Article

Doll therapy: A therapeutic means to meet past attachment needs and diminish behaviours of concern in a person living with dementia – a case study approach

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Leah Bisiani
Victoria University, Australia

Jocelyn Angus
Victoria University, Australia

Abstract

The aim of this research study was to examine the impact of the provision of a lifelike baby doll as a therapeutic tool on the behaviour of a person living with dementia. Specifically, this single case study assessed the potential benefits, if any, of the use of doll therapy in reducing behaviours of concern such as anxiety and agitation that may be associated with observed attachment needs of a person living with dementia.

Method: A single case study of a female participant, with moderately advanced Alzheimer's disease, was the subject of this research. The case study used both qualitative and quantitative research design and methodology in data collection and analysis.

Results: Demonstrated that doll therapy was a positive intervention for the person living with dementia who was the participant in this research. The findings indicate a reduction in behaviours of concern related to the need for attachment and a considerable decline in levels of anxiety and agitation. There was extensive ongoing improvement in social interaction and communication.

Conclusion: This research supports doll therapy as a therapeutic intervention that may be utilized within the ongoing care of some persons with dementia to meet needs for attachment and to reduce behaviours of concern. Despite some controversy on this topic, doll therapy should be considered as a therapeutic approach to further dementia care in light of this positive outcome.

Corresponding author:
Jocelyn Angus, Aged Services Management Unit, Faculty of Arts Education & Human Development, Victoria University, PO Box 14428, Melbourne, VIC 8001, Australia.
Email: Jocelyn.angus@vu.edu.au

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Introduction

There is overwhelming research evidence to suggest that emotional and stress-related behaviours are considered one of the most difficult and frustrating challenges for the person living with dementia and their caregivers – disturbing the quality of life for both (Baldini, Boustani, Sloane & Zimmerman, 2004; Sifton, 2004). Understanding these behaviours has progressed from being viewed as a disruptive effort to being understood as an *expression* of frustration, need and of core suffering related to the inability to verbalise a particular distress (Baldini et al., 2004). Ignoring the triggers for these behaviours neglects the needs of people living with dementia and often results in negative consequences (Killick & Allan, 2001).

Research related to the resolution and prevention of these behaviours of concern indicates that people living with dementia have their present reality strongly linked to past memories. There is evidence that a person in the moderate to advanced stages of dementia will respond favourably to familiar attachments related to long-term memories (Kitwood, 1997). Reminiscence is a way to discover forms of attachment and bonding from the past, which may serve to have meaning for the present (Angus & Bowen, 2011; Doyle, 1992; Price, Stevens & Le Barre, 1995). People living with dementia often attempt to search for meaning by reminiscing about the important times within the tapestry of their lives (Angus & Bowen, 2011). Conversely, yearning for an identifiable time or worrying about past relationships can also produce unease and agitation (Mace & Rabins, 1999). Failure to acknowledge and/or resolve these relationships is often exhibited in behaviours of concern (Hudson 2003; Tamura, Nakajima & Nambu, 2001).

Regeneration of past relationships, whether it is through the ongoing engagement with relatives, the use of a doll, soft toys and/or a pet, provides a means of engaging in activity that conveys significance to the individual's present life (Killick & Allan, 2001). Relatively new complementary therapies, such as 'doll therapy', may be potentially useful in reducing challenging and destructive behaviour and maintaining a fulfilling lifestyle for people with dementia. This reflects habitual activities in earlier life such as looking after family and children (Hudson, 2003; Tamura, Nakajima & Nambu, 2001).

This study utilizes a single case study to examine the effect of the provision of a doll as a therapeutic tool on the behaviour of a person living with dementia in a Residential Aged Care Facility (RACF). Specifically, the research examines the use of doll therapy in reducing behaviours of concern such as anxiety and agitation associated with observed past attachment needs. It is anticipated that in meeting past attachment and nurturing needs, doll therapy has the potential to reduce or prevent behaviours of concern and improve self-worth and wellbeing of the participant. This is a position supported by Mackenzie, Wood-Mitchell and James, (2007) where 'the use of the doll may... reinforce a familiar role to the person, increasing a feeling of competence and thus raising self-esteem' (p. 26).

Background

The literature offers differing viewpoints in relation to doll therapy, which challenge stereotypic assumptions of those working with people living with dementia (Bisiani, 2010).

Verity (2008), argues that the way we as researchers evaluate whether doll therapy is suitable for people living with dementia, or not, is based on many of our preconceived assumptions. Verity urges researchers not to make judgments on what *we* think is right for us or on *how* we would feel if given a doll. Stereotypes based on these assumptions become part of how we think, how we believe others should act at certain times of their life and how an older person should behave (Angus & Reeve, 2006). As practitioners, we can make wrong choices for people living with dementia by allowing our prejudices to take precedence, thereby misrepresenting their sense of personal and individual characteristics and needs (Killick & Allan, 2001). Moore, (2001) by observing the absolute joy demonstrated by some residents who were given a doll, suggests that these residents did not find the dolls demeaning, juvenile or dehumanizing so therefore nor should we make or rely on subjective judgment.

Dolls have been used in facilities for years to assist in contributing to a sense of wellbeing and a more positive lifestyle. Piccoli (2003) stated that people living with dementia who exhibit behaviours of concern could nurture dolls and that dolls have been 'used with success to manage restlessness, anxiety, wandering, absconding, shadowing, intrusiveness, withdrawal, aggression and even hallucinations' (pp. 269–272). Tamura, Nakajima and Nambu (2001), in an ethnographic study within a RACF, provided dolls in an activity where they positively distracted people living with dementia when they exhibited anxiety and frustration. In particular, reduction in behaviours of concern was observed to be linked with this distraction. They suggested that the 'patients looked happier, and are more expressive and this enables them to communicate better with others, promotes their social functioning and stimulates their senses and perceptions' (pp. 11–15). Dolls as a therapeutic tool may provide the impetus for activities for residents who previously were unable to engage in any type of activity (Mackenzie et al., 2007). Crisp (2000) suggests that pets, toys and dolls can provide an extremely important function in assisting older people to focus on the surrounding environment and to prevent social withdrawal by providing 'ready-made topics' of conversation, which then improve and maintain communication and social interaction (pp. 46–47). Verity (2008) described people living with dementia as having emotional requirements that include being considered, needed, and valued; to have occasion to care and feel worthy; to be devoted to, and loved, in return; and to communicate emotion without restraint. With their potent figurative meaning, dolls can be helpful in meeting those emotional requirements.

There is the view by some writers that encouraging and fostering false illusions by using a doll or encouraging fantasy may be disrespectful to a person living with dementia. Cayton (2001) suggests that the use of dolls is ethically unjust because caregivers are using an illusion to 'trick' the person. Korsgaard (1996) argued that according to the 'formula of humanity', compelling force and trickery are the most elementary forms of offence towards others. Schermer (2007) presents an alternative view that 'white lies' in the care of a person living with dementia should perhaps not be considered lies, since they are not a deliberate act to betray or trick. Schermer believes that if we disregard the potential benefits of dolls for emotional wellbeing then we may possibly jeopardize the stability of everyday life and the capacity to thrive. She argues that people living in their own inner world should never be forced out of it with a request to orientate to *our* truth and actuality, if all this will create for them is pain.

Another criticism is that the use of doll therapy may be perceived as a 'second childhood', thus dehumanizing and infantilizing that person (Hughes, Louw & Sabat, 2006). They suggest that doll therapy constitutes a 'rigid, deficit-based approach to care' that can foster negative attitudes towards caring for people living with dementia (p. 283). The authors argue that, if feasible, the real thing would be more appropriate, not as undignified and that using a doll and simulating play is completely different from how a child interacts with a doll. They contend that with children this can be seen as ‘play’ and ‘pretend’; however, they claim it can be negative for the person with dementia if the doll is perceived as a baby. Importantly, we should never lose the ability to keep in touch with our inner playfulness. This is a view supported by Wylie (2001) who proposes that within us all there lurks playfulness: ‘[u]ncovering such feelings helps us connect with emotions and memories that our adulthood and busy lifestyles rarely afford time or permission to recollect’ (p. 22).

Though there are differing opinions about the provision of dolls for people living with dementia, there is scant research evidence overall. There are, however, signs of a gradual change in attitude towards the positive aspect of the use of dolls. Schermer (2007) suggests that there is probably no theorist or ethicist who would be disposed to dispute that lying to a person living with dementia is totally immoral in *every* situation. Andrew (2006) provides some guidance here. The therapeutic value lies in the way the doll is presented, that ‘it is up to the person with dementia to decide whether it is a baby or a doll and it is the staff’s responsibility to reinforce whatever the person decides’ (p. 419). Andrew (in citing Marzanski) refers to this as a ‘justifiable benevolent deception’ where therapeutic privilege provides the person with a means to participate in a role that is meaningful and rewarding to them. This is a view supported by Killick and Allan (2001) who contend that *any intervention* that connects positively with people living with dementia at a profound level is essentially right. Ultimately, this paper supports Killick and Allan’s view that ‘it is not the activity itself which dictates the nature and meaning of an experience, but rather the way it is carried out’ (p. 115). When attempting to understand a person living with dementia we endeavour to capture these differing viewpoints and scrutinize the interpretation of what we observe. In this way we acknowledge, and thus support each person’s reality as his or her own personal truth (Patton, 2002). To date, there is no research evidence to suggest that doll therapy is destructive, dehumanizing, or disrespectful, nor is it of no benefit. If a doll is of benefit to the lifestyle of a person living with dementia, does not upset that person emotionally, provides 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 (Bisiani, 2010).This position is broadly supported by James, Reichelt, Morse, Mackenzie and Mukaetova-Ladinska (2005), who advocate for, ‘effective psychotherapeutic approaches that can be used either alongside, or independently of medicine’ (p. 19).

Theoretical underpinning

The theoretical underpinning of this study is guided by the principles of person-centred participatory research in dementia (Kitwood, 1997; Dewing, 2002) whereby the researcher engages with, and respects, the ways in which older people with dementia construct their multiple realities and their unique construction of their behaviours with whom they interact. As researchers, we respect these different experiences and perceptions, and aim to give these realities the ‘voice’ they deserve (Dewing, 2002; Patton, 2002). In person-centred research, these perspectives are considered more like a therapeutic encounter, which allows the researcher and the participant to share the search for meaning in the participant’s construction of their unique time and place.

When considering doll therapy as a possible intervention we also need to have a greater awareness of attachment behaviour if we want to communicate with people living with dementia (Killick & Allen, 2001; Kitwood, 1997; Miesen, 1999). Miesen, strongly influenced by Bowlby's (1969) theories of attachment in children, related this theory to people living with dementia and suggested that because dementia and related memory disturbances alter typical methods of communicating with others and the ability to recollect effectively, then those people 'must find security where they can' (p. 248). People living with dementia frequently find their environment constantly changing and bizarre, which can trigger feelings of loss of attachment and anxiety (Miesen, 1992). Those with 'anxious-ambivalent' styles of attachment can be inclined to feelings of desertion and rejection, which can lead to feeling fearful and powerless when attachment figures are not available (Magai & McFadden, 1995). According to Kitwood (1997), meeting that core need for attachment may have a direct effect on the existing needs of the person, with the conclusion that 'if the need is not met a person is likely to decline and retreat. When, however, the need is met, a person may be able to expand again, having a distinct place' (p. 83). Some people living with dementia select attachment figures. Miesen suggests 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; – in this study, the use of doll therapy attempts to address this need.

Ethics and informed consent

The inherent deception in the use of dolls is of ethical concern (Andrew, 2006). The issue of 'capacity' is a fundamental legal pre-condition to informed consent. This study observes the guidelines set out in *The National Statement of Ethical Conduct in Research Involving Humans* (Health and Medical Research Council, 1999, Section 4.5) that safeguard the voluntary nature of the participants with 'intellectual and mental impairment' to participate in, or to withdraw at any time from, the research process. This concept of informed consent with regard to research and practice is an area of ongoing debate because there is little inclusion of the person living with dementia as the consent-giver, with proxy informed consent being the most common method of consent, despite ethicists and researchers advocating that person-centred care approaches must at all times be paramount (Buhuniak, 2010; Dewing, 2002; Kitwood, 1997; Sherratt, Soteriou & Evans, 2007).

The presumption that people with dementia are not able to make decisions has been largely replaced by the proposition that capacity should initially be presumed and given agency alongside family members and service providers (Buhuniak, 2010; Sherrat, Soteroiu & Evans, 2007). The person with dementia, including those in the advanced stages, can still maintain intermittent insight into their own needs, and therefore retain the right to make their preferences known when able to make this decision (Sherrat, Soteroiu & Evans, 2007; Vass et al., 2003). This in turn has encouraged a number of studies seeking to hear the voice of the person with dementia (Angus & Bowen, 2011). Moody (1995) further advocates that being part of, and being empowered within, therapeutic research may be important to a person with dementia. Having their chance to contribute, may provide that person with a sense of significance through willingly consenting and being part of research process; a position echoed by a person with dementia who writes '[o]n my good days I will give all I've got. I will take part in anything and do all I can if I think that somewhere at some time it will help others to beat this awful disease' (Robinson, 2002, p.105).

Balancing the need to adhere to more structured forms of consent to incorporate more flexible methods that include and benefit people living with dementia in social research, we have drawn particularly on the work of Dewing (2002). From a person-centred perspective, gaining consent from people with dementia to participate in research is a meaningful and inclusive process that takes them seriously as capable persons (Dewing, 2002). We were guided by Dewing's (2002) notion of 'inclusionary consent' based on principles of social justice and personhood to include the person within the consent process. Throughout this research the process of consent required ongoing negotiation of consent with the person living with dementia and the 'person responsible' for the participant if he or she was deemed incapable of providing informed consent.

Of particular concern to the institutional ethics committee was the potential social risk of the participant being ridiculed or ostracized by other residents in the RACF due to his/her engagement with the doll. The risk of the participant being subjected to ridicule from other residents, visitors and staff would be minimized by the philosophy of care within the RACF where the research was to be conducted. This was guided by the well-established principles of person-centred care where the staff, residents and family engaged with, and respected, different encounters in the course of their day. The risk was also minimized by the empathetic manner in which staff and the researchers approached the research, and the emotional support provided during the research process. The researcher and care staff would ensure rigorous assessment processes prior to selection of the participant and that the intervention at no time during the course of the research distressed the participant. Any adverse events were to be reported to the care coordinator and a decision made whether to continue or withdraw the participant from the study, as appropriate to the participant's best interests. In this context, the research outcome was considered secondary to the best interests of the participant.

The research site

A Residential Aged Care Facility in Melbourne, Australia was the selected location for this study.[1] The venue was a small, homelike, warm and comfortable environment. It was compact and easy for residents living with dementia to move around comfortably without feeling overwhelmed by their surroundings. The care delivered in this RACF was guided by well-established principles of person-centred care (Kitwood, 1997), where management, 'on the floor' staff and relatives provided an interdisciplinary approach to the delivery of person-centred quality residential care. This approach was supported by an empowering style of ethical leadership that complemented the philosophy that directed this research study whereby the researcher engaged with, and respected, different experiences and perceptions of those with whom she interacted and gave them the voice they deserved (Dewing, 2002; Patton, 2002).

Methods and tools used for data collection:

This single case study used both qualitative and quantitative research methodologies in data collection and analysis. It utilized qualitative ethnographic techniques to observe the level of verbal communication and behaviours of concern of the participant within the context of the RACF. Field notes recorded the participant's types of behaviour and verbal interaction with others. Quantitative data included the use of an adjusted Aged Care Funding Instrument (ACFI) – a behavioural tool developed and trialled by a team led by Richard Rosewarne in consultation with residential aged care facilities, peak bodies and the Australian Government to ensure people living with dementia received the care and funding required in relation to the nature of their condition. The tool is a frequency-based tool to 'improve the funding system so services spend less time on paperwork and more time providing care' (Rosewarne & Opie, 2005, p.1).[2] For the purpose of this research, minor changes were made to the coding system to specifically evaluate anxiety-related behaviours linked to attachment. Otherwise, the method of completion of the form was identical (see Table 1). Care staff were trained to collect the observational data, record the frequency of behaviours of concern, analyze and evaluate the data. For the purposes of this paper, the data were grouped under three logical categories: physical, emotional and psycho/social behaviours.

The intervention tool

The doll selected was culturally appropriate, made of silicone, with a texture and appearance similar to human skin, eyes that closed and lifelike hair and eyelashes. The body was soft and flexible, and the doll's neck needed to be supported as in a newborn child. The face was anatomically correct, female, and the expression was one of peace and tranquility. The doll was dressed in typical baby clothes with a cloth cap and booties.

This single case study consisted of a three-phrase research process.

Phase 1: Pre-introduction of the doll

To meet the study's inclusion criteria, the participant required a documented diagnosis of moderately advanced Alzheimer's disease, who presented with exhibited behaviours of concern believed to be related to attachment needs, poor self-worth, anxiety and agitation and living in an RACF. Mary,[3] who was living with Alzheimer's disease in the advanced stage, was purposively selected based on daily, frequent, exhibition of behaviours of concern that directly related to the research question. The offer of participation in the research

Table 1. Adjusted behavioural tool (ACFI) codes by category

Category	Behavioural Code	Behaviour
Physical	B1	Trying to leave facility
	B2	Searching for attachment figure
	B3	Hyperventilation and distress
	B4	Resistive/anti-social
Emotional	B5	Asking for attachment figure
	B6	Tearful
	B7	Withdrawal
Psycho/social	B8	Repetitive
	B9	Agitation
	B10	Anxiety/tremors
	B11	Anti-social

process was as a verbal invitation, guided by Dewing's (2002) notion of 'inclusionary consent'. This process involved honesty and openness of the researcher about the nature of the research process. It also involved the need to explain the nature of the research on several occasions to ensure an ongoing understanding.

Staff were included in all aspects of the research process. Discussions were held at regular staff meetings in which information sheets were given to all staff and questions encouraged. No staff members expressed a negative view towards the use of doll therapy and all were genuinely excited about and engaged in the process. All staff involved completed a consent form prior to the commencement of the research.

Prior to the introduction of the doll, qualitative ethnographic techniques were used to observe the level of verbal communication and behaviours of concern within the context of the residential facility. Field notes recorded the types of behaviour and the nature of verbal interaction with others. These notes complemented the use of quantitative data, which included the adjusted (ACFI) behavioural tool completed by care staff for 24 hours per day over one week prior to the commencement of Phase 2 of the research. This tool was filled in by all care staff and was completed on a frequency-based method. That is, every time a behaviour of concern was exhibited, the care staff would document this immediately. The results of the analysis dictated the suitability of the participant for Phase 2 of the research.

Phase 2 Introduction of the doll

The doll was to be presented as a *gift* to Mary in the privacy of her own space – her bedroom – following the completion of Phase 1 of the study. It was anticipated, however, that if Mary did not accept the doll, it might be left in her room with close monitoring to establish if there was increased rapport with the doll over time. It was agreed, also, that if the doll created undue distress, the researcher would ask Mary if she would like the doll removed. If Mary preferred, the doll would be removed immediately. It was within this context that the research outcome was considered secondary to Mary's best interests.

Phase 3: Post-introduction of the doll

Following the introduction of the doll, the Phase 1 process was repeated over a period of one week.

Following Phases 1 and 2, qualitative analysis of the field notes and quantitative descriptive statistics compared behaviour pre- and post-introduction of the doll.

Results

It was observed that during Phase 1 of the study Mary became highly anxious, which would exacerbate further behaviours of an increasingly serious nature, including panic attacks, uncontrollable tremors and hyperventilation. Mary also had a past history of being socially withdrawn, often isolating herself from staff and residents (see Figure 1). The analysis of the field notes indicated that Mary rarely initiated conversation. Her conversation generally consisted of garbled, confused words, stuttering and inability to verbally express her needs. It was evident that Mary was constantly in a state of unrest, panic and distress, which impacted on her wellbeing and prevented her from living a fulfilling and stress-free lifestyle. These behaviours were being exhibited constantly from rising in the morning to settling at night when Mary was not being attended to 1:1 by care staff.

The positive reactions shown by Mary to the facility's pets and visiting children, where she demonstrated cuddles and other forms of affection were also noted in the field notes. She would, for small amounts of time, respond favourably to these types of strategies; however, once they were withdrawn, her distressing behaviours often recommenced immediately.

Following one week of observation and assessment of behaviour in Phase 1, it was agreed that Mary could benefit from doll therapy. She was exhibiting up to seven behaviours of concern, as represented in Figure 1. The doll was presented to Mary in the privacy of her room by the researcher and four staff. These staff members had an exceptional rapport with Mary. It was a reflective and emotional commencement to the research process. The doll was presented as a gift to Mary at a time when she was exhibiting anxiety, tearfulness and tremors. Her immediate reaction was overwhelming to observe. Mary 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' (Bisiani, 2010, p.43).

Over the week following the introduction of the doll (Phase 3), the researcher observed Mary, and care staff once again monitored changes in behaviour. A dramatic decline in behaviours of concern was observed at the end of the observation period, as documented on the adjusted ACFI behavioural tool (see Figure 2). The field observations of staff in Phase 3 of the study were momentous as well. All were touched by the change in behaviour and noted that Mary interacted with those present and initiated conversation without stuttering. Several of the staff were emotionally moved and had tears in their eyes. It was a remarkable reaction to observe: 'Mary continued to croon to the doll, patting her face and saying to us, 'isn't she just beautiful, look how good she is. She isn't making a peep'. We smiled at her and Mary smiled back' (Bisiani, 2010, p. 44).

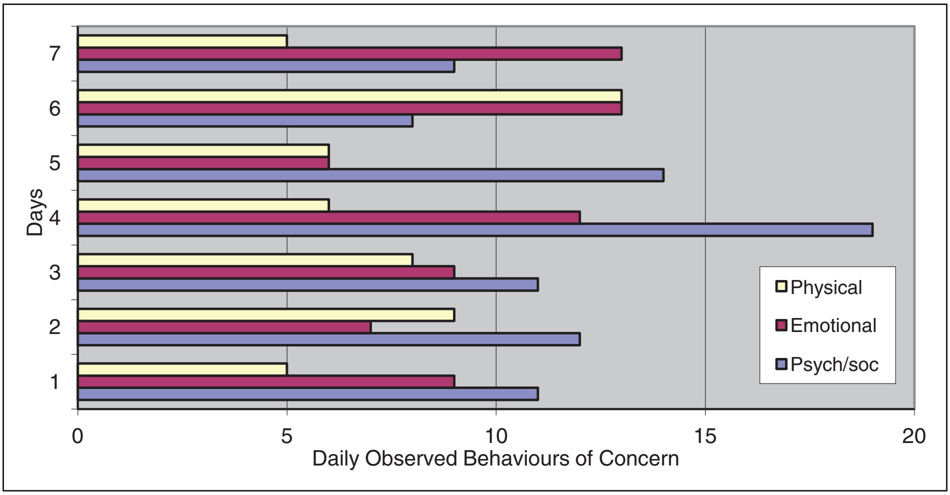

Figure 1. Behaviours pre-intervention over seven days.

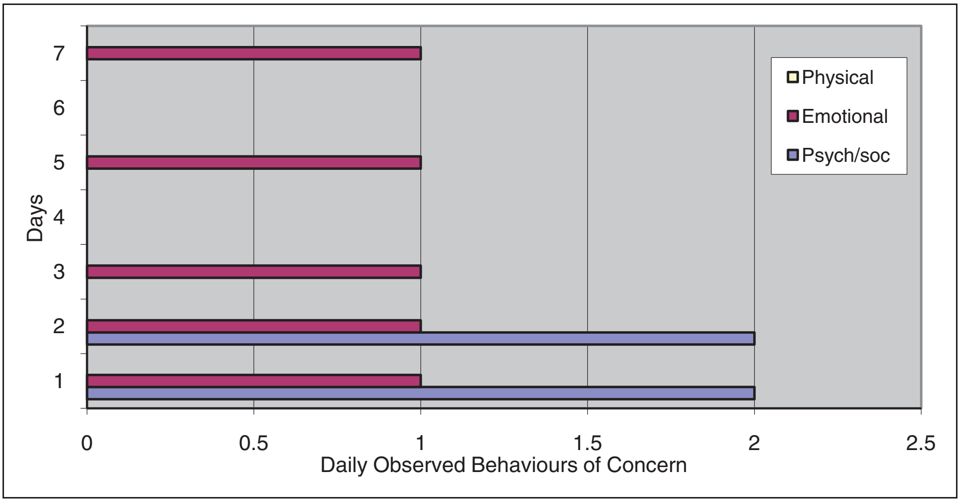

Figure 2. Behaviours post-intervention over seven days.

These results indicate that behaviours of concern were not *altogether* eradicated (see Figure 2). However, the reduction in the behaviours related to Mary, post-introduction of the doll, was too pronounced to ignore. There was an obvious considerable decline in behaviours post-introduction of the doll compared to behaviours exhibited pre-introduction of the doll (as shown in Figure 1). This result reflects a reduced number and frequency of the negative emotional behaviours that were part of Mary's everyday life. Thus it can be surmised that this result should be considered a positive intervention compared with Mary's previous day-to-day experience (as seen in Figure 1). Behaviours such as 'Trying to leave the facility' (B1) and 'Asking for attachment/child' (B5) were altogether eradicated. It is worth considering that Mary's responses could also be attributed to 1:1 interaction with staff, in conjunction with the presentation of the doll. However, according to Mary's history, this level of 1:1 interaction was effective for brief periods of time only, and as soon as the staff member left, she would again commence exhibiting the same behaviours of concern. The catalyst in maintaining the improved emotional state of Mary for longer periods of time appeared to be the introduction of the doll. Mary existed in a much happier space, moment-to-moment, day-to-day, for longer periods of time, post-introduction of the doll.

It was also observed that, initially, when Mary regarded the doll as a real baby, she would search for staff to 'babysit' and could become a little anxious that the baby needed ongoing care. Once staff accepted this responsibility on her behalf, she would be quite content. This only occurred for the first day of the research. Twice, in the first day, she became concerned the baby was not responding and at these times, staff reinforced to her that the baby was a doll and then this again allayed her anxiety immediately.

The results of the qualitative data indicated the following improvements and will be discussed in the next section:

- Reduction in appearance of anxiety and agitation, panic, tremors, hyperventilating, searching for attachment;

- Reduction of panic reduced unsteadiness of her gait;
- Improvement in Mary's dining experience;
- Improved social interaction with staff and other residents;
- Increased socialization;
- Improved ability to communicate without stuttering or becoming confused (as the doll was Mary's link to communicating with others);
- Improved self-esteem and self-worth as Mary was so proud to be the 'one' with the doll.

Discussion

This research supports doll therapy as a therapeutic intervention that may be utilized in the ongoing care of some persons living with dementia to meet needs for attachment and to reduce behaviours of concern. Mary demonstrated rapid and progressive improvements in behaviour, which were maintained, demonstrating the possibility of an ongoing positive impact related to providing longer-term benefits in this case. The intervention effectively gave meaning to her life and reduced the anxieties that infringed upon her wellbeing. The need for attachment was seemingly met – Mary did not think the doll was her child but she *relived* the emotion that coincided with attachment to happy, carefree times. It seemed to provide her with a sense of revisiting a time when she had that form of attachment.

The analysis of the field notes indicated that Mary also displayed much improved communication, with some loss of stuttering, especially when other residents or staff showed interest in the doll. Her renewed sense of calm and improved emotional being meant she was more open to interacting with others and even sought people to show the doll to. This stimulated many conversations that were not expected, due to Mary's poor ability to communicate pre-introduction of the doll. Male residents also showed an interest; for example, one gentleman with advanced Alzheimer's disease, approached Mary and asked, 'How old is the infant?' They spoke about the doll as if it was an infant, but it was also obvious that in their minds this changed from minute to minute, from doll to baby; however, this did not seem to cause any distress and was accepted by them both as normal. The gentleman then requested to 'have a hold of the baby', and when he did, his face lit up and he seemed content and delighted. Mary responded with delight, and other residents, some with dementia and some without, showed similar pleasure in the doll, (whether it was regarded as a doll or a baby), reinforcing that this type of therapy can benefit Mary and those with whom she shares her experience (Bisiani, 2010, pp. 46–48). Piccoli (2003) supports the view that dolls can be inclusive for both men and women who exhibit behaviours of concern because, in many cases, activities in earlier life for both men and women have been about looking after family and children.

The dialogic nature of the conversations with other residents and staff encouraged the reversal of social isolation and withdrawal. The dolls also had a flow-on effect, which assisted other people living with dementia within the facility to articulate *how* they felt. This in turn, had a positive impact on staff morale. Sifton (2004) argued strongly that in every interaction there is the opportunity for the person living with dementia to have some level of power and control and for their personhood to be appreciated and valued. The use of the doll appeared to be the catalyst for Mary to regain significance in her life and thus improve her self-worth and confidence.

Within the limitations of this single case study, Mary thought the doll was a baby, and sometimes a doll. During the research process, staff were reminded that the doll was to be used as a therapeutic tool and it did not matter whether Mary thought of the doll as a baby or a doll. They assessed Mary's behaviour at the time, so when she believed the doll was a doll they confirmed her belief at the time, and when she thought it was a baby, they then again would confirm this to her. This avoided conflicting suggestions and possible distress for Mary. Staff needed to respond to Mary's reality within the present moment. The field notes recorded that even when Mary regarded the doll as a baby, at no time did she give the doll a name, nor ever change her out of her clothes. She only nursed her, patted her, crooned to her and showed love. She did not try to feed her. So it could be assumed that even if the doll was considered a baby, Mary was utilizing the doll as a comfort to her own attachment needs, with limited insight into the needs of a baby. This reinforced the use of the doll as a *tool* to address the behaviours of concern, improve communication and social interaction, and provide Mary with a sense of self-worth and improved self-esteem.

With the reduction in behaviours of concern, there were other unexpected benefits. Mary was previously assessed as being at high risk of falls, related to episodes of anxiety, agitation and panic reflected in tremors and hyperventilation causing her to sway and buckle at the knees. This dramatically reduced or ceased when her focus was drawn to the doll and not to her own internal anxiety. Further research in the use of therapeutic tools could be warranted in the prevention of falls that are related to high anxiety levels.

Another benefit was observed at meal times, during which Mary quite often in the pre-introduction period would have numerous panic attacks in the dining room, thus affecting her nutritional intake and her enjoyment of the dining experience. Nursing the doll, and interacting with others, her dining experience was more positive, as was her nutritional intake; the outcome being improved dining experience as well as more effective management of weight.

Finally, care staff involved in the research were eager to express enthusiasm towards the positive results observed when the doll was used as a therapeutic tool. When staff saw how immediate the changes were, it reinforced to them the possibilities that are open to us in assisting other people living with dementia deal with negative emotion and ill-being. It also brought staff together, improving morale, and strengthened the team, in assisting with the reversal of Mary's agitative levels with the use of the therapeutic doll. The benefits for staff and residents as a constructive strategy, created benefits for care providers, as well as those living with dementia in assisting and providing support and effective and improved communication.

This single case study may provide the impetus for aged care providers to develop an increased sensitivity to therapeutic interventions that encourage positive ageing and wellbeing of people living with dementia. Kitwood (1997) acknowledged that having a sense of connection and association directly with the past allows us to keep hold of the inner self. He considered that people living with dementia continue to relate to past sequences of events and experiences that, if understood, can enable caregivers to better understand them as individuals. Kitwood believed we should not judge people living with dementia in relation to how *we* think an elderly person should behave. If we do so, then we are encouraging caregivers to become rigid in their ways of thinking, which does not follow the principles of person-centred care. It is crucial to meet individual needs, despite personal impressions, or attitudes to, the intervention or therapy. Killick and Allan (2001) also reinforce that there are situations which may not seem logical to us in relation to the 'current' self of a person living with dementia; however, it may be extremely important to that person when they were younger and be linked to their present. If a person living with dementia feels unsure or overwhelmed by the constant changes within their present reality, this may promote attachment to solid and comforting resources (Kitwood, 1997). If some people show a preference for a doll as an attachment figure, then we should encourage this therapeutic intervention to reduce anxiety and agitation associated with past attachment needs and enhance the wellbeing of those in our care.

Implications for practice

As practitioners, many of us have encountered dolls in RACF. They are often seen in residents' rooms on display or in a common area – cast aside in a chair, on top of a piano or upside down in a cardboard box – a cheerless reminder of some past activity. This study has reinforced our support for using doll therapy as a therapeutic encounter that respects the nature and meaning of that experience in a relationship of courteous reciprocity. The act of *gifting* the doll was central to this study. Like the giving of most gifts, this gift was carefully considered and planned with deference to the community including Mary, other residents, care staff and relatives. This gift enriched many lives in this RACF. We doubt whether this gift will end up discarded as a vestige of some past activity.

Conclusions

Within the limitation of a single case study, the results provided substantial and encouraging evidence to support the basis of this research: to assess the potential benefits, if any, of the use of doll therapy in reducing behaviours of concern such as anxiety and agitation that may be associated with observed attachment needs of a person with dementia. Despite some controversy on this topic, doll therapy should be considered as an approach to further dementia care. This paper also supports other researchers' views that, with care, doll therapy can be used to assist some people living with dementia to retain the ability to better manage their emotions and interact more socially (Miesen, 1992; Piccoli, 2003; Verity, 2008).

Crucially, this study advances understanding of (a) the use of a doll as a therapeutic tool in the behaviour of a person living with dementia; (b) the long-term attachment needs of the participant to reduce or prevent behaviours reflective of other needs; and (c) the effect of therapeutic interventions on the wellbeing of the participant. It also extends an understanding of the use of complementary therapy to inform professional practice, to promote opportunities for the exchange of knowledge, and to stimulate research and promote best practice. This study will also contribute to the general body of knowledge about the use of complementary therapy to meet past attachment needs of people living with dementia to improve their self-worth and wellbeing. Further, this research will hopefully encourage a change in attitude to one of the many alternative therapeutic ways of meeting the specific requirements of a person living with dementia. Such an outcome may contribute to an improved quality of life, growth and fulfilment in the maintenance of personhood. It may also help others with similar needs to benefit from the therapeutic provision of a doll to ameliorate the need for past attachments. As professionals we need to build upon this evidence to promote therapeutic interventions that demonstrate another valuable way forward in the provision of person-centred dementia care.

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Notes

1. Where there is a risk of identification of place, the name of the organisation and residential aged care facility has been removed.
2. For further information about the Aged Care Funding Instrument see Australian Government Department of Health and Ageing Website: http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-aboutacfi-history.htm
3. This is a pseudonym to prevent risk of identification. The researchers and staff were invited to call the participant by her first name.

References

Andrew, A. (2006). The ethics of using dolls and soft toys in dementia care. *Nursing & Residential Care*, *8*(9), 419–421.

Angus, J., & Bowen, S. (2011). Quiet please, there's a lady on stage: Centering the person with dementia in life story narrative. *Journal of Aging Studies*, *25*, 110–117.

Angus, J., & Reeve, P. (2006). Ageism: The threat to ageing-well in the 21st century. *Journal of Applied Gerontology*, *35*, 137–152.

Baldini, A. L., Boustani, M., Sloane, P. D., & Zimmerman, S. (2004). Behavioural symptoms in residential care/assisted living facilities: Prevalence, risk factors and medication management. *Journal of the American Geriatric Society*, *53*, 1610–1617.

Bisiani, L. (2010). *Exploring the use of doll therapy to meet past attachment needs and diminish behaviours of concern in people with dementia: A case study approach*. Unpublished minor thesis. Victoria University, Melbourne, Australia.

Bowlby, J. (1969). *Attachment and loss*: Volume 1 Attachment. London: Hogarth Press.

Buhuniak, S. M. (2010). Toward a political model of dementia: Power as compassionate care. *Journal of Aging Studies*, *24*, 231–240.

Cayton H. (2001). *From childhood to childhood? Autonomy, dignity and dependence through the ages of life*. Paper presented at the 15th Alzheimer's Disease International Conference, Christchurch, New Zealand. October.

Cayton, H. (2006). From childhood to childhood? Autonomy and dependence through the ages of life. In J. C. Hughes, S. J. Louw, & S. R. Sabat (Eds), *Dementia: Mind, meaning, and the person*. New York: Oxford University Press.

Crisp, J. (2000). *Keeping in touch with someone who has Alzheimer's*. Australia: Ausmed Publications.

Dewing, J. (2002). From ritual to relationship: A person-centred approach to consent in qualitative research with older people who have dementia. *Dementia*, *1*(2), 157–171.

Doyle, D. (1992). Have we looked beyond the physical and psychosocial? *Journal of Pain and Symptom Management*, *7*(5), 302–311.

Health and Medical Research Council. (1999). *National statement on ethical conduct in research involving humans*. Canberra, Australia.

Hudson, R. (2003). Introduction. In R. Hudson (Ed), *Dementia nursing: a guide to practice* (pp. xxviii-xxvi) Melbourne, Australia: Ausmed Publications.

Hughes, J. C., Louw, S. J., & Sabat, S. R. (2006). *Dementia: Mind, meaning, and the person*. New York: Oxford University Press.

James, I., Reichelt, F., Morse, R., Mackenzie, L., & Mukaetova-Ladinska, E. (2005). The therapeutic use of dolls in dementia care. *Journal of Dementia Care*, *13*(3), 19–21.

Killick, J., & Allan, K. (2001). *Communication and the care of people with dementia*. Buckingham: Open University Press.

Kitwood, T. (1997). *Dementia reconsidered – the person comes first*. Buckingham: Open University Press.

Korsgaard, C. M. (1996). *Creating the kingdom of ends*. Cambridge: Cambridge Press.

Mace, N. L., & Rabins, P. V. (1999). *The 36 hour day: A family guide to caring for persons with Alzheimer's disease-related dementing illnesses, and memory loss in later life*. Maryland: The John Hopkins University Press.

Mackenzie, L., Wood-Mitchell, A., & James, I. (2007). Guidelines on using dolls. *Journal of Dementia Care*, *15*(1), 26–27.

Magai, C., & McFadden, S. H. (1995). *The roles of emotions in social and personality development: History, theory and research*. New York: Plenum Press.

Miesen, B. M. L. (1992). Attachment theory and dementia. In G. M. M. Jones, & B. M. Miesen (Eds), *Caregiving in dementia: Research and applications*. London: Routledge.

Miesen, B. M. L. (1999). *Dementia in close up*. London: Routledge.

Moody, H. R. (1995). Issues of equity in the selection of subjects for experimental research in senile dementia of the Alzheimer's type. In V. L. Melnick, & N. N. Dubler (Eds), *Alzheimer's dilemmas and clinical research. Clifton*. NJ: Human Press.

Moore, D. (2001). 'It's like a gold medal and it's mine' – Dolls in dementia care. *The Journal of Dementia Care*, *9*(6), 20–22.

Patton, M. Q. (2002). *Qualitative research and evaluation methods*, 3rd edn. Thousand Oaks CA: Sage Publications.

Piccoli, S. (2003). Creative care. In R. Hudson (Ed.), *Dementia nursing: A guide to practice* (pp. 269–272) Melbourne. Australia: Ausmed Publications.

Price, J. L., Stevens, H., & La Barre, M. C. (1995). Spiritual caregiving in nursing practice. *Journal of Psychosocial Nursing*, *33*(12), 5–9.

Robinson, E. (2002). Should people with Alzheimer's Disease take part in research? In H. Wilkinson (Ed.), *The perspectives of people with dementia: Research methods and motivation* (pp. 101–108). London: Jessica Kingsley.

Rosewarne, R. (2005). *National aged care funding instrument (ACFI) trial*. Retrieved 16th March, 2011, from www.aacs.com.au/kb/article.aspx?id=10005.

Sherratt, C., Soteriou, T., & Evans, S. (2007). Ethical Issues in social research involving people with dementia. *Dementia*, *6*(4), 463–47.

Schermer, M. (2007). Nothing but the truth? On truth and deception in dementia care. *Bioethics*, *21*, 13–22.

Sifton, C. B.(2004). *Navigating the Alzheimer's journey: A compass for caregiving*. Maryland: Health Professional Press.

Tamura, T., Nakajima, K., & Nambu, M. (2001). Baby dolls as therapeutic tools for severe dementia patients. *Gerontechnology*, *1*(2), 111–118.

Vass, A. A., Minardi, H. A., Ward, R., Aggarwal, N., Garfield, C., & Cybyk, B. (2003). Research into communication patterns and consequences for effective care of people with Alzheimer's and their carers. *Dementia*, *2*(1), 21–48.

Verity, J. (2008). Doll therapy. Retrieved 9th September, 2008, from www.dementiacareaustralia.com/index.php/library/doll-therapy.html.

Wylie, K. (2001). Expressing her playfulness, love and laughter. *Journal of Dementia Care*, 9(6), 22–23.

Author Biographies

Leah Bisiani is a registered nurse with more than 25 years experience in aged care/dementia-specific care. Her ground-breaking strategies in dementia care were recently acknowledged in the Lend Lease Global Award for Excellence in April 2011 for innovations in person-centred care models and behaviour management of residents living with dementia.

Jocelyn Angus is a social gerontologist and senior lecturer and coordinator of the postgraduate aged and dementia services program at Victoria University, Melbourne. Her national and international publications reflect her commitment to educational leadership and research in the psychosocial concerns of older people.