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Developing Core Competences for Working Therapeutically With People With Dementia and Their Families

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ABSTRACT

Background: Without a cure for dementia, providing psychosocial support to people living with the condition is imperative. There is a developing evidence base for psychological and therapeutic support for people living with dementia. However, there is little to guide therapists working in this area, in terms of approaches and techniques that are likely to be successful.

Methods: In the present study, we utilised different methods to engage people with dementia and their family members in discussions around ways in which psychotherapists could improve the delivery and accessibility of person-centred therapy, to develop core competences for therapists. We brought together evidence from interviews with people with dementia, their families, and psychotherapists, with workshops utilising a World Café approach.

Findings: We hosted four workshops with 47 participants in total. Using thematic analysis, we identified core themes across the different forms of data. We developed core competences in four areas: knowledge of dementia, therapeutic techniques and skills, therapeutic relationship and scope of practice.

Discussion: The competences developed present an overview of expectations for those working therapeutically with families affected by dementia. It is hoped that their development leads to increased awareness of the specialist skills needed to engage with people with dementia, valuing of these skills for psychotherapists.

1 | Introduction

Dementia is a complex neurological condition that results from a variety of diseases and injuries that affect the brain, damaging nerve cells and leading to progressively more significant cognitive impairment and loss of cognitive abilities (Livingston et al. 2020; World Health Organization 2025). Around 57 million people have dementia worldwide, over 60% of whom live in low- and middle-income countries, and there are nearly 10 million new cases annually (World Health Organisation 2025). Alzheimer's disease is the most common form of dementia, comprising 60%–70% of cases (Livingston et al. 2020). Dementia is currently the seventh leading cause of death and a major cause of disability and dependency amongst older people globally (World Health Organisation 2025). Dementia impacts a person's quality of life, relationships and sense of identity; therefore, it is essential that we consider the social and psychological impact of dementia, using existing

Key Points

- A range of therapeutic approaches have demonstrated benefits for individuals living with dementia. Working effectively with this population demands a therapist who is skilled, responsive and knowledgeable about their specific needs.
- Currently, there are no established core competences for therapists working with people with dementia, which could provide them with the confidence and assurance that their therapeutic practices align with contemporary practice and evidence.
- The competences developed here can be utilised by individuals to review areas of competence and identify priorities for professional development, in line with service priorities.

theories to guide our focus. The quality of interactions with a person with dementia has a great influence on their course through dementia, as well as their well-being and functional abilities (Kitwood 1997).

Without a cure for dementia, providing psychosocial support is imperative. Whilst the importance of psychological and therapeutic support for people living with dementia has been highlighted for 30 years (Zarit and Knight 1996), there is still limited evidence for their effectiveness, although the benefits of psychotherapy have begun to be explored (Shoesmith et al. 2022). Evidence suggests that counselling and psychotherapeutic interventions, including cognitive behavioural therapy, problem adaptation therapy and person-centred counselling, can be effective for people with dementia and their caregivers, particularly when delivered face to face (Shoesmith et al. 2022). Counselling interventions can support maintenance of a sense of 'self' and increase self-acceptance and well-being, and reduce depression and anxiety for people with dementia (Birtwell and Dubrow-Marshall 2018; Cheston and Ivanecka 2017; Orgeta et al. 2015). A recent systematic review explored the impact of therapeutic counselling on the emotional experiences of people with dementia (Mathews et al. 2024). A range of benefits were identified when therapy was tailored to the individual and considered the progression of dementia. Counselling improved symptoms of depression and anxiety for people living with early to moderate dementia and positively affected mood for those with more advanced dementia (Mathews et al. 2024).

A key component of a successful therapeutic process is supporting a reformulation of a person's relationship to self while continuing to live with and work towards acceptance of the dementia diagnosis, and its impact on their life. Furthermore, therapists who employ a person-centred, skilful, culturally sensitive and relational approach may be more likely to see therapeutic benefits in counselling. This could support effective (and embodied) communication, fostering an empowering approach that facilitates personal control for individuals, regardless of age, stage and form of dementia (Mathews et al. 2024). This aligns with the areas that people with dementia have previously identified as priorities for focus in therapy: managing the loss of physical abilities and identity; developing coping mechanisms; and talking about feelings as a source of support (Birtwell and Dubrow-Marshall 2018). However, the overall evidence base to date presents mixed effectiveness of psychotherapeutic interventions on various outcomes (Shoesmith et al. 2022). Therefore, individualised formulation-driven, person-centred, systemically-orientated relational, and tailored approaches are important (Ball 2024; Jeffery et al. 2025; Mathews et al. 2024; Shoesmith et al. 2022), as they permit customised modifications to therapy based on an individual's cognitive abilities (Tay et al. 2019). However, currently there are no core competences available to therapists to guide their work in this way.

Within existing evidence, whilst some interventions were successful for people with dementia alone, the majority were delivered to people with dementia with a family member or caregiver (Shoesmith et al. 2022). This may reflect earlier opinions that people with moderate to severe dementia could not benefit from therapeutic interventions (Zarit and Knight 1996), and therefore were not offered these alone. People with dementia are likely to require increased caregiver participation as their condition progresses (Spector et al. 2015), and therapeutically engaging with a family offers a unique perspective. Systemic therapy builds capacity for dialogue, creates space to acknowledge denial, thereby facilitating a better dementia journey, and offers an opportunity for the family system to process emotions, grief and uncertainty (Ball 2024; Jeffery et al. 2025). There remains an individualistic bias of research focusing on the outcomes of the person with dementia, and at times on caregiver stress, yet neglects the impacts and influence of dementia on the family and/or social system and on its functioning (Jeffery 2019; Jeffery et al. 2025). Such systems may be forced to manage anxiety and/or depression, challenges of negotiating life with cognitive impairment, learning to live with a diagnosis of dementia, adjusting to changes and uncertainty. These are complex processes, requiring a skilled therapist to support people with dementia and their families to negotiate (Ball 2024; Shoesmith et al. 2022). Identifying these specialist skills, many of which transcend therapeutic modalities and professions, is an important step in advancing the field of psychotherapy for dementia.

There is a wide field of professional therapy training which has varying levels of coverage of content related to dementia, although many include none. To ensure therapists have the skills and confidence to identify potential signs and symptoms of dementia amongst clients (Zarit and Knight 1996), and deliver psychotherapeutic interventions to this population, competences should be developed (Mast and Lichtenberg 2022). These are 'sets of knowledge, skills, traits, motives and attitudes that are required for effective performance in a wide range of psychotherapeutic activities' (Chen et al. 2025). This includes areas such as professional knowledge, communication, assessment, intervention, application of theory, relationship building, consistency, understanding, emotional sensitivity, openness, responsibility and integrity (Chen et al. 2025; Roe 2002). Whilst these literature reviews did not specifically relate to dementia, they offer a solid foundation on which our competence development process could be built. Competences for dementia have been developed in other contexts, such as criteria for ensuring effective care provided by nurses working with older adults (Ballantyne et al. 1998; Williams et al. 2005). Therefore, drawing together this

knowledge with our understanding of the role of psychotherapeutic interventions for people with dementia, we aimed to develop a set of core competences for therapists working with families affected by dementia.

2 | Methods

The development of competences formed part of a larger project exploring the experiences of psychotherapy amongst families affected by dementia. For an overview of our approach, see Griffiths, Charura et al. (n.d., under review).

2.1 | Approach to Formulating Competences

We drew on competency frameworks developed by Roth et al. (2009), Williams et al. (2005) and Kay et al. (2023). Their three overarching principles guided our competence development. Firstly, we aligned as closely to the evidence base as possible, meaning that an intervention carried out in line with the competences described in the model should be close to best practice and therefore likely to result in better outcomes for clients and their support network. We consulted existing competences for therapists working with groups that may require adaptations to therapy, such as children and young people (Roth et al. 2011). Secondly, we engaged multiple methods of data collection, which are outlined below. Thirdly, to ensure utility for those who use it, we clustered competences in a manner that reflects and aligns with the experience of living with dementia, or supporting someone living with dementia, to facilitate their use in routine practice.

2.2 | Design

A mixed-methods research approach was undertaken, incorporating data from semi-structured interviews with people with dementia, their families and therapists, triangulated with data from workshops utilising a World Café approach, to formulate the competences. The World Café took place across two workshops (four sessions in total; each conducted twice in different locations). This is a participatory method of data collection that aims to recreate the atmosphere of a café, and encourage discussions between participants. We chose this approach to explore the themes and topics considered relevant to people living with dementia and their families (Löhr et al. 2020), through facilitated dialogue and mutual learning amongst participants (Recchia et al. 2022). This method is inclusive for people with dementia (Bates et al. 2022) due to its relaxed environment and the potential for multiple communication styles and aids to be used. Furthermore, World Cafés align with calls for people with dementia to be involved in the design and delivery of psychotherapeutic interventions (Morgan 2021). The approach aims to encourage structured conversations through establishing temporary 'cafés', where participants can sit, eat and talk together at tables of usually four to five people (Löhr et al. 2020). The World Café enabled participants to speak freely and openly without being guided by the researchers or their underlying assumptions. We encouraged all participants to contribute equally, listening to and learning from one another (Griffiths, Charura, et al., n.d., under review).

2.3 | Procedure

Participants were people with dementia and their family members or friends, who had received psychotherapeutic interventions. In order to ensure that our workshops were applicable to people with dementia, they were planned with inclusivity and accessibility as core priorities. This included selecting locations that were easy to travel to and navigate, scheduling with consideration for travel time, and avoiding disruption to people's daily routines. The room was laid out in a welcoming and informal café style, with four or five tables with tablecloths that could be written or drawn on throughout, in line with World Café guidance (Löhr et al. 2020). At all workshops, attendees received lunch before the workshop began, with refreshments available throughout. Catering was chosen with the needs of people with dementia in mind, that is, flavours and textures suitable for people with dementia and older attendees, while being mindful of dietary requirements. One table was designated as a 'quiet area'. To ensure the workshops were accessible to people with dementia, we incorporated a range of inclusive methods aimed at fostering creativity, including opportunities for drawing, speaking and writing.

Within Workshop 1a, we planned five rounds to structure informal conversations around the following questions or areas of discussion:

1. The right therapist for me (drawing task)
2. How I communicate and like people to speak to me (writing task)
3. Who is important to you and how would you like them to be involved in your care? (discussion and/or writing task)
4. What would you like healthcare staff to know about you? (discussion and/or writing task)
5. What is important to you to get the most out of therapy? (discussion)
6. What does your ideal therapy experience look like? (Lego SeriousPlay or discussion)

During discussions at Workshop 1a, participants reflected that one discussion question was unclear and suggested rephrasing it. The consensus was that 'What is important to you to get the most out of therapy?' should be amended to 'What would have happened to make you feel you had a good session?' The research team amended the discussion topics schedule after Workshop 1a and used it in subsequent workshops. Furthermore, participants reflected on the importance of discussing recommendations for therapist training that could be included in the competences. As a result, the following question was included in the discussion topics schedule for Workshop 1b: 'What do you think is the most important thing we can teach therapists?' This enabled the research team to collect straightforward recommendations for therapist training from people living with dementia and family members. One of the workshops used Lego SeriousPlay to address Question 6. Lego SeriousPlay is a facilitated, hands-on

method that uses Lego bricks to help participants express ideas, experiences and emotions through symbolic model building. This was particularly useful for our participants as it enabled them to express complex and abstract ideas in tangible, visual ways. The models served as conversation starters, allowing participants to share personal insights and, in some cases, co-construct a shared vision of what meaningful, supportive psychotherapy should look like. This session was designed and delivered by W.D., a certified Lego SeriousPlay Facilitator. By encouraging storytelling and reflection around the models created, this method supports deeper insight, shared understanding and co-creation of knowledge, especially in groups where verbal communication may be challenging or uneven. At another workshop, a virtual table was established to accommodate those who were unable to attend in person.

In facilitating the workshops, we ensured that participants had a voice by encouraging small group discussions. We ensured that those who were less confident or who had sensory impairments that may have made communication challenging were given space to speak and were invited to share their perspectives. These contributions were either written on tablecloths by participants or in field notes by researchers. Each table then provided feedback to the wider group, triangulating between different groups, and checked our joint understanding. Members of the research team supported engagement and assisted anyone who needed access to a quiet reflective space.

2.4 | Ethical Considerations

The study received ethical approval from the University of Liverpool's Ethics Committee (project ID: 11311). All participants provided informed written consent before participation. A debrief sheet was provided to participants, which included contact details of organisations that can offer support for people living with dementia and family members. At the start of each workshop, members of the research team reminded participants that they could leave any conversations they would prefer to. 'Quiet areas' were prepared in advance, giving participants a space located away from the main discussion area to take a break and reflect. While the World Café method suggests that participants move between tables, the research team adapted the method for participants with limited mobility; they could stay at the first table without having to move around the room if they wished, and instead the discussion topic sheets, handouts and refreshments were brought to them.

2.5 | Reflexivity

Within the World Café approach, participants should be positioned as experts in the topic area, with researchers facilitating conversations (Clements et al. 2024). However, as part of introducing each research team member, our professional and personal backgrounds were explored. We shared our personal and professional experiences of dementia, including delivering or researching psychotherapy for this population. This process of continually immersing ourselves in and orienting towards lived experiences, and sharing our biases, facilitated an environment that was conducive to staying close to the data. This sustained an openness to hear different voices and the depth of their meanings. This process was enhanced by the diversity of our backgrounds and training, alongside our therapeutic and academic skills in reflexivity.

2.6 | Data Analysis

Data from the workshops were analysed using a phenomenologically informed approach to reflexive thematic analysis (Braun and Clarke 2022; Finlay 2014; Landrum and Davis 2023; Pietersma 2000). This approach encourages a critical examination of our perspectives as researchers, our assumptions about dementia, interactions with the data, and how this influenced the identification and interpretation of themes, and consequently the formulation of competences. It was important for us to understand the lived experiences of the people living with dementia and their families, and to centre these within the developed competences. Alongside workshop data, we incorporated and triangulated data from interviews with people with dementia and their families ($N=23$, Griffiths, Gates, et al., n.d., under review), and trained psychotherapists ($N=21$, Griffiths, Gates, et al., n.d., under review) conducted earlier within the same project. These interviews identified challenges with navigating therapy with dementia, finding a place for the person with dementia within the therapeutic space and creating and maintaining a therapeutic relationship (Griffiths, Gates, et al., n.d., under review). We immersed ourselves by engaging with participant data sources (i.e., transcripts, notes, drawings and keywords written on tablecloths participants used to describe Lego models). We identified initial codes, noting interesting or significant aspects of the participants' accounts about their lived experiences of dementia and encounters with therapeutic services. We then developed and critically examined themes, reflecting on how our own perspectives might have influenced their development, such as identifying what questions we had not asked and why. This prompted us to return to the participants to ask further questions and clarify unclear aspects. Themes were then refined, before initial competences were written. Triangulation with participants and consultation with stakeholders through an iterative process of three rounds ensured the trustworthiness and rigour of our approach. The research team then shared the initial themes with the lay advisory group, who offered their perspectives.

3 | Findings

We hosted a total of four workshops; two workshops each conducted twice, held in two cities in England. A total of 47 participants were recruited, comprising 23 people with dementia and 24 family members (see Table 1 for an overview of participant demographics).

3.1 | Process of Competence Conceptualisation and Development

3.1.1 | The Formation of Competences

The competences we have formulated provide an overview of the skills required to provide therapeutic interventions to people affected by dementia. They were designed using a three tier structure (Roth et al. 2009; Roth and Pilling 2008), aimed at people whose roles include different levels of direct and

TABLE 1 | Workshop participant demographics.

Characteristics										
Workshop	**1a**		**1b**		**2a**		**2b**		**All workshops**	
Location	**Leeds**		**London**		**Leeds**		**London**			
	n	**%**	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
Attendance										
Workshop total[a]	17	100	14	100	8	100	8	100	47	100
People living with dementia	9	53	7	50	5	62	2	25	23	49
Family members or relatives	8	47	7	50	3	38	6	75	24	51
Age										
30–44	2	12	1	7	—	—	—	—	3	6
45–59	4	24	1	7	1	13	2	25	8	17
60–74	5	29	6	43	4	50	6	75	21	45
75–84	6	35	4	29	3	37	—	—	13	28
85+	—	—	2	14	—	—	—	—	2	4
Gender										
Male	9	53	5	36	5	63	3	37	22	47
Female	8	47	9	64	3	37	5	63	25	53
Ethnicity										
White British	15	88	12	86	8	100	5	63	40	85
Black British	1	6	1	7	—	—	2	26	4	8
British Asian	—	—	1	7	—	—	1	13	2	4
White Other	1	6	—	—	—	—	—	—	1	2
Type of dementia										
Alzheimer's disease	4	45	4	57	2	40	2	100	12	52
Mixed	1	11	1	14	1	20	—	—	3	13
Vascular	1	11	—	—	—	—	—	—	1	4
Post cortical atrophy	1	11	—	—	1	20	—	—	2	9
Young onset	1	11	—	—	—	—	—	—	1	4
Frontotemporal	1	11	—	—	1	20	—	—	2	9
Lewy Bodies	—	—	1	14	—	—	—	—	1	4
Unsure/unable to confirm	—	—	1	14	—	—	—	—	1	4
Form of therapy received										
CBT	1	6	—	—	—	—	—	—	1	2
Counselling	4	24	1	7	3	38	1	13	9	26
Couples therapy	2	12	—	—	2	26	—	—	4	9
CBT and talking therapy	—	—	1	7	—	—	1	13	2	4
Unsure/unable to confirm	10	58	12	86	3	38	6	74	31	67

[a]Some participants attended more than one workshop. Their demographic data are presented in the columns for each workshop and therefore they appear more than once.

indirect work with people with dementia. We briefly describe each of the domains in Table 2 to outline what they encapsulate; however, we assert that practitioners will integrate the most appropriate ones for themselves depending on their role, context and practice. For example, all therapists are expected to have generic competences as they may come across people with dementia in their work, regardless of the service they work within. Specialist competences are for all people who spend a proportion of their working time therapeutically supporting people with dementia and their families. Leading competences are for those managing, delivering or commissioning services for families affected by dementia. The final competences can be found at https://sites.google.com/sheffield.ac.uk/dementia-core-competences.

3.1.2 | Development of Competences

In this section, we briefly describe the iterative process of developing evidence-based competences for therapists delivering interventions for people living with dementia (see Figure 1 for an overview of competence development). This was a dialogical

TABLE 2 | Overview of level of competences.

These competences provide an overview of skills required to provide therapeutic interventions to people affected by dementia. They have been designed at three levels. Which are most appropriate depends on an individual's role. The levels are designed to be progressive, so if working at a specialist level, generic competences should also be met.
Generic: Knowledge and skills in these areas is required for all people working therapeutically. Expectations are that those working therapeutically should meet these competences, as they may come across people with dementia in their work.
Specialist: Expectations are that all people who spend a proportion of their working time therapeutically supporting people with dementia and their families should meet these competences.
Leading: Expectations are that all people who are supervising or managing people working therapeutically supporting people with dementia and their families, or who are responsible for leading, delivering or commissioning services, should meet these competences.

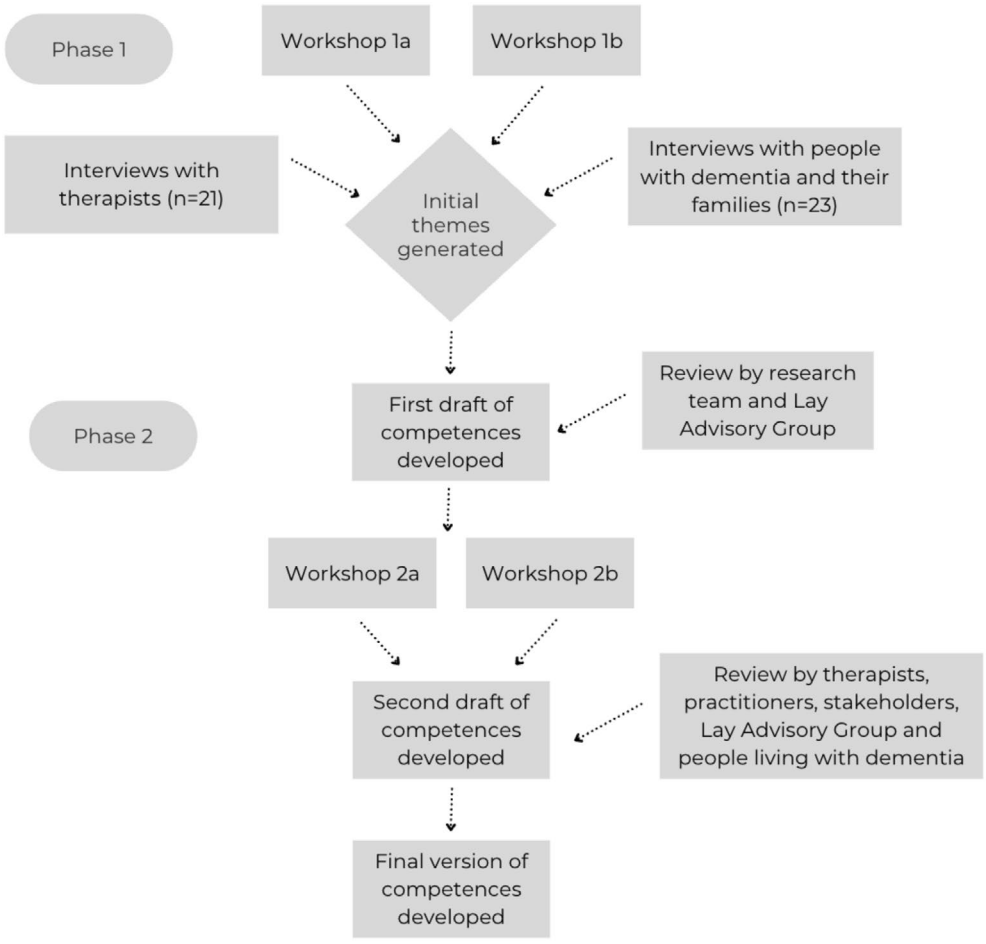

FIGURE 1 | Overview of competence development process.

TABLE 3 | Examples of development of competence wording across iterations.

Area of competence	Initial wording	Final wording
Knowledge of dementia	Appreciation of common misconceptions about the efficacy of anti-dementia medications.	Appreciation of social and professional discourses around medicines used to treat dementia.
Therapeutic techniques and skills	Working knowledge of modalities, their evidence for use with people with dementia, and understanding of why they might or might not be appropriate for those with memory loss.	Working knowledge of modalities, their evidence for use with people with dementia, and understanding of appropriateness and adaptability for those with memory loss.
Therapeutic relationship	Continued focus on development and maintenance of good therapeutic relationship and contracting in ways which appreciate the unique perspective held by the person with dementia.	Continued focus on development and maintenance of good therapeutic relationship and contracting in ways which appreciate the unique perspective of the world held by the person with dementia. This may include poor recognition of therapists, misunderstanding of session aims, or confusion around roles.
Scope of practice	Able to recognise the emotional impact and challenges of providing therapy to this population to those being supervised.	Identify and recognise the emotional impact and challenges of providing therapy to this population on therapists being supervised, and provide appropriate support and/or adjustments.

process in which meanings evolved between the research team and the research participants who shared their lived experiences.

Our workshops, using a World Café approach (Griffiths, Charura, et al., n.d., under review), were used to generate ideas for the competences and review areas of focus. Analysis of interviews from earlier stages of the project revealed that participants voiced experiences of variation in practice and limitations in the therapists they had worked with, stating that they lacked key knowledge and skills in working with dementia. At worst, the participants articulated that therapists practice in ways that were felt to be harmful and eroded their sense of hope, for example by referring to dementia as a 'death sentence' (Griffiths, Gates, et al., n.d., under review).

A sub-group (A.W.G., D.C. and Y.M.-O'.C.) then met to formulate the draft competencies, drawing directly from the quotes and themes that the groups had generated. Our formulation of competences included a reflexive and duoethnographic process. This initial set of 105 competences spanning generic, specialist and leading levels focused on four main areas, which are outlined in the next section. These were then reviewed by the wider team, including the lay advisory group. See Table 3 for examples of changes in wording across versions of competences.

Once the draft competences were prepared, we utilised Workshops 2a and 2b to gather feedback on their content. We asked participants to review the draft competences and answer three questions: 'what is important?', 'what is not important?' and 'is there anything missing?' for the four areas of core competences that had been initially developed. We also asked participants to reflect on whether they felt each competence was required at a generic, specialist or leading level, identified through the question 'who needs to know this?'. This resulted in important edits and enhanced depth to the competences (see Griffiths, Charura, et al., n.d., for examples of specific changes to competence statements). For example, participants raised issues around grief and loss, which they felt were not adequately recognised or addressed within the first draft. Following this workshop, the research team conducted a further round of content review to add, remove, and restructure any competences, in line with feedback. During this review, competences were changed from saying 'able to' to 'demonstrates competence in' or 'working knowledge of', with the rationale that anyone can state they are able to do something, without necessarily demonstrating competence. We also reflected on the importance of considering multiple perspectives around knowledge. Within workshops, participants discussed two distinct sets of knowledge about dementia; firstly, the neurological underpinnings of dementia, but secondly, the way in which the person may make sense of, respond to and cope with their symptoms. The second set of knowledge is particularly important within the therapeutic space, as the danger of focusing on the neurological underpinnings only is that everything becomes seen through that prism, and a therapist fails to help the person to explore and make sense of the impact of dementia.

The updated draft competences were then sent by email or post to therapists, practitioners, stakeholders, including professional bodies, people working within the field, the lay advisory group and people living with dementia (termed stakeholders). After one final round of revisions, we incorporated the final feedback and sent the finalised competences to stakeholders.

3.1.3 | Overview of Competence Areas

The developed competences cover four areas of practice: knowledge of dementia, therapeutic techniques and skills, therapeutic relationship, and scope of practice; and require

an understanding of therapeutic formulation. Practitioners may be guided by a range of formulation frameworks, for example American Psychological Association (2012), The Health and Care Professions Council (2024) or British Psychological Society (2025). Competences around working knowledge of dementia focus on awareness of the presentation, impact and trajectory of dementia; understanding the wider context within which the person with dementia sits, such as how cultural, societal and community understandings of dementia may impact on someone's presentation within a service; knowledge of the presentation of mental health problems amongst people with dementia; and knowledge of relevant legal issues, such as mental capacity and finances. Therapeutic techniques and skills competences focus on skills to deliver therapy to people affected by dementia, to work with the person with dementia to develop the formulation and identify goals for psychotherapeutic interventions; to communicate with people with dementia using kindness, patience and compassion; to create adaptations to therapy for people with dementia, including the use of interpreters, adapting communication style and pace in line with individual's needs, such as increased eye contact, writing down complex information, confirming understanding, or slowing the pace of therapy; to show flexibility in how therapeutic skills are implemented with people with dementia, such as the number of sessions, location of sessions or involvement of family members; and to work sensitively around issues of diversity. Competences related to therapeutic relationship focus on developing and communicating about the therapeutic relationship in ways which appreciate the unique perspective of the world held by the person with dementia and taking a systemic approach to understanding dementia, considering how the person with dementia's understanding of a relationship or relational context may be different to their family members. Finally, competences related to scope of practice focus on awareness of own practice and appreciation of the complexities of delivering services for people with dementia, recognising the emotional impact and challenges of providing therapy to this population on oneself, and accessing supervision for this appropriately; and managing complex confidentiality and boundary issues within families where one person has dementia.

The above competences are related to three domains based on role and service positioning, in line with existing competence frameworks (e.g., Roth and Pilling 2007; Roth et al. 2009), which differentiate between competences that all therapists should possess, those applying to more specific forms of therapeutic modality, and those related to supervision and leadership. Here, rather than applying to a specific form of therapeutic modality, we applied these to a specific population. These were identified through the review and reflection on existing competence frameworks, triangulated with evidence from interviews, in which participants highlighted the range of specialist knowledge and skills required to regularly deliver therapy to people affected by dementia. Finally, within workshops, where participants reviewed draft competence statements, we asked them to reflect on 'who should meet this competence?', which helped us to identify the appropriate level for each competence. The most basic competences are targeted at a *generic* level, meaning that all people who are working therapeutically should meet these competences (see Table 2). More complex competences that require a more nuanced understanding of dementia and working with people with dementia are targeted at a *specialist* level. Practitioners who need to demonstrate these competences may work in contexts such as older adult assessment and diagnosis, neuropsychology and memory services, as well as family and systemic therapeutic teams working across the lifespan. Finally, competences for those *leading* services shift away from therapeutic delivery and relate to maintaining up-to-date knowledge of the evidence base for dementia care, supervising therapists, and delivering inclusive services for people with dementia. This includes awareness of national and local policies, as well as developments in pharmacological and therapeutic interventions, and how these apply to service provision priorities. Thus, whilst important for all therapists to be aware of policies, the leading competences apply more to those in senior and leading roles, whose competences are central in informing service delivery, design, and transformation. Furthermore, leaders will also have competences in interpreting data from research in order to ensure the integration of evidence-based practice and practice-based evidence in informing best practice, and the development of new treatments and interventions for dementia.

3.1.4 | Trustworthiness

In relation to trustworthiness, we were informed by the four broad principles outlined by Yardley (2000). These are: sensitivity to context in which the research is done, commitment and rigour, transparency and coherence in the research processes followed, and impact and importance (Yardley 2000). In relation to sensitivity to context, we considered the most appropriate ways to include people with dementia within our research methods. For example, we offered a choice of whether and how people with dementia and their families moved around the room together or separately; we ensured there was always a quiet table available; and encouraged creative participation for those with and without dementia to avoid any 'othering' of those living with dementia. Commitment and rigour in our competence development process were demonstrated through consistent inclusion of individuals throughout the process in a way that worked for them, that is, attending workshops, providing feedback via email, and researcher visits to discuss competences. We have demonstrated transparency and coherence in our research through the process outlined here, showing the link between our data (i.e., quotes from participants) and the developed competences. Finally, the impact and importance of these competences are demonstrated by the recognition of the importance of this work by families affected by dementia, academia and professional bodies. It is both ethical and important for these competences to guide the delivery of therapeutic interventions to families affected by dementia.

4 | Discussion

The present study aimed to utilise different methods to engage people with dementia and their family members in discussions around ways in which psychotherapists could improve the delivery and accessibility of person-centred therapy through the development of core competences for psychotherapists.

The growing evidence base for psychotherapeutic interventions with people with dementia suggests that these are being delivered, even without standardisation in expectations for training and competences. Therefore, those delivering such interventions must possess the appropriate knowledge and skills related to dementia. Our earlier work identified that 'learning on the job' is seen as appropriate when working with this population (Sass et al. 2022); however, the importance of therapists knowing the presentation, impact, and trajectory of dementia over time cannot be overstated, to avoid families feeling like they need to 'teach' their therapist about dementia (O'Donnell et al., n.d., under review). The competences here may map to existing training frameworks, such as the UK Dementia Training Standards Framework (Department of Health 2018). However, given many of the psychotherapists who may engage with these competences do not regularly work with people with dementia, they are unlikely to engage with such frameworks within their role, and therefore will not focus on developing competence working with people with dementia within their plan for continued professional development. Therefore, the development of these competences offers a specialised pathway for psychotherapists to develop expertise in working with people with dementia.

As more countries establish national dementia policies, the recognition of psychotherapeutic interventions for this population is increasing. For example, Canada's National Dementia Strategy (Public Agency of Canada 2019) highlights the benefits of psychological support delivered within the community. The plan proposes to implement this by employing psychologists to deliver evidence-based and culturally appropriate psychological support to people living with dementia and their families. Malaysia's Dementia Action Plan 2023–2030 (Ministry of Health Malaysia 2024) seeks to develop integrated care for dementia, incorporating multi-component interventions through a multidisciplinary approach for the improvement of people with dementia's cognitive and psychological health. Mexico's National Dementia Plan 2024 (Instituto Nacional de Geriatría 2024) references psychosocial interventions and explicitly recommends programmes of psychological support. However, there are many policies where psychological support is not mentioned, and further, countries that are yet to develop a national dementia strategy or policy.

Traditionally, psychotherapeutic modalities were formulated from a broadly Westernised perspective. However, given the diverse societies in which we live, it is important to recognise that psychotherapeutic interventions must engage and respond to individuals, families and communities in culturally appropriate ways, whilst maintaining core therapeutic components (James et al. 2021). This includes understanding and valuing different conceptualisations of mental and physical health across the lifespan, and the role of spirituality, different forms of medicine, interventions and healing approaches within this. We are currently at an inflection point at which members of the public accessing psychotherapies are asking questions and challenging the status quo of how therapy has always been practiced. For example, whilst it is widely accepted in some therapeutic modalities that the therapy space is for the individual client, being open-minded to learning from the family system can add value to both the experience for the person with dementia and the therapeutic process. Therefore, it is important for ongoing reflection and learning to be engaged with, to ensure the continued relevance of the developed competences.

4.1 | Clinical Implications

As people with dementia value speaking to a therapist who knows about and understands dementia (Griffiths et al. 2021; Griffiths, Gates, et al., n.d., under review), therapists being able to demonstrate that they meet a core set of competences could inform and reassure families affected by dementia. As time is limited within such sessions, being able to prioritise issues that are important will be well received by families. As older adults are less likely to be referred to or receive psychotherapeutic interventions (e.g., Morgan 2021), vital opportunities to help people accept, understand and respond to their dementia diagnosis may be being missed (Keady et al. 2007). Where families have the opportunity to engage with psychotherapeutic interventions, these experiences are broadly positive (Griffiths et al. 2021; Jeffery 2019; Shoesmith et al. 2022). The development of these competences challenges different modalities to adopt an effective approach to working beyond the individual, as dementia affects the whole family and system. Therefore, therapists should ensure that those with dementia are referred to appropriate services, with the support of their family where relevant.

At the point of dementia diagnosis, there may be concerns about understanding of the diagnosis, comorbid experiences of depression and/or anxiety in facing existential angst and uncertainty, what the future might look like, and the impact on family relationships (Griffiths, Gates, et al., n.d., under review). For others, it may be grief of lost occupation, reduced meaningful activities and loss of a planned future. Therefore, being aware of the diversity of the areas of concern that people may bring to the therapeutic space will allow a greater understanding of the experiences of those with dementia. It is also important to recognise the many ways in which people with dementia experience diversity, in line with the social GGRRAAACCEEESSS guidelines (Burnham 2012).

As each individual with dementia experiences a unique set of symptoms, their cognitive abilities should be considered in therapeutic delivery (Tay et al. 2019), and a standardised approach is unlikely to work. Despite this, using the competences outlined here as a guide to develop appropriate knowledge and skills will provide clinicians with a basis on which to build specialist knowledge relevant to their client base, incorporating recommended adaptations to therapy for this population (Robinson and Moghaddam 2022).

At present, the majority of practitioners find that the generic focus of therapy has been to explore emotions, even when the practitioner does not have specialist knowledge of dementia. When speaking to families affected by dementia, some of the challenges noted were that they often found it unhelpful to process their experiences in therapy while also educating the practitioner. This likely impacts the efficacy and outcomes of therapy and limits the client's opportunity to experience a validating and empathic practitioner. One implication of the developed competences is that the burden is on the client and carers, who must negotiate roles as educators whilst also engaging in therapy.

The growing evidence base also challenges the assumptions that people with dementia cannot engage with psychotherapy or develop a meaningful therapeutic relationship (Sommerbeck 2006). These competences offer a foundation to challenge ageism and therapeutic practices which are denied to people living with dementia on the basis that they will not benefit, by showing what needs to be adapted. The competences also challenge practices of importing therapies without appropriate adaptation to work with dementia. By engaging with these competences, practitioners and researchers will be able to work authentically with clients across the lifespan, using evidence-based adaptations. It is hoped that the development of such competences increases the confidence of psychotherapists in their skills to work with this population.

Internationally, there are different assessment, formulation (and diagnosis) guidelines and taxonomies (British Psychological Society 2025). It is therefore important that therapeutic practitioners and counsellors, people with dementia and their families maintain a critical awareness of the benefits and concerns around diagnosis, potential stigma of receiving a dementia diagnosis, and the implications of this on the therapeutic process. This highlights the importance of dementia-informed supervision for psychotherapists and continuous personal and professional development in this area.

Finally, the competences provide a foundation on which policy changes can be informed and standards set, in line with practice in other areas, such as child and adolescent mental health. This helps the process of raising the confidence of psychotherapists, the quality of services, and ultimately improving the lives of clients and families who receive them. Dementia is recognised as a public health priority by the World Health Organisation, and, as such, offering appropriate diagnosis, treatment and care, and support for families should be prioritised (World Health Organisation 2025).

4.2 | Limitations of the Research

There are several limitations associated with this work. Our workshops included participants with a wide range of experiences that are often under-represented within dementia research, such as people with young onset dementia, same-sex couples, people who live alone, and non-White British participants. We acknowledge that our sample lacked lived experiences of ethnic diversity and minoritised cultures, which may have resulted in reduced discussion of diversity during workshops. Our research team is diverse in many ways, and developed the competences inclusively through the duoethography process. Our sample also did not represent individuals who may struggle to communicate verbally, or for whom English is not a language they are confident speaking. These individuals may face additional barriers to accessing psychotherapy services, particularly within the UK, and further consideration of their needs is required. Dementia is not openly discussed or disclosed within many diverse ethnic communities (McDermott et al. 2025). This can lead to family carers and people with dementia feeling isolated and unsupported. Mainstream dementia support services and hospitals often fail to meet the cultural and religious needs of diverse communities (Parveen et al. 2017). Home-based care supported by external care agencies can be helpful, but ensuring consistency in care staff to deliver culturally appropriate care can be extremely difficult (McDermott et al. 2025). Secondly, recruitment to the initial interviews and to workshops was mainly through local support groups, Join Dementia Research and existing researcher networks. Individuals who regularly attend support groups are likely to already be engaged with a range of services, and to have access to recent knowledge and developments in dementia care. Therefore, we may not have heard from individuals for whom accessing support groups or research is difficult, or for whom participating in a workshop could be challenging. Whilst we aimed to recruit these individuals through NHS services, this presented challenges, given poor access to psychotherapy in many areas of the UK.

4.3 | Future Research

Future research should explore the impact of these competences on referrals to, and experiences of, psychotherapeutic interventions within healthcare services. Recent randomised controlled trials exploring specific modalities adapted for dementia, such as problem adaptation therapy, have shown limited impact on outcomes such as depression (Howard et al. 2024). However, despite this, people with dementia continue to express appreciation of psychotherapeutic interventions, and beliefs in positive outcomes associated with this (Griffiths, Gates, et al., n.d., under review). Therefore, consideration should be given to the most appropriate methodologies for exploring the impact and value of such interventions with populations affected by dementia, drawing on evidence from and listening to the voices of people with dementia and their families.

5 | Conclusion

In conclusion, the competences developed here present an overview of expectations for those working therapeutically with families affected by dementia. It is hoped that their development leads to increased awareness of the specialist skills needed to engage with people with dementia, valuing of these skills for psychotherapists, and, ultimately, improvements in national and international policies, increased funding, and more effective service delivery for this population.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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