The number of people affected by dementia is increasing rapidly. Alzheimer’s Disease International (2012) estimates that the number of people with dementia worldwide will increase threefold by 2050, from 40 million to 115 million.

In the light of this growing global population, research has been undertaken on enhancing the wellbeing of people with dementia. Therapies that have proved successful include music therapy, aromatherapy, constructing memory boxes and sensory/tactile activities (Holt et al 2009, Woods et al 2012, Vink et al 2013). These therapies centre on beneficent principles in relation to improving quality of life. An added benefit of these therapies is that they often reduce the need for psychotropic medications, such as risperidone or olanzapine, that have side effects, most commonly increased sedation (James et al 2008).

Doll therapy shares a number of similarities with these therapies. Engagement with a doll comes in a variety of forms that might include holding, talking to, cuddling or hugging, feeding or dressing (Mitchell and Templeton 2014). It has been associated with a number of benefits for some people (James et al 2006).

These include increased levels of engagement with other residents, family and care staff, reduction in episodes of distress, improved dietary intake and generally an increased level of wellbeing (Mitchell and O’Donnell 2013). In the light of the potential benefits associated with doll therapy, use in clinical practice has been growing globally (Mitchell and Templeton 2013). However, despite its potential benefits commentators on doll therapy remain divided (Mitchell and Templeton 2014).

**Definition**

According to Verity (2006), doll therapy is the careful use of dolls to improve the wellbeing of people with dementia. Moore (2001) explored the controversy surrounding doll therapy as he documented its effect on practice. He first perceived doll therapy as infantile, childish, patronising and demeaning, but changed his opinion after witnessing patients with dementia using the doll and seeing the benefits as a mechanism to address distressed behaviour. Lash (2005) also found advantages to using doll therapy, describing an experience of a patient who used a teddy bear that helped with challenging behaviour and opened up a new channel of communication with the care team.
Verity (2006) declared that ‘the debate was over’ and cited many case studies of individuals who had benefited from doll therapy. Many others have given further positive accounts of play and doll therapy (Knocker 2002, James et al 2006, Higgins 2010, Risiani and Angus 2013).

The use of dolls in care has been criticised (Mitchell and Templeton 2014). Boas (1998) believed the practice of providing a doll to anyone with dementia could be demeaning, while Cayton (2001) posed questions about the veracity, or truthfulness, of the practice. This is because people with dementia who engage with doll therapy often believe their doll to be a live baby. Salari (2002) was also uncomfortable with the therapy due to its similarity to play therapy, which is often used with children.

The issue of truth-telling in particular is a common thread that appears to exist in all ethical discussions about the therapy (Boas 1998, Cayton 2001, Salari 2002, Mitchell and Templeton 2013, 2014).

Current practice guidelines on doll therapy advise healthcare professionals to validate or ‘go along’ with people with dementia if they believe their doll to be a baby (Mackenzie et al 2007). This validation can cause health professionals some distress because facilitation of a false reality goes against their moral and professional values (Mitchell and Templeton 2014). That being said, there are a number of people who believe the wellbeing of people with dementia is most important and health professionals’ validation of this reality is therapeutic (Andrew 2006, Tuckett 2012, Culley et al 2013).

**Research findings**

Up until around seven to eight years ago, the literature on doll therapy was formulated largely from personal opinion, or anecdotal evidence, because no empirical studies had been carried out (Mitchell and O’Donnell 2013). The Newcastle challenging behaviour service in the UK pioneered a trio of studies that sought to illuminate the extent to which dolls could be therapeutic for people with dementia in practice (James et al 2006, Mackenzie et al 2006, Ellingford et al 2007). Collectively the studies described the following benefits:

- Reduced agitation and aggression.
- Reduced tendency to wander.
- Increased wellbeing.
- Increased interaction with staff and family members.
- Reduction in use of psychotropic drugs.

While the advantages outweighed the disadvantages, some drawbacks were noted, including:

- Not everyone wanted to engage with a doll.
- Relative and staff scepticism.

### Box 1  Recommendations for use of doll therapy for people with dementia

- Inform family and healthcare professionals in the unit before introduction of dolls. Family members should be provided with a summary of the potential benefits. Importantly, all parties must be made aware that when a doll is introduced and is accepted by a person with dementia, it will not usually be removed.
- If doll therapy is to be used by more than one person with dementia in the same unit, healthcare professionals should seek to provide different styles of doll, that is, with different clothes. One example is shown in Figure 1 (page 26). This will limit potential confusion over ownership because a doll should belong to one person.
- Avoid dolls that cry or have their eyes closed. These have been shown to distress some people with dementia, either because they cannot stop their doll from crying or they believe their doll to be a baby that has died.
- Help people with dementia to make their own choice about engaging with dolls, that is, do not force them on everyone; rather place them in an area where people with dementia can make their own decisions. Naturally, this can be difficult if mobility or sight is reduced.
- Keep accurate care plans relating to doll therapy. Of particular importance is monitoring levels of fatigue, because caring for a doll as if it were a baby is tiring.
- If people name their doll, all healthcare professionals and family members should be encouraged to use this name. Also, if people believe the doll to be a baby, this belief should not be invalidated.
- The doll should never be removed without permission of the person with dementia. When removing the doll, healthcare professionals and family members should hold the doll as if it were a living baby and explain where they are taking it, for example, if the doll is dirty, it is going to be washed.
- If storing the doll, do not place it in a box, on the floor or on a radiator. It should be put in a safe place because the person engaging with it may perceive it to be in danger.

(Adapted from Moore 2001, Mackenzie et al 2007, Scott 2011)

- In some cases increased distress, for example, when a doll was mislaid.
- Pre-intervention, if healthcare staff failed to predict which residents might benefit from doll therapy. After investigation by the service, a number of other clinicians/researchers sought to examine doll therapy empirically (Fraser and James 2008, Minshull 2009, Risiani and Angus 2013, Stephens et al 2013). These studies shed further light on the phenomenon and are recommended reading for practitioners who wish to know more about the benefits of doll therapy. Importantly, these studies largely reinforce the advantages and disadvantages, as outlined by the Newcastle challenging behaviour service.

**Conclusion**

Doll therapy has the potential to improve the lives of some people with dementia. While its use in health care is growing, it remains a therapy that is poorly understood by healthcare professionals. Box 1 is a compilation of guidelines based on the evidence. Naturally, these guidelines are more like...
recommendations owing to the fact that there has been limited empirical investigation of the intervention.

The lack of investigation is probably a result of contention about the therapy. Despite its potential benefits there are a number of clinicians who think that providing a doll to a person with dementia equates to what Kitwood (1997) deemed infantilisation or treating the person with dementia as a child. This treatment is detrimental because it increases the stigma associated with the condition (Mitchell and O’Donnell 2013).

Healthcare professionals who care for people with dementia find themselves in a difficult position when considering doll therapy. There are ethical positions that support engagement and disengagement with dolls (Mitchell and Templeton 2014). Practitioners should keep the person with dementia at the heart of their decision making by asking the question: will the individual with dementia benefit from doll therapy?

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Conflict of interest
None declared

References
Boas I (1998) Why do we have to give the name ‘therapy’ to companionship and activities that are, or should be, a part of normal functioning in people with dementia? International Journal of Geriatric Psychiatry. 11, 1093-1098.