

Beyond truth and deception: a contextual decision-making model for dementia care

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Abstract

Purpose – This study aims to develop the Contextual Decision-Making Model in Dementia Care (CDM-DC), a practice-oriented framework for structuring professional deliberation when factual truthfulness, experienced reality and emotional well-being come into tension.

Design/methodology/approach – The CDM-DC was developed through an integrative process of conceptual analysis and synthesis drawing on literature on therapeutic lying and deception, dementia communication, person-centred care, professional judgement and ethical decision-making.

Findings – The model comprises three interrelated levels: situational assessment, consideration of a repertoire of communicative strategies and ethical-contextual validation. It distinguishes six communicative strategies ranging from adapted truth-telling to therapeutic lying and proposes five criteria for evaluating the appropriateness of a proposed response. The model is iterative rather than prescriptive, allowing decisions to be reconsidered as circumstances or consequences change.

Practical implications – The CDM-DC provides a common structure and vocabulary for examining complex communicative situations in dementia care and may support professional reflection, supervision, education and interdisciplinary ethical deliberation. As a conceptual framework, its practical utility requires subsequent empirical examination.

Originality/value – The model moves beyond the conventional truth-versus-lying dichotomy by integrating contextual assessment, communicative alternatives and explicit ethical scrutiny within a single decision-making framework.

Keywords Dementia, Therapeutic lying, Communication, Decision-making, Person-centred care, Professional judgement

Paper type Research paper

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1. Introduction

Communication is a central component of dementia care and one of the areas in which the consequences of cognitive impairment become particularly visible in everyday interactions. Changes in memory, orientation, language and the interpretation of events may affect how a person understands information and communicates with others. Communication, therefore, requires sensitivity to not only cognitive abilities but also emotional state, subjective experience and relational context (Alsawy *et al.*, 2017; Eggenberger *et al.*, 2013).

For professionals and family caregivers, these changing communicative needs can create considerable uncertainty. Difficulties become particularly apparent when factual truthfulness appears to conflict with the person's immediate emotional well-being. A person living with dementia may repeatedly ask about someone who has died, wish to return to a home in which they no longer live or interpret a current situation through experiences from an earlier period of life. Providing factual information may support orientation or autonomy, but in other circumstances may cause distress that is repeatedly experienced as new. Conversely, withholding or modifying information may reduce immediate distress while raising concerns about autonomy, dignity and trust (Dresser, 2021; Tieu, 2021).

Therapeutic lying is one of the most controversial responses to such situations. Broadly understood, it involves deliberately communicating information that does not correspond to factual reality, usually to prevent distress or promote well-being (Tieu, 2021). Deceptive practices have been documented in everyday dementia care (Elvish *et al.*, 2010), but their ethical legitimacy remains contested. Concerns about autonomy, dignity and trust coexist with arguments that strict adherence to factual truth may sometimes produce avoidable harm (Dresser, 2021; Mitchell, 2014). From a care ethics perspective, the moral evaluation of deception also depends on the person, relationship and circumstances in which care takes place (Huang *et al.*, 2022).

However, the practical problem extends beyond deciding whether therapeutic lying is acceptable. Professionals can draw on a wider repertoire of responses, including adapted or simplified truth-telling, emotional validation, redirection and deliberate deception. These strategies differ in their relationship to factual reality, their purposes and their potential consequences. Reducing professional decision-making to a choice between telling the truth and lying may, therefore, obscure both the alternatives available and the contextual reasoning involved in selecting among them (Tieu, 2021).

Empirical evidence further suggests that these decisions are not necessarily grounded in a shared understanding of therapeutic lying. Research with social workers has found that practices involving departures from factual truth may occur even among professionals unfamiliar with the concept itself (Yusta-Tirado *et al.*, 2025). Research using the Attitudes towards Lying to People with Dementia scale has also identified distinct dimensions in professional attitudes, reflecting concern for the person's well-being alongside differing levels of acceptance of lying (Yusta-Tirado *et al.*, 2024). Although these findings derive primarily from social work, they illustrate a wider issue in dementia care: professionals may make complex communicative decisions without a common framework for articulating and critically examining the reasoning behind them.

Such decisions are inherently situated. The appropriateness of a response may depend on the person's cognitive and emotional state, the nature and recurrence of the situation, the anticipated consequences of factual information, relational factors and the purpose of the intervention. Organisational circumstances and the views of other members of the care team may also influence practice. Consequently, no single communicative response can be assumed to be appropriate across situations, while general ethical principles may be insufficient on their own to guide everyday professional judgement (Huang *et al.*, 2022).

Despite growing literature on the ethics and use of therapeutic lying, less attention has been given to structuring how professionals deliberate between communicative alternatives in concrete situations. Existing work has examined the moral permissibility of deception and documented its use in dementia care (Dresser, 2021; Elvish *et al.*, 2010; Huang *et al.*, 2022; Tieu, 2021), but there remains a need to connect situational assessment, consideration of available responses and critical ethical evaluation within a single practice-oriented framework.

This article, therefore, develops the Contextual Decision-Making Model in Dementia Care (CDM-DC), a conceptual framework designed to support structured professional deliberation when factual truthfulness, experienced reality and emotional well-being come into tension. Intended primarily for health and social care professionals working directly with people living with dementia, the model does not prescribe whether therapeutic lying should be used or assume that existing practices are inherently legitimate. Instead, it organises deliberation around three interrelated components: situational assessment, consideration of communicative responses and ethical-contextual validation. In doing so, the CDM-DC seeks to move professional decision-making beyond a binary opposition between truth and deception towards a more explicit, critical and context-sensitive approach.

2. Conceptualising communicative responses beyond the truth–lie dichotomy

2.1 *Therapeutic lying: definitions and conceptual boundaries*

Therapeutic lying commonly refers to the deliberate communication of false information to a person living with dementia with the intention of promoting well-being, preventing harm or reducing distress (Mitchell, 2014; Tieu, 2021). The term *therapeutic*, therefore, refers primarily to the intended purpose of the deception rather than to any established therapeutic efficacy. Benevolent intention alone does not determine whether a deceptive response is ethically justified or beneficial in a particular situation.

Its conceptual boundaries, however, remain difficult to establish. Discussions of truthfulness in dementia care encompass heterogeneous practices, including explicit false statements, withholding or selectively presenting information, diversion, redirection and responses to the emotional meaning of a person's communication (Dresser, 2021; Elvish *et al.*, 2010; Tieu, 2021). These strategies may arise in similar circumstances, but should not automatically be treated as equivalent forms of therapeutic lying. Emotional validation may acknowledge feelings without confirming or challenging factual content, while redirection may shift the focus of an interaction without introducing false information. Diversion is more ambiguous, as it may involve explicit deception or implicitly affirm the person's understanding of a situation (Tieu, 2021).

Therapeutic lying is, therefore, better understood as one possible response within a broader repertoire of communicative strategies used when factual reality, experienced reality and emotional well-being come into tension. This distinction separates deliberate deception from other forms of non-corrective communication and avoids treating every departure from strict reality orientation as lying. The CDM-DC builds on this distinction by locating therapeutic lying within a wider range of communicative possibilities, allowing different responses to be considered separately and subjected to proportionate ethical scrutiny.

2.2 *Ethical tensions and the limits of principle-based approaches*

The ethical debate surrounding therapeutic lying has often been framed as a conflict between competing moral obligations. Truthfulness and respect for autonomy provide strong reasons against deception, while beneficence and non-maleficence may support responses intended to prevent avoidable distress or harm (Beauchamp and Childress, 2019). In dementia care, this tension is particularly complex: changes in cognitive capacity do not remove the moral significance of truthfulness, but may alter the consequences of providing factual information in particular circumstances. Schermer (2007), for example, argues that although deception remains *prima facie* morally problematic, its justification cannot be considered independently of the person's capacities and well-being. More recent discussions similarly highlight the tension between professional commitments to honesty and circumstances in which limited therapeutic lying may be perceived as more benevolent than truth-telling (Wheaton, 2022).

The limitation of relying exclusively on general ethical principles is not that autonomy, beneficence or truthfulness cease to matter, but that they may provide competing reasons for action without determining how they should be balanced in a particular situation. At the same time, treating cognitive impairment as sufficient justification for deception risks paternalism and underestimates the continuing importance of truth and truthful relationships for people living with dementia. Dementia should, therefore, not, in itself, suspend the moral presumption in favour of truthfulness.

These tensions support an approach that retains relevant moral principles while also attending to relationships, vulnerability and the circumstances in which care is provided. Care ethics offers one such perspective by locating moral judgement within relationships of dependency and responsibility rather than solely in the application of abstract principles

(Tronto, 1993). Applied to dementia care, this supports a situated evaluation of communicative decisions without assuming that contextual sensitivity legitimises deception. The challenge is, therefore, not to replace principles with context, but to consider how truthfulness, autonomy, well-being and relational responsibilities interact in particular situations.

2.3 Person-centred dementia care and communication

Person-centred approaches have reshaped dementia care by shifting attention from cognitive impairment alone towards personhood, subjective experience, relationships and individual needs (Kitwood, 1997; Brooker, 2007). Subsequent developments have reinforced person-centred care as a framework that recognises the preferences, capacities and lived experience of people with dementia (Manthorpe and Samsi, 2016). Communication, from this perspective, is not limited to transmitting or correcting factual information, but forms part of the relational process through which the person is recognised and supported.

Person-centred communication requires responsiveness to individual abilities, emotions and communicative needs. Strategies may include adapting language and interaction, validating emotional expression, facilitating participation and adjusting communication to the particular circumstances (Mundadan *et al.*, 2023; O'Rourke *et al.*, 2022). This broadens the range of possible responses when experienced and factual reality diverge, beyond either direct correction or deception. Importantly, person-centred care does not itself justify therapeutic lying; any response must still be considered in relation to the individual, the meaning of the interaction and its potential consequences.

For the CDM-DC, person-centred care, therefore, provides a basis for understanding communication as a contextual and relational decision rather than a predetermined response to cognitive impairment. However, it does not determine which strategy should be selected when truthfulness, experienced reality and emotional well-being come into tension. The CDM-DC addresses this transition from general principles of person-centred communication to situated professional decision-making.

2.4 Professional judgement, uncertainty and tacit knowledge

Professional decision-making in health and social care often involves situations in which evidence, formal guidance and general rules do not determine a single course of action. Professional judgement, therefore, requires interpreting information in relation to the circumstances of a particular case, particularly when uncertainty and competing considerations are present (Schön, 1983; Taylor, 2012). This is especially relevant in dementia care, where professionals may need to balance autonomy, safety, well-being and relational considerations in changing cognitive and emotional circumstances.

Tacit knowledge helps explain how experience contributes to such judgement. Polanyi (1966) described forms of knowing that cannot be fully articulated, while Schön (1983) emphasised reflection within professional practice when situations do not readily conform to established rules. Experience may, therefore, influence how professionals recognise relevant features of a situation and anticipate possible consequences without every element of their reasoning being explicitly formulated. However, experiential knowledge is not inherently reliable or ethically justified; professional practices may also reproduce assumptions, routines or biases that require critical examination.

The CDM-DC does not, therefore, treat tacit knowledge as a justification for therapeutic lying or seek simply to reproduce existing practice. Rather, it provides a basis for understanding why communicative decisions may rely on situated professional judgement that remains only partially articulated. The framework seeks to make relevant considerations

more explicit, allowing them to be examined alongside available evidence and subjected to ethical scrutiny. In this sense, the CDM-DC supports a transition from largely implicit judgement towards structured deliberation without assuming that existing professional practices are necessarily appropriate.

2.5 Towards a practice-oriented decision-making framework

The preceding perspectives address complementary dimensions of communicative decision-making in dementia care, including ethical considerations, person-centred communication and professional judgement under uncertainty. However, they do not provide a structured means of integrating situational factors, communicative alternatives and ethical evaluation when factual truthfulness, experienced reality and emotional well-being come into tension.

This does not imply an absence of decision-making frameworks in dementia care more broadly. Existing approaches have made important contributions to shared decision-making, person-centred communication and participation in care decisions (Daly *et al.*, 2018). The specific gap addressed here concerns the lack of an integrated framework for structuring professional deliberation across different communicative responses when direct factual correction may conflict with other care considerations.

The CDM-DC addresses this gap by integrating situational assessment, consideration of communicative alternatives and ethical-contextual validation. Rather than prescribing a predetermined response or legitimising existing practice, it provides a structure through which professional judgement can be made explicit and critically examined in context.

3. Methodological approach

The CDM-DC was developed as a conceptual framework through an integrative process of analysis and synthesis. Conceptual research reorganises existing knowledge, connects previously separated perspectives and develops new ways of understanding a phenomenon rather than testing hypotheses through primary empirical data (Jaakkola, 2020; MacInnis, 2011). This approach was appropriate because the CDM-DC brings together several bodies of knowledge, including therapeutic lying and deception, dementia communication, person-centred care, professional judgement and ethical decision-making.

The model-building process comprised three interrelated stages. First, relevant conceptual and empirical literature was critically examined to identify considerations involved in communicative decision-making when factual truthfulness may conflict with the person's experienced reality or emotional well-being. The analysis drew on literature concerning therapeutic lying and deception (Schermer, 2007; Tieu, 2021), person-centred dementia care and communication (Manthorpe and Samsi, 2016; O'Rourke *et al.*, 2022), professional judgement under uncertainty (Taylor, 2012) and previous empirical research on professionals' knowledge, use and attitudes towards therapeutic lying (Yusta-Tirado *et al.*, 2024, 2025).

Second, the concepts identified across these bodies of literature were compared according to their function within the decision-making process. The analysis distinguished between factors relevant to understanding the situation, the communicative responses available and considerations for evaluating the appropriateness of a proposed response. This provided the basis for organising the model into three domains: situational assessment, consideration of communicative strategies and ethical-contextual validation.

Third, these domains were integrated into a sequential but non-prescriptive conceptual structure and iteratively examined for conceptual coherence, overlap between components and consistency with the framework's intended purpose. This process resulted in the three-level architecture presented below. Consistent with conceptual model building, the CDM-

DC is proposed as an analytical framework for subsequent empirical examination rather than as a validated decision rule or clinical protocol (Jaakkola, 2020; Whetten, 1989).

4. The contextual decision-making model in dementia care (CDM-DC)

The CDM-DC is a practice-oriented conceptual framework designed to structure professional deliberation when communicative decisions involve tensions between factual truthfulness, the person's experienced reality and emotional well-being. Intended primarily for health and social care professionals working directly with people living with dementia, it focuses on how alternative communicative responses can be considered in relation to the circumstances of a particular situation rather than prescribing whether therapeutic lying is acceptable in general.

The framework does not prescribe a specific response or assume that existing practices are necessarily appropriate. Instead, it structures deliberation around three interrelated levels:

1. situational assessment, which identifies characteristics of the person and situation relevant to the decision;
2. consideration of communicative strategies, which examines possible responses beyond a binary choice between truth and deception; and
3. ethical-contextual validation, which evaluates the proposed response in relation to its purpose, proportionality and implications for the person.

Although analytically differentiated, these levels remain interconnected, allowing decisions to be reconsidered as circumstances or anticipated consequences change.

4.1 Situational assessment

The first level of the CDM-DC involves developing a contextual understanding of the situation before considering a communicative response. This assessment extends beyond cognitive status to factors relating to the person, the characteristics of the situation, the anticipated consequences of factual truth-telling and the purpose of the proposed response. These four dimensions reflect the person-centred and context-sensitive principles outlined above and are summarised in Table 1 (Long *et al.*, 2024; Tuckett, 2012).

Person-related factors: The first dimension concerns the person's cognitive and emotional circumstances at the time of the interaction, including cognitive impairment, current capacity to understand the information being communicated, degree of disorientation and emotional state. These factors cannot be inferred solely from diagnosis or general cognitive functioning, as communication needs and responses may vary between individuals and situations (Alsawy *et al.*, 2017; O'Rourke *et al.*, 2022). Assessment should, therefore, focus on how the person is experiencing and understanding the situation at that moment.

Table 1 Dimensions of situational assessment

<i>Dimension</i>	<i>Main components</i>	<i>Relevance for decision-making</i>
Person-related factors	Cognitive functioning, situational understanding, disorientation, emotional state	Identifies how the person is experiencing and able to understand the situation
Nature of the situation	Emotional intensity, recurrence, immediate risk	Establishes the characteristics and urgency of the communicative dilemma
Anticipated impact of truth-telling	Understanding, orientation, distress, potential benefit or harm	Examines the likely consequences of providing factual information
Purpose of the communicative response	Relief of distress, prevention of harm, facilitation of care, professional or organisational convenience	Clarifies the intended goal and whose interests are primarily served

Nature of the situation: The second dimension concerns the circumstances giving rise to the communicative dilemma, including emotional intensity, recurrence and any immediate risk to the person or others. These characteristics influence both the urgency of the response and the communicative options that can reasonably be considered. Evidence suggests that decisions concerning deception in dementia care are closely related to the circumstances in which communication occurs rather than to a universally applicable rule regarding truth-telling (Long *et al.*, 2024; Tuckett, 2012).

Anticipated impact of truth-telling: The third dimension considers the likely consequences of communicating factual information, including whether it can be meaningfully understood and whether it is likely to support orientation or decision-making, cause avoidable distress or repeatedly recreate an emotionally painful experience. This does not make distress sufficient justification for deception; rather, the anticipated consequences of truth-telling form one element of the wider assessment (Schermer, 2007; Tuckett, 2012).

Purpose of the communicative response: The fourth dimension requires the intended purpose of the response to be made explicit. A strategy intended to alleviate distress or prevent harm differs ethically from one motivated primarily by staff convenience, organisational demands or avoidance of a difficult interaction. Deception in dementia care may serve different purposes, including reducing residents' distress, facilitating care and saving time (Tuckett, 2012). Identifying whose interests are primarily served is, therefore, relevant to both contextual assessment and subsequent ethical evaluation.

These dimensions are interrelated rather than sequential criteria or independent variables. Situational assessment does not determine the decision itself, but provides a contextualised understanding of the communicative dilemma from which alternative responses can be considered.

4.2 Repertoire of communicative strategies

Following situational assessment, the second level of the CDM-DC considers the communicative responses potentially available to the professional. Rather than framing the decision as a binary choice between truth-telling and lying, the model distinguishes six strategies according to how they engage with factual information, the person's experienced reality and the emotional meaning of the interaction. This reflects the broader range of responses described in dementia care and avoids treating every non-corrective form of communication as deception (Hughes, 2021; Tieu, 2021).

The six strategies do not constitute a rigid hierarchy or consecutive stages. Although some involve a clearer departure from factual truth than others, emotional validation and redirection cannot be positioned simply on a linear scale of truthfulness because neither necessarily involves false information. The repertoire, therefore, provides an analytical structure for considering alternatives rather than a normative scale. Where several responses appear appropriate, preference should generally be given to those that meet the communicative needs of the situation without introducing unnecessary deception, subject to the contextual and ethical assessment developed across the model.

Adapted truth-telling retains factual accuracy while modifying how information is communicated. Language, timing, tone or the amount of information provided may be adjusted to the person's abilities and emotional circumstances, preserving truthfulness while recognising the need to adapt communication to the individual (Alsawy *et al.*, 2017; O'Rourke *et al.*, 2022).

Partial or simplified truth-telling communicates information that remains factually grounded while limiting its complexity or scope. No false information is deliberately introduced, although some information may be withheld or not emphasised. Its use nevertheless

requires consideration of whether omitted information is relevant to the person's autonomy or decision-making.

Emotional validation responds primarily to the emotional meaning expressed by the person rather than correcting the factual content of their account. Fear, sadness, concern or other emotions may be acknowledged without confirming that the person's interpretation of events is factually accurate, providing an alternative to both direct reality correction and deliberate deception.

Redirection or distraction shifts attention towards another topic, activity or stimulus when continued engagement with the original issue is unlikely to be helpful. It does not necessarily involve false information, although diversion may become deceptive when it explicitly or implicitly confirms something the professional believes to be false (Tieu, 2021). Its appropriateness, therefore, depends on its purpose and impact on the person.

Alignment with perceived reality involves responding within the person's current interpretation of events without necessarily constructing an explicit false account. It extends beyond emotional validation by engaging more directly with the person's experienced reality. Ethical discussions have recognised this as a communicative possibility distinct from a straightforward opposition between truth-telling and lying, although it still requires contextual justification (Hughes, 2021).

Finally, therapeutic lying involves deliberately communicating information known or believed by the professional to be false with the intention of protecting the person, preventing harm or reducing distress. Because it explicitly introduces deception, it raises particular concerns regarding autonomy, trust and justification (Dresser, 2021; Schermer, 2007). Within the CDM-DC, it is therefore one option within the broader repertoire rather than the default response when factual truth-telling appears problematic.

The repertoire makes visible the alternatives between direct factual correction and explicit deception while preserving their conceptual differences. Strategy selection follows situational assessment but remains provisional until subjected to the ethical-contextual validation described in the third level of the CDM-DC. The six strategies are summarised in Table 2.

4.3 Ethical-contextual validation of the decision

The third level of the CDM-DC subjects the proposed communicative response to ethical-contextual validation. Situational assessment and the identification of a potentially suitable strategy are not sufficient to justify a decision; the response must also be examined in relation to its necessity, consequences and implications for the person. This applies to all strategies within the repertoire, as deception, withholding information, validation or

Table 2 Communicative strategies repertoire

Strategy	Degree of alignment with factual reality	Main objective
Adapted truth	Full alignment	Provide information in an understandable and acceptable way
Partial/simplified truth	Factual basis maintained	Reduce unnecessary complexity or distress without introducing false information
Emotional validation	Factual position not necessarily addressed	Acknowledge and support emotional experience
Redirection/distraction	Factual issue temporarily redirected	Shift attention away from distressing or unproductive content
Alignment with perceived reality	Engagement with the person's experienced reality	Sustain interaction and reduce distress without necessarily constructing an explicit false account
Therapeutic lying	Deliberate departure from factual reality	Protect the person from distress or harm through intentionally false information

redirection may raise ethical concerns depending on how and why they are used ([Dresser, 2021](#); [Long et al., 2024](#)).

The validation process is organised around five interrelated criteria.

Proportionality: The proposed response should be proportionate to the seriousness and characteristics of the situation. Restricting access to information, reinforcing an inaccurate understanding of events or deliberately introducing false information requires stronger justification than responses without comparable ethical costs. The anticipated benefit should, therefore, be sufficient to justify potential effects on autonomy, trust or other relevant interests ([Beauchamp and Childress, 2019](#)).

Minimal intrusion: Where more than one strategy could appropriately address the situation, preference should be given to the option that achieves the relevant purpose while interfering least with the person's autonomy and access to truthful information. This does not establish a fixed hierarchy between strategies, but requires consideration of whether a less ethically problematic alternative could reasonably achieve the same purpose before adopting deception or another potentially restrictive response.

Orientation towards the person's well-being: The anticipated consequences should be evaluated primarily from the perspective of the person receiving care, considering distress and safety alongside dignity, emotional security, participation and the quality of the interaction. Short-term effectiveness should not automatically be equated with benefit where a strategy primarily serves professional or organisational convenience or undermines other dimensions of the person's well-being ([Kitwood, 1997](#); [Long et al., 2024](#)).

Relational and biographical coherence: The response should be considered in relation to the person's values, life history, preferences and significant relationships insofar as these are known. Dementia does not eliminate the relevance of personal identity or relational history to ethical decision-making. A context-sensitive response should, therefore, consider whether the proposed strategy is consistent with what is known about the person and the relationships involved ([Hughes, 2021](#); [Tronto, 1993](#)).

Professional and organisational accountability: Communicative decisions occur within care relationships, professional teams and organisational contexts. Where recurrent or ethically complex strategies are used, their rationale should be capable of being articulated, discussed and reviewed rather than remaining solely a matter of individual judgement. Coordination may also reduce contradictory responses between caregivers. However, consistency with established practice does not itself constitute ethical justification, and organisational routines should remain open to critical examination.

These criteria provide a structure for deliberation rather than a checklist that mechanically determines the appropriate response. A strategy initially considered suitable may need to be reconsidered if it cannot be justified through ethical-contextual validation. Validation also remains provisional, as changes in the person's condition, the situation or the consequences of a response may require reassessment. In this way, the third level links contextual professional judgement with explicit ethical scrutiny. The five ethical-contextual validation criteria are summarised in [Table 3](#).

4.4 Operational integration of the CDM-DC

The three levels of the CDM-DC operate as an interconnected and iterative process rather than a rigid decision sequence. Situational assessment establishes the contextual basis of the dilemma; the repertoire of strategies broadens the available responses beyond a binary choice between truth-telling and deception; and ethical-contextual validation examines whether the proposed response can be justified in relation to the person and the circumstances of care.

Table 3 Ethical and contextual validation criteria

<i>Criterion</i>	<i>Description</i>	<i>Function in decision-making</i>	<i>Key reference</i>
Proportionality	Adjustment of the response to the seriousness and characteristics of the situation	Ensures that ethically consequential strategies receive sufficient justification	Beauchamp and Childress (2019)
Minimal intrusion	Preference for the least intrusive ethically appropriate option	Encourages consideration of less restrictive or deceptive alternatives	Beauchamp and Childress (2019)
Orientation to well-being	Consideration of emotional well-being, dignity, safety and quality of interaction	Aligns the decision with person-centred care	Kitwood (1997) ; Long et al. (2024)
Relational and biographical coherence	Consistency with the person's values, life history and significant relationships	Preserves identity and relational integrity	Hughes (2021) ; Tronto (1993)
Professional and organisational accountability	Articulation, coordination and review of decisions within the care context	Promotes consistency while enabling professional and ethical scrutiny	–

A strategy considered appropriate following initial assessment may require reconsideration if it does not satisfy the ethical-contextual criteria or if its consequences differ from those anticipated. Changes in the person's cognitive or emotional state, recurrence of the situation or new information may similarly require renewed assessment. Reassessment is, therefore, integral to professional deliberation rather than occurring only when a communicative response has failed.

Taken together, the three levels provide a structure through which professional judgement can be articulated, examined and revised while retaining the contextual flexibility required in dementia care. The CDM-DC, thus, shifts the central question from whether therapeutic lying is acceptable in general to how a particular communicative response can be selected and ethically justified in a particular situation.

5. Discussion

The CDM-DC contributes to the literature on therapeutic lying in dementia care by shifting attention from whether deception can be ethically acceptable in general towards how communicative responses may be considered and justified in particular situations. Previous research has established that deception and other non-corrective responses occur in dementia care and generate considerable ethical disagreement ([Dresser, 2021](#); [Elvish et al., 2010](#); [Schou-Juul and Lauridsen, 2024](#)). However, documenting these practices or professional attitudes towards them does not explain how situational, communicative and ethical considerations can be integrated when selecting a response.

A first contribution of the model is to distinguish three related components of professional deliberation: understanding the situation, considering available communicative responses and evaluating whether a proposed response can be ethically justified. This structure acknowledges the contextual character of dementia communication without assuming that professional experience alone justifies practice. This is particularly relevant because decisions involving deception may reflect benevolent intentions alongside practical pressures, established routines or caregiver needs. Qualitative evidence similarly indicates that caregivers' understandings and justifications of lying are heterogeneous and embedded within particular care circumstances ([Schou-Juul and Lauridsen, 2024](#)).

A second contribution is the conceptualisation of communicative alternatives beyond a binary opposition between truth-telling and therapeutic lying. The CDM-DC does not treat intermediate responses as progressively greater forms of deception, recognising that diversion, engagement with experienced reality and explicit lying are not necessarily equivalent communicative acts ([Hughes, 2021](#); [Tieu, 2021](#)). Emotional validation or redirection, for example, may avoid direct factual correction without deliberately introducing

false information. Treating these responses as a repertoire, therefore, preserves relevant conceptual distinctions while making alternative responses more visible.

This distinction is also important for person-centred care. Person-centredness can neither be reduced to avoiding distress nor does prioritising subjective experience automatically justify deception. Long *et al.* (2024) identify tensions between therapeutic lying and person-centred care, particularly where deception risks manipulation or fails to respect personhood. Dresser (2021) similarly argues that more respectful and less risky alternatives may sometimes be available even when benevolent deception appears defensible. The CDM-DC responds by requiring consideration of communicative alternatives and subsequent ethical-contextual evaluation, positioning therapeutic lying as one possible strategy requiring justification rather than as an inherently person-centred intervention.

A third contribution is the incorporation of explicit ethical scrutiny within the decision-making process. The model does not replace established ethical principles with contextual judgement. Instead, its validation criteria provide a structure for examining the implications of a proposed response. This is consistent with arguments that deception should not be evaluated solely through its immediate effects on distress and that non-deceptive alternatives should be preferred where they can achieve comparable benefits (Schermer, 2007). The iterative character of the CDM-DC further recognises that justification may need to be reconsidered when circumstances or the consequences of a response change.

The framework may also support professional education, supervision and interdisciplinary ethical deliberation by providing a common structure and vocabulary for examining difficult communicative situations. At this stage, however, the CDM-DC should not be interpreted as a clinical protocol or evidence-based decision rule. Its components could provide a basis for case-based training and structured scenarios through which professional reasoning and alternative communicative decisions can be examined.

Several limitations should be acknowledged. First, the CDM-DC is conceptual and has not yet undergone empirical validation. Its dimensions, strategies and validation criteria require examination with professionals, people living with dementia where feasible, and family caregivers before conclusions can be drawn regarding their relevance or practical utility. Second, although its development integrates literature from dementia care, ethics, communication and professional decision-making, it does not derive from a systematic review and may not encompass every relevant factor. Third, some of the empirical evidence informing the model derives from particular professional groups and care contexts, limiting assumptions about transferability across disciplines, cultural settings and stages of dementia. Finally, boundaries between some communicative strategies may remain difficult to establish in practice, particularly where diversion or alignment with perceived reality implicitly confirms information believed to be inaccurate.

These limitations also indicate priorities for further research. Initial work should examine the relevance and clarity of the model and its components with relevant professionals and stakeholders. Practice-based vignettes could then explore how professionals apply the CDM-DC across situations varying in cognitive capacity, emotional distress, risk and communicative context. Further research should examine whether the framework improves the transparency and consistency of professional reasoning without encouraging unnecessary deception. More formal decision-support or implementation tools would require evidence from these subsequent stages.

Overall, the CDM-DC should be understood as an initial conceptual structure for organising deliberation rather than as a solution to the ethical controversy surrounding therapeutic lying. Its contribution lies in distinguishing contextual assessment, communicative possibilities and ethical validation while connecting them within an iterative process. In doing so, it provides a framework for examining how communicative decisions in dementia care can be made more explicit, critically scrutinised and responsive to the circumstances of the individual person.

6. Conclusions

This article has approached therapeutic lying in dementia care as part of a broader problem of communicative decision-making rather than solely as a question of whether deception is ethically acceptable. The CDM-DC addresses this problem through three interrelated levels: situational assessment, consideration of a repertoire of communicative strategies and ethical-contextual validation. Together, they provide a structure for considering how communicative responses can be selected and justified in relation to the person and the circumstances of care.

The principal contribution of the CDM-DC lies in moving beyond a binary opposition between truth-telling and lying while preserving meaningful ethical distinctions between communicative responses. Avoiding factual correction neither is necessarily equivalent to deception nor is reducing distress sufficient to justify therapeutic lying. Instead, the framework makes the purpose, alternatives, anticipated consequences and ethical implications of communicative decisions more explicit, supporting professional judgement without replacing it with predetermined rules.

At this stage, the CDM-DC remains a conceptual framework rather than a validated decision tool or intervention protocol. Further research should examine the relevance and clarity of its components, their application across professional and care contexts and the framework's usefulness in practice-based scenarios. The CDM-DC, therefore, provides a basis for the empirical study of contextualised communicative decision-making and for exploring how person-centred dementia care can be combined with explicit ethical scrutiny.

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