# Early-career physiotherapists' experiences of working with people with dementia: An exploratory phenomenological study

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## Abstract

***Objectives***: Most research in the healthcare professions relating to interpersonal work with individuals who have dementia addresses domains where the practitioner is actively trained for this task. Little research has, however, investigated clinical interaction between physiotherapists and those with dementia. Moreover, contemporary tertiary physiotherapy education has to date provided little pertinent preparatory curriculum content. This paper, thus, reports findings from a UK-based exploratory study of early-career physiotherapists' lived experiences of managing clinical encounters with people with dementia.

***Design***: A qualitative investigative framework was adopted. Semi-structured interviews were conducted and investigated using the core conventions of Interpretative Phenomenological Analysis.

***Participants***: With institutional ethical approval, N=5 early-career physiotherapists were purposively recruited. Of these, n=4 were female and n=1 was male, with a minimum of one year of post-qualification experience and a maximum of four (*mean* = 1.8), and an age range of 23 to 33 years (*mean* = 25.6).

***Results***: Three superordinate themes emerged: (1) Confidence, communication and experience. (2) Family members and significant others' involvement in the care. (3) The learning journey.

***Conclusion and Implications***: Participants indicated that while their physiotherapy education did little to prepare them for the realities of working with individuals with dementia, providing more 'raw information' about dementia syndromes would have had only limited utility. Training around the emotional costs, social contexts and interpersonal demands of the work were viewed as a prospectively stronger grounding. Future research around curriculum development in physiotherapy, might encourage greater emphasis on communication, resilience and confidence around dementia.

## Contribution of the Paper

- This paper provides phenomenological insight into how early-career physiotherapists develop embodied knowledge and adaptive communication through direct encounters with people with dementia.
- It is illuminated how relationships with family members and multidisciplinary colleagues shape therapeutic efficacy and professional identity in dementia care.
- A disconnect is identified between (limited) propositional knowledge from education and tacit understanding required for practice, suggesting implications for experiential learning.
- The issues of emotional labour and adaptive resilience for physiotherapists working with people with dementia emerges as a key concern.

**Keywords:** Physiotherapy; Dementia; Education; Phenomenology; Qualitative

## Introduction

Given a broadly ageing population, around 150 million people around the globe are expected to be living with dementia by 2050, nearly three times the estimate for 2019.[1] The challenges posed to existing healthcare models by this projected progression in rates of dementia, and the corollary demands upon care capacity, are well-noted in contemporary literature pertaining to the UK (the site of this study) and beyond.[2]

Most healthcare research addressing interpersonal work around individuals with dementia has, to date, addressed professions and specialisms wherein dementia itself is a primary focus for a trained practitioner. Older-age psychiatry and nursing are exemplars therein.[3-6] This body of work has produced a wealth of instructive evidence regarding practitioner experience and best practice, which has largely ensured a routine and grounded updating of professional guidance and taught curricula around dementia awareness.[3, 4] Even in these areas, it is well noted that direct communication and relationship-building with individuals with dementia can remain challenging for even the most experienced clinicians.[7, 8]

Care for individuals with dementia is not, however, exclusively delivered by trained 'dementia specialists'. Indeed, a wide range of characteristic comorbidities mandate that a variety of allied health professionals (AHPs) are also likely be involved.[9, 10] For example, individuals with dementia tend to be more sedentary than age-equivalent others, and are particularly prone to emergent difficulties around coordination, balance and muscle strength, with a significantly elevated risk of breaks and fractures.[11-14] In all of these circumstances, physiotherapy will be a central element of their direct care.[15, 16] Historically, however, research relating to how the interpersonal management of such clients has been accomplished in physiotherapy has been scant at best. Indeed, a pre-pandemic scoping review drawn together by Hall et al.[17] concluded there was (at the time) little robust evidence available relating to the experiences of physiotherapists working with clients with dementia. Rather, a more persistent focus of physiotherapy research in this domain had remained upon achieving technical efficacy.[18] A more recent scoping review has analogously demonstrated that the dementia-related education/training needs of physiotherapists remain under-researched,[16] while a synthesis of available evidence indicated that physiotherapists at all levels are typically low in confidence around both their knowledge of dementia in general, and their interpersonal capacities regarding working with individuals with dementia.[15]

It is observably the case that even within this limited body of dementia-related research, there has been little specific emphasis on the experiences of early-career physiotherapists.[15] This is, perhaps, surprising given that this group is arguably the most vulnerable among qualified physiotherapists to interpersonal challenges that can emerge from working with individuals with dementia. Having (by definition) accrued limited professional experience, they are disproportionately reliant on their tertiary education when managing any salient clinical encounter.[19] Even in healthcare professions where dementia is a key feature of taught curricula, however, it is well noted that new practitioners can feel unprepared for the diverse and often unpredictable ways in which dementia can impact upon an individual's vocal and physical behaviour.[4, 8, 20] Dementia-related content in physiotherapy curricula, in the UK and elsewhere, meanwhile, has tended to remain minimal and generalised in character,[10, 19] prospectively amplifying the problem.

This matter is of particular concern given recent evidence emergent of diagnostic radiography, another AHP in which education and training around the care and management of individuals with dementia has historically been very limited, despite routine clinical contact (similarly due to breaks and fractures).[21] This work indicated that effectively leaving early-career practitioners to learn how to manage the complexities of working with individuals with dementia ‘on-the-job’ can have substantial, enduring and progressively detrimental impacts upon professional confidence and self-efficacy.[2, 21, 22] Extant evidence relating to low professional confidence in physiotherapists, from student level onwards,[10, 15] would seem to indicate a parity around dementia-related practice that remains under-examined.

The UK-based qualitative findings reported below, thus, aim to add to the evidence-base around experiences of recently qualified physiotherapists when interacting with individuals with dementia, and are explored with a view to informing practical clinical work and training/education.

## Methods

### *Design*

Interpretative Phenomenological Analysis (henceforth IPA) was utilised as a specific methodology for illuminating the everyday experiences of recently qualified physiotherapists when working with individuals with dementia. IPA has a strong history of producing instructive qualitative research in the broader AHP domain,[21, 23, 24] although it has only recently begun to find traction in physiotherapy.[25] While it has evolved as an approach since its inception, the core emphasis of IPA is useful here in terms of its efficacy for elucidating "…nuance, experience and innovation as they manifest in everyday accounts of practice developed by clinicians at-work."[21] COREQ reporting standards are observed throughout.

In line with the conditions of an exploratory IPA study set out by Hemmings and Soundy,[25] the first N=5 recently qualified physiotherapists were interviewed, with full institutional ethical approval and informed consent from all participants.

***Participants and Recruitment***

Inclusion criteria for participation were set as:

- A physiotherapist with a formal UK qualification.
- A minimum of 1 year of post-qualification experience, and a maximum of 4 years.
- Direct experience of working with individuals with dementia

The limits of recency herein were established in accordance with the concerns of Randall and Phoenix,[26] regarding the prospective degradation of participant memory around topical issues. Meanwhile, and given the project-logical position, a singular exclusion criterion was set as:

- Having had formal/specialist training around dementia, post-qualification.

This criterion was used to help sustain a degree of experiential homogeneity in the sample, as is consistent with an IPA approach.[27] The aim of the study was to explore the experiences of 'general' early-career physiotherapists rather than those of trained specialists in dementia care, the latter of which would likely warrant a separate investigation. While participants were permitted to self-define in terms of 'formal/specialist training', all in the extant sample were clear that they had received little or no training at all.

A social media post was released containing a brief outline of the project and an invite to share the post with others. This was deemed the most effective approach to attaining a geographically dispersed sample within the pragmatics of research timeframe. Interested parties then emailed the researcher to receive the participant information sheet and participant consent form. Once suitability was established, and consent was gained, participants arranged their interviews with the researcher at a convenient time for themselves. The final sample is as shown in Table 1

*Table 1: Participant Demographics and Interview Details*

| *Participant* | *Age* | *Gender* | *Years qualified* | *Interview length* | *Transcript (words)* |
|---|---|---|---|---|---|
| *P1* | 23 | Female | 1 | 19:00 | 3,092 |
| *P2* | 24 | Female | 1 | 18:44 | 3,247 |
| *P3* | 26 | Male | 4 | 17:23 | 2,730 |
| *P4* | 33 | Female | 2 | 26:47 | 3,607 |
| *P5* | 22 | Female | 1 | 22:33 | 3,403 |
| *Mean* | 25.6 |  | 1.8 | 21.29 | 3,215.8 |

### *Ethical Approval*

Ethical approval for the study was granted via the lead author's governing ethics board, ref: 1212/MHPM/23.

### *Data Collection*

A semi-structured interview schedule, available as a supplemental file, was prepared by the first author (a female physiotherapist) and the second (a male social psychologist with extensive experience of qualitative health research). Interviews were conducted by the first author, and all took place via Microsoft Teams at a time of participants' choosing. Key issues were advanced for discussion in as open a manner as possible, to allow the participant to develop a narrative in their own way and expand upon examples whenever they wished to do so.[21] Additionally, prompts were given, when required, to encourage the participants to provide specific examples relating to their own experiences.

### *Data Analysis*

Data were inductively analysed following the guidance for an IPA study outlined by Biggerstaff and Thompson.[28] The provisional encounter and coding of the data was initially undertaken by the first author and then verified by the second. Preliminary textual themes were then clustered together by both authors to form major subordinate themes that outlined specific issues. These were then scaled down by both authors into three global superordinate themes that held consistency across the entire dataset, and fully expressed issues raised by all participants (schematised in figure 1).

### *Trustworthiness*

In line with the conditions outlined by Yardley,[29] 'transparency and coherence' was handled via the authors' best capacity, within a limited wordcount, to maintain coherence with the participants' voiced concerns. In the analysis below, all discussed concepts are demonstrated with reference to formal evidence in support of their veracity. Furthermore, as a check of 'impact and importance', this paper's findings were taken to a key international conference of physiotherapy peers. While feedback attained from said conference mandated no reinterpretation of the data, ideas shared were integrated into the final discussion below in terms of improving the framing and reach of the work.

## Results

Three overlapping superordinate themes pertaining to the individuals' experiences were revealed during analysis:

1. Confidence, communication and experience
2. Family members and significant others' involvement in the care
3. The Learning journey

The relationship between the major subordinate and superordinate themes is schematised in figure 1.

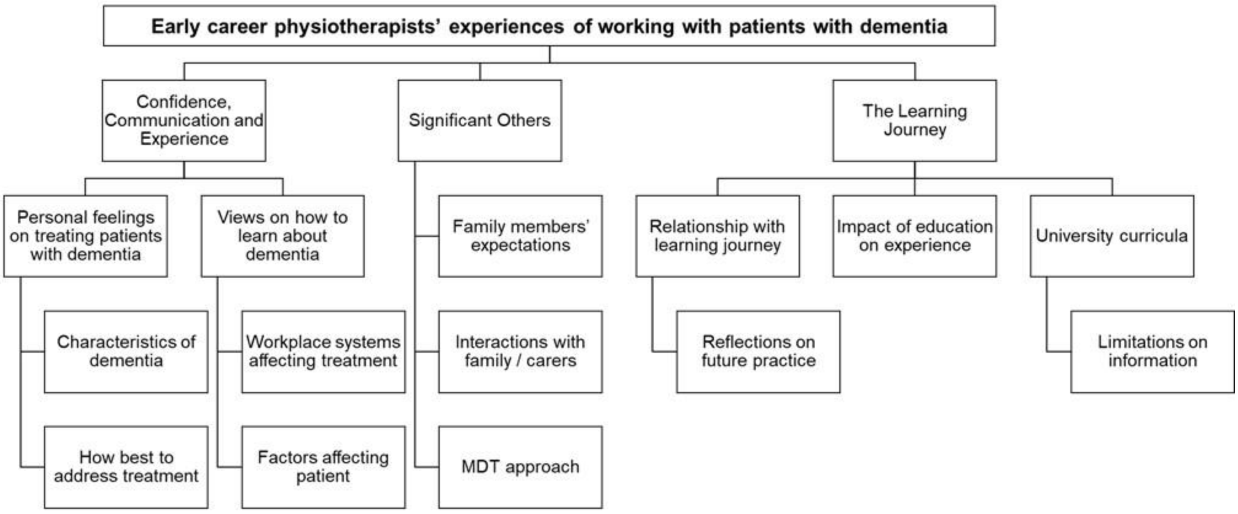

*Figure 1: Thematic Map*

### *Superordinate theme 1: Confidence, communication and experience*

The first superordinate theme addresses the participants' early experiences as they navigated the complexities of practical work with individuals affected by dementia. Their accounts underscored a dynamic interplay between early vulnerability and developing empowerment, suggesting an ultimately transformative process that had contributed to shaping their professional identity.

Participants articulated their earliest experiences using emotionally charged language; "difficult," "daunting," "anxious," and "struggle" were routine features that typified their immediate post-qualification sense of professional uncertainty. This contrasted with descriptions of gradually developing capacities for therapeutic connection, which were characterised by terms such as "rewarding," "heart-warming," "pleasurable," and "intriguing." It should not go unobserved, however, that some reductive language (not least "dementia patient") persevered in some narratives, when it was demonstrably not dementia itself for which they were receiving physiotherapy.

> P3: *"[I]t is quite daunting at the start...you do not really know what to do with them."*
>
> P5: *"[I]t is definitely rewarding when you see improvements...seeing them every day and having that continuity with them."*
>
> P1: *"I feel confidence working with dementia patients [now], I quite enjoy it, there are some really heart-warming stories as well that come with it."*

Participants made sense of their developing professional confidence through this order of experiential learning. Their narratives suggest that such confidence had emerged not through abstract knowledge but through the lived reality of repeated encounters.

> P1: *"I have definitely become more confident...seeing more people it just got a bit easier...the more exposure you get to it, the more you learn and pick up different skills."*
>
> P4: *"The more patients you see, the better at it you get."*

A further interpretative layer emerged around one-to-one communication, which participants experienced less as a technical skill than as 'a way of being' with individuals with dementia. Their accounts revealed an important shift in communicative stance, as they discovered that conventional approaches often failed to create genuine connection.

> *P2: "[Y]ou have to communicate quite differently...your questions have to be more direct."*
>
> *P4: "[Standard/abstract] instructions like 'Can you stand up?'...[may mean] nothing to them...you have to try and make things purposeful."*

> *P5: "[The patient] was trying to get out of the hospital because she didn't know where she was...she tried to throw her zimmer frame at the door...I pulled up a chair next to her and just talked to her calmy...she didn't really have any idea what was going on... it did help calm her down and it stopped her from trying to break out of the ward."*

This reported adaptation of communication style reflects the participants' growing understanding that connecting with individuals with dementia required a substantial recalibration of their interpersonal approach, illuminating the intersubjective nature of (physio)therapeutic relationships in this context.

### ***Superordinate theme 2: Family members and significant others' involvement in the care***

When exploring the intersubjective dimensions of dementia care, participants consistently emphasized the significance of family presence. Family members became viewed not as straightforward information sources, but as essential bridges between the client's past identity and present reality, typically helping create an atmosphere of security and connection:

> P2: *"[I]t is nice to see when the family members come in...patients are more engaging...they are the people that know them best."*

> P5: *"[T]hey are often disorientated and do not know where they are...someone that is familiar would help."*

P3's account vividly illuminates how a spouse's presence transformed the therapeutic encounter, showing clearly how the client's sense of safety was often grounded in enduring emotional bonds rather than what they had hitherto understood to be 'good clinical practice'.

> *"[O]ne [patient]...was a nurse...she could not even remember her name...but she could remember her whole love story with her husband...she would recognise only her*

> *husband...she would not let you touch her...do any treatments or even assist in terms of walking....but with husband present she had reassurance...a familiar face that she knows is there."*

Although participants' predominant experience of family was as facilitators of effective physiotherapy, this was not always the case. P4, for example, highlighted how the tension between family expectations and clinical realities could negatively impact upon therapeutic relationships:

> *"[F]amilies think 'Why is my relative not getting physio regularly? She was walking before...now she cannot even get out of bed.' Expectations of the family [can put] quite a lot of pressure on physiotherapists."*

Beyond immediate family, participants described a broader relational network that had shaped their care experiences. Care home staff and colleagues were often reported to be co-creators of understanding, offering glimpses into the client's lifeworld, and supporting new ways of meaningful engagement:

> P1: *"[G]iving the care home a ring and seeing how they respond...do they like a certain drink...something they like being called...do they like dolls or babies...so you can relate to them on that level."*
>
> P4: "*[The] knowledge of other members of the MDT...discussions with your teammates and sharing experiences...it is really important to reflect upon your experiences with your teammates...you can learn from each other."*

### *Superordinate theme 3: The learning journey*

As initially addressed in the first theme, a shared sense of professional vulnerability emerged as participants reflected on their educational preparation. Their accounts revealed an experienced disconnect between formal learning and subsequent practice, with their university education being seen to have offered (at best) a surface-level engagement with dementia care. This perceived shortcoming engendered a sense among some of having been cast adrift in early professional encounters.

> P1: *"[I]f I had the training, my treatments would have been more successful from the get-go rather than having that trial-and-error approach which takes longer to find the right way of doing things."*

Despite this perceived gap, all participants demonstrated an understanding of dementia's complex nature, recognising that the condition can manifests in a range of ways for different clients.

> P2: *"[Y]ou have a diagnosis of dementia, but it does not mean that everyone is affected in the same way...someone with dementia might talk to you as we are right now...[but] it might completely affect their personality...[they might] be a completely different person to who they were before."*

Some participants went as far as to reframe their lack of formal (educational) preparation as a catalyst for more 'authentic' learning. For these, being 'thrown in' was experienced as an opportunity for professional growth and self-directed discovery:

> P2: *"I did some [research] to get more of an idea about the different sorts of dementia and how they affect different people."*

> P2: *"Now I am working, I think I have learnt a lot more because I have been thrown in."*

Through this situated learning, participants developed innovative approaches that emerged from efforts to actively attune a client's ways of being. Their accounts revealed moments of genuine connection, where clinical breakthroughs occurred through an understanding of their clients' own worlds outside of their dementia:

> P4: *"[There was] a patient who had dementia, but also Creutzfeldt-Jakob disease...he had been a hoist transfer for three months...other physios had written him off...this patient was completely new to me...tried to stand to the ReTurn, but he just couldn't do it, couldn't stand to the frame either...I noticed it was more of a cognitive issue, he couldn't comprehend the ReTurn or the frame...we actually managed to stand him up with handhold assistance of two...this is a patient who'd been hoisted for three months, walked the length of the ward and back...a simple gesture like holding your hand out...automatically as a person you reach for someone's hand, don't you? So, he was able to respond to that."*
>
> P1: *"[I]ntroducing a zimmer frame or something like that can be quite challenging...one guy we had...he was a farmer...struggling to push the wheeled zimmer frame...we were saying push it like a wheelbarrow...that clicked in his brain, he was then able to do the task and push it."*

## Discussion

This exploratory study using IPA reveals significant cross-cutting issues in early-career physiotherapists' experiences of working with clients living with dementia. These are addressed below with reference to contemporary academic literature.

Participants consistently implied a disconnect between the abstract knowledge they had acquired through formal education and training, and the tacit understanding required for effective clinical practice, rendering early encounters difficult or even traumatic. This observation is consonant with the findings of Quick et al.[10, 15] regarding low confidence among physiotherapists of a variety of experience levels, and analogous work in diagnostic radiography.[21, 22] Participants in this study further described how their confidence developed primarily through embodied practice rather than abstract learning.[30, 31] This experiential learning trajectory is evidenced across accounts of developing clinical interactions, navigating family relationships and managing learning journeys. Significantly herein, participants largely reported acquiring a functional sense of how to adapt communication, modify treatments, and interpret non-verbal cues by watching and learning within their first few years of practice. This capacity to be ‘comfortable’ when working with individuals with dementia at such an early-career stage contrasts with much of the extant knowledge in physiotherapy and elsewhere.[7, 15, 21]

It is not clear whether the above was an outcome of an inherently greater self-efficacy and/or positive outlook within the (small) and relatively young sample, or simply a less challenging set of experiences among the participants than might be the norm for an early-career physiotherapist, although the sampling method would suggest the latter is unlikely. What is clear, however, is that the participants in this study were quick to learn from both positive and negative experience without the latter becoming a longer-term professional hindrance.

This embodied dimension has significant implications for physiotherapy education. Current approaches prioritising propositional knowledge about dementia syndromes may inadequately prepare practitioners for clinical reality.[2, 10, 21, 22] Educational approaches incorporating embodied learning through simulation, supervised clinical exposure, and reflective practice may better facilitate the development of tacit knowledge essential for effective dementia care.[32, 33] Successful interventions in the evidence collected depended not only on technical competence but also on a clinician’s ability to navigate complex relational dynamics between practitioner, patient, family members, and broader care networks.[20, 21, 34, 35] This was an intersubjective matter that permeated experiences across all participants' concerns and are commonly identified issues in literature outside of the physiotherapy field,[15, 16] but seldom within it. However, it was also evident that the data in this study did not always match trends in extant literature regarding the impact of working with individuals with dementia, and at a relatively early stage. This might also feed into the matters above; the participants in this generation of physiotherapists had the tacit tools to manage with some serenity what others had found to advance professional insecurity. The reasons for this are a clear topic for further research.

The therapeutic alliance, a well-established theme in contemporary AHP literature, emerged in participants' accounts not as isolated dyadic interaction, but as a matter explicitly situated within broader relational networks.[36, 37] Family members in the current study were seen to function as both essential facilitators and sources of emotional complexity, while multidisciplinary team members were documented to have provided crucial support and shared knowledge for participants. This finding both echoes and extends the work of Hall et al.[17], highlighting how the effectiveness of physiotherapy can depend on successfully navigating complex intersubjective spaces. However, and as observed by Miller et al.[21] regarding diagnostic radiography, the impact of family members on practice was not taken by participants to be a universal positive.

A final issue concerns the significant emotional labour involved in dementia care and its impact on participants' professional identity formation.[38] The emotional labour involved for a practitioner involved in dementia care has been well documented in nursing literature,[39, 40] but remains largely underexplored in physiotherapy contexts. In the study above, participants' narratives routinely revealed how working with individuals living with dementia had involved complex emotional processes that transcended technical practice. Analysis indicated that participants' initial sense of frustration, helplessness and anxiety around dementia often emerged as an active precursor to developing an emotional resilience that facilitated an ability to find reward and meaning in practice. This emotional trajectory was interwoven with their developing professional identity, shifting participants' sense of self from 'students' who expected to straightforwardly apply learned techniques to 'practitioners' who understood their role as fundamentally adaptive.

### *Limitations and Implications*

This study has limitations that are important to observe. While the sample size itself is consistent with an exploratory IPA approach, conditions of ethical approval circumscribed reporting of the participants' original HEIs or geographical areas of practice. This limits key aspects of contextualisation around specific educational curriculum and workplace demands. Similarly, participants were not asked to estimate/state the quantitative extent of their experience of working with individuals who have dementia, largely to avoid excluding potential candidates with valuable insights from a smaller number of cases.

The documented issues above suggest several practical implications, all with import for future research. Educational approaches for students in physiotherapy should balance propositional knowledge with opportunities for embodied learning. Training in family-oriented communication and recognizing a patient's subjective experience could enhance a practitioners' capacity to navigate complex relational dynamics. Finally, acknowledging a physiotherapist's emotional labour involved should represent an important priority for both educational institutions and healthcare organisations.

## Conclusion

As the global prevalence of dementia increases, enhancing trainee physiotherapists' preparation for corollary practice becomes increasingly important. While the phenomenological analysis above paints a more broadly positive picture of early-career practitioners' experiences of working with individuals with dementia than have emerged from many studies elsewhere in AHP domain, it nevertheless underscores how effective preparation requires attention not only to technical knowledge but also to the embodied, intersubjective and emotional matters that constitute the lived experience of providing practical physiotherapy.

## References

1. Nichols E, Steinmetz JD, Vollset SE, et al. Estimation of the global prevalence of dementia in 2019 and forecasted prevalence in 2050: an analysis for the Global Burden of Disease Study 2019. The Lancet Public health 2022. DOI: 10.1016/S2468-2667(21)00249-8.

2. Higgins R, Spacey A and Innes A. Optimising care and the patient experience for people living with dementia: The perceptions of radiography practitioners. Radiography 2023. DOI: 10.1016/j.radi.2023.01.016.

3. Baillie L, Merritt J and Cox J. Caring for older people with dementia in hospital. Part two: strategies. Nurs Older People 2012; 24: 22–26.

4. Baillie L, Cox J and Merritt J. Caring for older people with dementia in hospital Part one: challenges. Nurs Older People 2012; 24: 33–37.

5. Baker C, Huxley P, Dennis M, et al. Alleviating staff stress in care homes for people with dementia: protocol for stepped-wedge cluster randomised trial to evaluate a web-based Mindfulness- Stress Reduction course. BMC Psychiat 2015; 15: 1–9.

6. Barton S, Findlay D and Blake RA. The management of inappropriate vocalisation in dementia: a hierarchical approach. Int J Geriatr Psychiatry 2005; 20: 1180–1186.

7. Manthorpe J. The dement in the community: Social work practice with people with dementia revisited. Dementia 2016; 15: 1100–1111.

8. Tullo ES, Young TJ and Lee RP. Medical students' views about person-centred communication in dementia care. Dementia 2016; 17: 573–584.

9. Bergman H, Borson S, Jessen F, et al. Dementia and comorbidities in primary care: a scoping review. BMC Primar Care 2023. DOI: 10.1186/s12875-023-02229-9.

10. Quick SM, Lawler K, Shannon MM, et al. Physiotherapy students are underprepared to work with people living with dementia: a qualitative study. Physiotherapy 2024. DOI: 10.1016/j.physio.2023.09.004.

11. Kröpelin TF, Neyens JCL, Halfens RJG, et al. Fall determinants in older long-term care residents with dementia: a systematic review. Int Psychogeriatr 2013. DOI: 10.1017/S1041610212001937.

12. Wang H, Hung C, Lin S, et al. Increased risk of hip fractures in patients with dementia: a nationwide population-based study. BMC neurology 2014. DOI: 10.1186/s12883-014-0175-2.

13. Taylor ME, Delbaere K, Lord SR, et al. Physical impairments in cognitively impaired older people: implications for risk of falls. Int Psychogeriatr 2013. DOI: 10.1017/S1041610212001184.

14. Livingston G, Huntley J, Sommerlad A, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. The Lancet 2020. DOI: 10.1016/S0140-6736(20)30367-6.

15. Quick SM, Snowdon DA, Lawler K, et al. Physical therapist and physical therapist student knowledge, confidence, attitudes, and beliefs about providing care for people with dementia: A mixed-methods systematic review. Phys Ther 2022. DOI: 10.1093/ptj/pzac010.

16. O'Sullivan T, McVeigh JG, Timmons S, et al. Education and training interventions for physiotherapists working in dementia care: a scoping review. Physiotherapy 2023. DOI: 10.1016/j.physio.2022.11.002.

17. Hall AJ, Lang IA, Endacott R, et al. Physiotherapy interventions for people with dementia and a hip fracture − a scoping review of the literature. Physiotherapy 2017. DOI: 10.1016/j.physio.2017.01.001.

18. Brett L, Noblet T, Jorgensen M, et al. The use of physiotherapy in nursing homes internationally: A systematic review. PloS One 2019. DOI: 10.1371/journal.pone.0219488.

19. O'Sullivan T, Foley T, Timmons S, et al. Dementia content and delivery in physiotherapy curricula: an international study of entry level physiotherapy programmes in Ireland the United Kingdom and New Zealand. Physiotherapy 2024. DOI: 10.1016/j.physio.2024.07.001.

20. Russell CW. People with dementia, contributing to learning and teaching in higher education: Innovative practice. Dementia 2020. DOI: 10.1177/1471301216685460.

21. Miller PK, Booth L and Spacey A. Dementia and clinical interaction in frontline radiography: Mapping the practical experiences of junior clinicians in the UK. Dementia 2019. DOI: 10.1177/1471301217700742.

22. Higgins R, Spacey A and Innes A. Delivering person-centred dementia care: Perceptions of radiography practitioners within diagnostic imaging and radiotherapy departments. Dementia (London, England) 2023. DOI: 10.1177/14713012231189061.

23. Scanlon H, Latchford G and Allsop M. 'So being here is. . . I feel like I'm being a social worker again, at the hospice': Using interpretative phenomenological analysis to explore social workers' experiences of hospice work. Palliat Med 2024. DOI: 10.1177/02692163231220163.

24. Crunenberg R, Charles C, Lallemand A, et al. Interpretative phenomenological analysis of the collaboration among healthcare professionals in the nursing home setting. Explor Res Clin Soc Pharm 2024. DOI: 10.1016/j.rcsop.2024.100424.

25. Hemmings L and Soundy A. Experiences of physiotherapy in mental health: an interpretative phenomenological analysis of barriers and facilitators to care. Physiotherapy 2020. DOI: 10.1016/j.physio.2020.01.001.

26. Randall WL and Phoenix C. The problem with truth in qualitative interviews: reflections from a narrative perspective. Qual Res Spor Exerc 2009. DOI: 10.1080/19398440902908993.

27. Smith JA. Interpretative phenomenological analysis: Getting at lived experience. The journal of positive psychology 2017. DOI: 10.1080/17439760.2016.1262622.

28. Biggerstaff D and Thompson AR. Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research. Qual Res Psychol 2008. DOI: 10.1080/14780880802314304.

29. Yardley L. Dilemmas in Qualitative Health Research. Psychol Health 2000. DOI: 10.1080/08870440008400302.

30. Anderson A, Morrow J, Knighton A, et al. The Patient's Experience of Working with Multiple Allied Health Professional Students – A Qualitative Interview Study. J Patient Exp 2024. DOI: 10.1177/23743735241241461.

31. Smith S, Godley S, Anderson A, et al. Employing a coaching model of supervision during physiotherapy placements: Charting the learner experience in England. Physiotherapy 2025. DOI: 10.1016/j.physio.2025.101463.

32. Bowden A, Chang H, Wilson V, et al. The impact of ageing simulation education on healthcare professionals to promote person-centred care towards older people: A literature review. Nurs Educ Pract 2021. DOI: 10.1016/j.nepr.2021.103077.

33. Keane JM, Franklin NF and Vaughan B. Simulation to educate healthcare providers working within residential age care settings: A scoping review. Nurse Educ Today 2020. DOI: 10.1016/j.nedt.2019.104228.

34. Emmett C, Poole M, Bond J, et al. Homeward bound or bound for a home? Assessing the capacity of dementia patients to make decisions about hospital discharge: Comparing practice with legal standards. Int J Law Psychiatry 2013. DOI: 10.1016/j.ijlp.2012.11.009.

35. Poole M, Bond J, Emmett C, et al. Going home? An ethnographic study of assessment of capacity and best interests in people with dementia being discharged from hospital. BMC Geriatrics 2014. DOI: 10.1186/1471-2318-14-56.

36. Ruth-Sahd L. Student nurse dyads create a community of learning: Proposing a holistic clinical education theory. J Adv Nurs 2011. DOI: 10.1111/j.1365-2648.2011.05690.x.

37. Austria MJ, Baraki K and Doig AK. Collaborative Learning Using Nursing Student Dyads in the Clinical Setting. In J Nurs Educ Schol 2013. DOI: 10.1515/ijnes-2012-0026.

38. Quinn C, Hillman A, Barbosa A, et al. Emotional Labor in Dementia Research. Qual Health Res 2024. DOI: 10.1177/10497323241274709.

39. Kim J. Emotional Labor in the Care Field and Empathy-enhancing Education by Reading Literature: A Brief Review. Iran J Public Health 2018.

40. Slootman M, Mudde AL and The A. Frontstage nursing and backstage growth: The emotional labour of student nurses in Dutch nursing homes. Nursing Inquiry 2023. DOI: 10.1111/nin.12570.