ability to unlock emotions, this then allows emotional floodgates to open, and repressed emotions to flow" (p.20).

A range of similar case studies support these conclusion (Walker 2005; Bisiani and Angus 2012; Redwood 2005; Minshull 2009). These studies found that clients were able to regain lost communication skills, actively engage in reminiscence and contribute to group working.

Fraser and James (2008) discuss DT's use within groups. They state that a daily group for doll users developed during their study. The use of the doll as a common and familiar subject allowed for easy engagement between doll users, which subsequently increased communication with staff and families. The researchers also noted an increase in non-verbal communication, including eye contact and touch. Overall staff felt that DT facilitated the innate human need for social interaction within the home. Mackenzie et al. (2006) found similar results, stating that interaction increased on introduction of DT and remained consistently high thereafter. In an initial investigation into DT within Japan, Tamura et.al (2001p.117) also found during their experiment that interaction increased amongst doll users.

In relation to reminiscence, Kitwood (1997) states that a positive connection to the individual's past allows the older person with dementia to retain their identity and sense of self. This can be encouraged through reminiscence to allow carers to understand the person holistically, and is essential to providing person-centred care. Fraser and James (2008) found that DT evoked memories cognitively, emotionally and physically. The researchers felt this to be "beneficial as they may relate to periods of happy times and offer a sense of satisfaction and enjoyment" (p.60).

### **Meeting Attachment and Nurturing Needs**

Bowlby (1969) recognised the significance of attachment within older age, stating that the need for a secure emotional connection often increased

during ill health, feelings of threat, anxiety and loss, and approaching death. Kitwood (1997) agrees, stating that attachment is a core human need allowing older people to feel wanted, needed, useful, engaged and secure. Miesen (1993) and Moore (2001) share similar opinions. Throughout DT research, most studies indicate that DT can meet attachment needs through simulating familiar roles and providing a sense of purpose (Scott 2011). Likewise Fraser and James (2008) identified dolls as stable attachment figures which provide comfort, meaningful touch, close contact and security, and allow the person to retain and develop personal identity.

In a case study Bisiani and Angus (2012 p.445) recall one client who was "instantly preoccupied by the doll, held out her arms, looked down at the doll, ceased shaking, became calm, looked up and said, very clearly, 'this is what makes life beautiful'". They witnessed an instant increase in attachment and positive behaviours and a major decrease in challenging behaviours. Consequently, the client's self-esteem and communication also improved, which had positive effects for her overall health and wellbeing. These were long-term therapeutic outcomes.

Fraser and James (2008) reported that older people with dementia responded so well to DT due to the comfort, reassurance, overcoming of loneliness, sense of validation and inclusion that the person with dementia gained through attachment behaviours. In one case an older person with dementia stated that the doll reminded her of being a mother and allowed her to recreate attachments through reminiscence. Bisiani and Angus (2012) discuss reminiscence through DT as a way of developing new attachments and overcoming previous negative attachments which otherwise encourage challenging behaviours.

With regards to nurturing behaviours, Alander, Prescott and James (2013) witnessed participants carrying, feeding and dressing the dolls. The authors related this to maternal/paternal instincts and nurturing tendencies, relating in parenthood. The authors also argue that DT offers consistency, "continuous companionship" at the individual's disposal, a "sense of connection" and makes the individual feel "less socially isolated and lonely" (p.7) without the demands of human relationships. Tamura et al. (2001) found similar results, with participants clapping, cuddling and stroking the dolls.

Similarly, James et al. (2005) discuss a case study whereby the client became more expressive, was proud of the doll and displayed nurturing behaviours. These new behaviours encouraged staff to engage with her and enabled positive attachments. They observed that attachments were unique to each participant. Ehrenfeld and Bergman (1995) and Ehrenfeld (2003) found similar results, suggesting that stronger attachments formed with families and staff through reminiscence and secure attachment. Scott (2002) gives her opinion as a practicing social worker. She referred to her client's previous caring role within the family unit throughout her life. The client found these roles difficult to relinquish, and obsessed over family members, straining relationships. This reduced significantly once she focussed her attention upon her doll, allowing her to remain at home with her family. Verity (2006) discusses two similar case examples. One

participant was able to employ her caring attitude therapeutically, positively redirecting her from looking after other residents. Similarly, the other participant was able to connect to suppressed emotions and apologise to his daughter for being absent during her childhood. This was a significant healing process for his daughter and encouraged a closer relationship to form. Lash (2005) offers another example whereby during an unsettled stay in hospital a client's agitated behaviours subsided when she was given her bear to comfort her.

### **Acting as a Transitional Object**

A key part of making a transition into residential care involves maintaining roles and responsibilities, often achieved through transitional objects. Alander, Prescott and James (2013) indicate that DT can provide a meaningful proxy caregiver role which allows ease of transition from home into permanent care or a hospital setting.

Loboprabhu, Molinari and Lomax (2007) feel that the transitional object is an underestimated and under-researched element in dementia care, as it can act as a secure anchor for older people with dementia. Dolls can be familiar and emotionally charged objects therefore providing comfort and security. They felt however, that it was difficult to introduce transitional objects to older people with dementia and therefore encourage the use of objects which carried emotional value prior to dementia. Wylie (2001) concurs, stating that one participant had taken dolls and bears from home. These allowed for easier transition into residential care, and provided comfort and security within the unfamiliar setting. Stephens, Cheston and Gleeson (2012) gained similar results.

Fraser and James (2008) found that older people with dementia "lose figures and/or objects of meaningful attachment, such as family members, and familiar and sentimental belongings" (p.60). They therefore recognise that a doll can act as a significant object creating comfort and security. Bisiani and Angus (2012 p.5) state that "those who cling to dolls and soft toys appear to be embracing a transitional object that may be considered a representation of the personal support that they yearn for". Linking closely to attachment behaviours, Miesen also states that transitional objects decrease tendencies for parental fixation whereby the person searches for an attachment figure to provide them with security and familiarity.

DT can also act as a transitional object when situations change (Redwood 2005). One participant became very distressed when her son's visit ended and was difficult to calm/redirect. However, by using DT carers found that she was "enraptured, and it clearly gave her the chance to express emotion, reminisce and have a break from worrying about where her son was" (p.10). DT clearly acted as a transitional object through offering security.

### **Provision of sensory stimulation and engagement in activities**

McKee et al. (2005) argue that when older people with dementia remain active and stimulated they hold positive self-images, retain overall life satisfaction and benefit from fuller social engagement. Bailey, Gilbert and Herweyer (1992) found DT to be a valuable source of sensory stimulation which provided and encouraged involvement in activities and meaningful tasks. Similarly Moore (2001 p.22) adds that this provides individuals with a role, purpose and sense of achievement: "it's like a gold medal and it's mine". Verity (2006 p.26) adds that DT provides the individual with "absorbing, enjoyable and stimulating activity bringing past learned skills" into use, independently and flexibly.

DT affords a sense of achievement, purpose, responsibility and pride. Participants within their study "appeared to elicit positive emotions bringing happiness and pleasure to the person" (p.6) through playing with and nurturing the doll (Alander, Prescott and James 2013). DT's flexible approach afforded older people with dementia opportunities for meaningful activity. Bisiani and Angus (2012 p.448) describe these as tasks which "reflects habitual activities in earlier life such as looking after family and children". Andrew (2006 p.419) adds that DT therefore "provides an opportunity for the person to give care rather than receive it" through engaging in instinctive and rewarding activities that they know and remember how to do. He argues that this preserves dignity and facilitates achievement and control and allows opportunities for reminiscence.

Redwood (2005) discusses how two of her participants in particular gained sensory stimulation through DT as they were able to engage in group activities or in individual play with the doll. She adds that for one client DT brought a calming influence that enabled group activity. Fraser and James (2008) discuss similar findings. Individually, older people with dementia were enabled to reminisce about past roles of childhood/parenthood through play and care-taking activities. Previously, it was difficult to engage older people with dementia in most activities due to cognitive decline and lack of concentration, but staff found that DT acted as a "catalyst [for] meaningful social exchange" (p.61). With its flexible approach it can be incorporated into other activities and provides the older person with dementia with a sense of accomplishment, improved self-esteem and motivation.

Again, Tamura et al. (2001) discuss their observations whereby DT was used to provide stimulation and positive distraction from anxious behaviours. Mackenzie et.al (2006) agree that an overwhelming sense of calm was felt during their study. Residents were more engaged in activities, more amenable to personal care tasks and able to gain sensory and mental stimulation through doll interaction. In a more recent paper, Mackenzie, Wood-Mitchell and James (2007 p.26) describe dolls as being a "vehicle for activities for residents who previously were unwilling to engage in any type of activity".

## **Additional Identified Outcomes**

- DT allows individuals to retain physical, social and mental capacities Alander, Prescott and James (2013).
- Although DT involves minimal movement (laughing, smiling and cuddling) it discouraged idleness and promoted physical abilities and motor skills (Gibson 2005).
- Mobility, pace and general physical health can be improved through walking dolls in prams, and using basic movements with dolls.
- Gibson (2005) found personal care tasks became easier to undertake as the service user was calmer. This had positive repercussions for her health. Therefore dolls encourage "effective in promoting healing and motivation in patients with dementia" and should be used from a health perspective (Tamura et.al 2001 p.118).
- From a mental health perspective, Bisiani and Angus (2012) record dramatic reduction or elimination of anxiety, panic attacks, hyperventilation and tremors which in turn reduced falls.
- DT can also meet unmet need and simulate new experiences through simulation of care giving through role play. This promotes continuous life-long learning and achievement (Alander, Prescott and James 2013). DT can also encourage reminiscence of past experiences (Bisiani and Angus 2012; Redwood 2005) and can be done independently or with the aid of others, objects and discussion.

## **Analysis**

It is clear from the literature discussed that there are benefits to DT that can be applied by a range of professionals within residential care/nursing homes, (James et.al. 2005), with individuals living in the community (Scott 2002), in clinical settings (Lash 2005) and with people without dementia (Mackenzie, Wood-Mitchell and James 2007). With consideration to its limitations, there is much strong evidence in favour of DT as an individual and flexible, person-centred and needs-led approach. Alander, Prescott and James (2013) articulate that DT can elicit positive emotions by meeting a variety of different needs for individuals, and found that non doll users generally understood and accepted others' use of dolls. Further study indicated that residents experienced social connectedness, increased interaction and the development of supportive relationships through sharing dolls and discussing them.

Bisiani and Angus (2012 p.457) summarise that for their client Mary, DT acted as a "catalyst for Mary to regain significance in her life and thus improve her self-worth and confidence". This indicates the level of positive change possible through DT. Gibson (2005) found that her mother regained some control, familiarity and connection to the world outside her own reality. Similarly, Higgins (2010 p.18) states that the "well-being of someone with dementia is very much dependant on the environment they

are in, and finding ways to enhance the individual's well-being is the goal of person-centred care". This recognises that as person-centred working is considered vital in dementia care (Kitwood, 1997) that DT is a valid and relevant therapeutic approach.

DT seems to offer a positive calming effect for older people with dementia whereby a "general reduction of socially inappropriate behaviours" and agitation occurs (Alander, Prescott and James 2013 p.9). Ellingford et al. (2007) agreed this to be the most apparent outcome for older people with dementia. Following a three month longitudinal study they found a major reduction in challenging behaviours and significant increases in positive behaviours by those who used dolls, suggesting positive long-term outcomes. Fraser and James (2008) add that DT enhances interaction with the person with dementia through the creation of a common ground. This, as in reduction of challenging behaviour, is "one of the main strengths of the doll" (p.61).

### **Interpretation**

The most prevalent outcome of DT is that it increases wellbeing, thereby reducing challenging behaviour (Mackenzie et al. 2006; Ellingford et al. 2007). Robert et al. (2005) found that 60-90% of older persons with dementia display challenging behaviour and in a typical UK care home over 40% of residents will be prescribed neuroleptic medications to control behaviours (Dempsey and Moore 2005). James et al. (2008) conclude that new approaches are needed to decrease medication use as medications have limited desired outcomes and carry negative side-effects. Problems include increased falls, accelerated cognitive decline and tardive dyskinesia (neurological disorder causing involuntary spasms) (McShane et al. 1997).

Despite these warnings many older people with dementia are routinely treated with medication because staff trust in, reflecting "...low staffing and training levels, and management opposed to therapeutic cultures" (Verity 2006 p.37). Weaver (2007 p.376) adds that "pharmacological treatment options are recommended if behaviour poses an immediate risk to the individual or to others" but that other therapies, including DT, should firstly be considered.

There remain key debates around DT. Some research indicates that families and workers can appear sceptical/negative about DT in relation to age-appropriateness, finding it potentially demeaning and confusing (Mackenzie et al. 2006). Some families feel DT is infantilising and conveys indignity (Andrew 2006). Furthermore, concerns exist around validating the older person with dementia's perceived realities of dolls being babies. Cayton (2001) and Salari (2002) state that dementia should not be seen as a second childhood, and agree that employing and validating potentially misleading therapies is deceiving and disrespectful.

Minshull (2009 p.36) states that validation should be viewed as the "avoidance of an unnecessary truth rather than a lie". This is agreed throughout most of the research addressing DT ethics (Andrew 2006; Bisiani and Angus 2012; Higgins 2010; Schermer 2007).

Following the implementation of DT however, all staff felt that older people with dementia's lives were better/much better. In particular staff have conveyed concerns about men using DT (Minshull 2009). Mackenzie, Wood-Mitchell and James (2006) recommend provision of literature and training for staff/families prior to implementation. With acceptance of DT Bisiani and Angus (2012 p.458) state that DT "brought staff together improving morale, and strengthened the team".

Gibson (2005) states that DT can be invaluable to the family. Andrew (2006 p.419) argues that DT "could be seen as preserving the person's dignity, rather than diminishing it" by reducing challenging behaviours and increasing wellbeing. Lash (2005) agrees. Andrew (2006) adds that challenging behaviours also affect other residents, and concludes that if DT reduces these, it would be unethical to discourage DT. Overall, DT is an approach open to debate, and there is clearly further research required to address key issues of practice culture and implementation aligned to family perception and understanding of the therapy and its objectives.

### **Potential difficulties in the introduction and use of Doll Therapy**

Although DT research emphasises positive outcomes there are limitations and potential difficulties in practice. Mackenzie, Wood-Mitchell and James (2007) warn that one client became distressed about her doll being removed and that consideration should be given to childhood/parenthood experiences before introducing DT. Dolls should not be removed without good reason and assurance of its return. It has proven difficult however to predict complications in doll use. Walker (2005) warns of further difficulties if the doll is broken, lost or misplaced. Staff should provide durable dolls, and keep these safe.

Mackenzie et.al (2006) found that some users confused dolls for babies, and became distressed over ownership of dolls. Other difficulties occurred if older people with dementia became overstimulated, fatigued, overly occupied or attempted to feed dolls. Gibson (2005) found distraction and preoccupation to be particularly problematic during mealtimes and bedtimes. Other researchers concur. Gibson cautions further, stating that her expectations were too high as her mother was still distressed on occasions. Higgins (2010) Tamura et al. (2001) encourages sessional work, stating that this is effective in reducing dependence, although limits positive outcomes.

Stevenson (2010) warns of possible difficulties relating to non-users. James, Mitchell and Mukaetova-Ladinska (2006) recognised that some non-users expressed their disapproval of DT openly. Individuals should be informed of why others use dolls and reassured that they need not participate.

Overall, Higgins (2010 p.20) summarises that a "lack of a standardised approach to using dolls with people with dementia remains a concern" although there are suggestions for use (Moore 2001; Mackenzie Wood-Mitchell and James 2007; Stevenson 2010). James et al. (2005) suggest a cautious approach be taken as there is still limited research into DT's immediate and long-term effects.

## **Relevance to social care**

A key consideration for this paper is the relevance DT has to social care practice. 'Social care practice' here can be extended to nursing staff, social workers, community workers, residential care staff and professional carers. By examining theories, national policy, Scottish Social Services Council (SSSC) codes of practice and practice values it is evident that DT can be considered as a potential intervention.

With regards to theory, Maslow's hierarchy of needs and Erikson's life stage approach are key within social care practice. Trevithick (2005) discusses Maslow's Hierarchy of Need, showing that four of five levels relate to interaction and social needs. These are felt to be inherent human needs, many of which can be met through DT. Similarly, Santrock (2002) details Erikson's Life Stage theory whereby the final stage is Integrity versus Despair. However older people with dementia can regress to earlier developmental stages, focussing on self-care, looking after others and learning new skills. DT can be used flexibly to allow the person to fulfil their felt needs. Other key theories include Kitwood's (1997) teachings around Person-Centred care and Bowlby's (1969) theory of Attachment. These have been linked to DT within research.

When considering the social policy context, the most current policy, Scotland's National Dementia Strategy (Scottish Government 2010) identifies several outcomes. These relate to encouraging the development of skills and knowledge, responding more appropriately to challenging behaviours and further researching dementia care. DT's outcomes therefore clearly align themselves with current national objectives, and would prove valuable as a social care intervention.

Finally, the SSSC (2009) codes of practice should be considered. These clearly explain that workers must update their knowledge, respect service user rights and choices, promote their independence and ensure clients cause no harm to themselves or others. With reference to the research identified throughout, DT is clearly supported by these codes. Similarly, social care values should be considered. These include client self-determination and independence (Thompson 2009) and therefore support DT. Again, ethical issues may encourage some to question values such as honesty and integrity, however generally Social Work values support DT. Clearly there are links between social care practice and DT. Therefore DT should be considered by social care workers as a potentially effective intervention as part of care plans (Verity 2006) and should be considered to maintain clients within the community (Scott 2002).

## **Summary**

Overall, DT offers a new and exciting therapeutic intervention to social care practitioners. DT is currently being examined within the USA, Australia, Japan and Britain and a pilot study within the Netherlands (Pezzati et al.2014) shows that DT is spreading. The therapy can be considered a simple and flexible way of engaging older people with dementia and allowing them "an opportunity to deal with ongoing inner psychological distress in a more adaptive way" (James 2011 p.157). At its

best Moore (2001) hopes that doll therapy can ensure dementia is not about "confusion, forgetfulness and inevitable decline" but can transform an individual's own experience and "involve an awakening of the ability for playfulness, laughter, love and affection" (p.23).

When considering the overall value of DT, there are clear benefits to older people with dementia. Bisiani and Angus (2012 p.450) summarise current thinking around the effectiveness of DT, and state that "to date, there is no research evidence to suggest that doll therapy is destructive, dehumanizing, or disrespectful, nor is it of no benefit". They conclude that if DT "does not upset that person emotionally, provides a sense of solace and joy, a sense of calm, improves communication and reduces behaviours of concern, then there is a place for doll therapy to be examined as a form of therapeutic encounter" (p.450). Mitchell and O'Donnell (2013 p.331) refer to existing literature and argue that 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". As most experimental studies (James, Mackenzie and Mukaetove-Ladinska 2006; Mackenzie et al.2006; Ellingford 2007) use older people with dementia within the same geographical area results may be limited in their transferability. However, as Minshull (2009 p.35) states "despite an apparent consensus, doll therapy remains controversial", and people are often critical of the approach. Any concerns expressed by staff, families and other residents should be addressed through the provision of training and literature on DT and it's potential benefits.

### **Conclusion**

As research remains limited further exploration need to be carried out with older people in the community, in hospital settings and also those without dementia to determine who may benefit from it. This research needs to be transferable between populations in different geographical locations. So far research has identified the needs which DT seeks to address and its main outcomes. To become a reliable intervention we need to understand why dolls work for some older people with dementia but not for others and how to predict doll use/success. There also needs to be training for staff and relatives to ensure the intervention is managed effectively and safely.

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