# Therapeutic lying in dementia care: social workers' decision-making and attitudinal dimensions

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**Abstract**

**Purpose** – *This study aims to examine the differential roles of the person-focused and lie-focused dimensions of the Attitudes toward Lying to People with Dementia scale (ALPD) in relation to therapeutic lying among social workers.*

**Design/methodology/approach** – *A cross-sectional online survey was conducted with 253 Spanish social workers working with older adults. Correlations, t-tests, logistic regression and linear regression models were performed.*

**Findings** – *Both ALPD dimensions were strongly correlated but showed different associations. Person-focused attitudes were associated with use and frequency of therapeutic lying, whereas lie-focused attitudes were more strongly associated with acceptability.*

**Research limitations/implications** – *The cross-sectional design and self-report measures limit causal inference and may introduce social desirability bias. The findings support analyzing ALPD dimensions separately in future research.*

**Practical implications** – *The findings highlight the importance of reflective and context-sensitive approaches to ethical decision-making and professional training in dementia care.*

**Social implications** – *Understanding how professionals justify therapeutic lying may contribute to more informed and person-centered dementia-care practices.*

**Originality/value** – *Unlike previous studies using global ALPD scores, this study demonstrates that person-focused and lie-focused attitudes play distinct roles in professional decision-making and moral evaluation.*

**Keywords** *Attitudes, Ethical decision-making, Social workers, Dementia care, Social work practice, Therapeutic lying*

**Paper type** *Research paper*

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## 1. Introduction

Caring for people with dementia frequently involves complex ethical dilemmas arising from the progressive decline in cognitive functioning, particularly in relation to orientation, memory and judgment. In this context, health and social-care professionals often face situations in which strictly truthful communication may generate significant distress, anxiety or disruptive behaviors. This has contributed to the emergence and use of alternative strategies such as *therapeutic lying* (Elvish *et al.*, 2010; James *et al.*, 2006; Mahieu *et al.*, 2016). The term therapeutic lying has been used in dementia-care literature to describe situations in which professionals or caregivers intentionally depart from strict truth-telling to prevent avoidable distress, reduce agitation or maintain emotional well-being in people living with dementia (James *et al.*, 2006; Elvish *et al.*, 2010; Mahieu *et al.*, 2016). Such situations commonly arise when a person's perception of reality differs from their immediate circumstances, for example, when they ask to return home, search for a deceased relative

Received 12 May 2026
Revised 15 June 2026
Accepted 12 July 2026

or become distressed by information they are no longer able to process. In these contexts, professionals often face a practical and ethical tension between correcting inaccurate beliefs and responding in ways that minimize suffering and preserve emotional comfort (Elvish *et al.*, 2010; Mahieu *et al.*, 2016).

Therapeutic lying has been defined as the deliberate modification, omission or distortion of the truth with the aim of reducing emotional distress or promoting the well-being of the person with dementia. Although its use is widely documented in clinical and social-care practice, it remains ethically controversial, as it lies at the intersection of principles such as truthfulness, autonomy and beneficence (Baldwin, 2007; Elvish *et al.*, 2010; Spriggs, 2011). This debate has been further enriched by contemporary approaches emphasizing the ethics of care and relational autonomy, highlighting the need to contextualize ethical decision-making in situations of vulnerability, where strict adherence to truth-telling may conflict with the person's well-being (Nuffield Council on Bioethics, 2009; Spriggs, 2011).

Since its emergence in the dementia-care literature, therapeutic lying has generated considerable ethical debate. Supporters argue that it may represent a compassionate response in situations where strict truth-telling is likely to cause distress without providing meaningful benefit, whereas critics maintain that any intentional deception risks undermining autonomy, dignity and trust. As a result, therapeutic lying has often been discussed as an example of the broader tension between respect for truth and the responsibility to promote the well-being of vulnerable individuals (Baldwin, 2007; James *et al.*, 2006; Mahieu *et al.*, 2016; Spriggs, 2011).

Beyond its conceptual definition, therapeutic lying represents a situated practice that involves complex processes of moral justification by professionals. Empirical evidence suggests that a substantial proportion of those working with individuals with cognitive impairment report having used this strategy in their practice while also expressing ambivalent attitudes regarding its legitimacy (Elvish *et al.*, 2010; James *et al.*, 2006; Mahieu *et al.*, 2016). This ambivalence has been interpreted as reflecting the coexistence of different forms of ethical reasoning, combining considerations related to well-being, professional duty and personal values (Baldwin, 2007; Culley and Gillett, 2016).

In Spain, as in many other countries, support for people living with dementia is provided through a combination of health and social-care services, including community-based programs, residential-care settings and family support services. Within these contexts, social workers are involved in assessment, care planning, service coordination and support for family caregivers. Consequently, they frequently encounter situations in which ethical considerations, professional responsibilities and the well-being of the person with dementia must be balanced in everyday practice (World Health Organization, 2021).

In this context, several studies have sought to systematically examine attitudes toward therapeutic lying, including the development of specific instruments such as the *Attitudes toward Lying to People with Dementia scale* (ALPD) (Elvish *et al.*, 2010). This scale has been widely used in subsequent research and has contributed to advancing the empirical understanding of the phenomenon, particularly with regard to its acceptability and its relationship with professional practice (Mahieu *et al.*, 2016).

However, despite evidence supporting the multidimensional structure of the ALPD – distinguishing between *person-focused* and *lie-focused* attitudes – most empirical studies have relied on a single aggregated total score. This predominant use of a global measure represents an important limitation, as it may oversimplify a construct that is theoretically composed of distinct dimensions.

More specifically, aggregating both subscales may obscure meaningful differences in how professionals justify the use of therapeutic lying. While *person-focused* attitudes appear to be grounded in a care-oriented logic aimed at promoting well-being and reducing distress, *lie-focused* attitudes reflect a more general stance toward the acceptability of lying as a

professional tool. This distinction is consistent with broader theoretical frameworks on ethical decision-making in contexts of vulnerability, in which care-based justifications may differ from those grounded in more normative or principle-based approaches (Held, 2006; Tronto, 1993).

Despite this, empirical evidence regarding the differential role of these dimensions remains limited. In particular, it is still unclear whether they contribute differently to explaining the use of therapeutic lying in professional practice and its perceived acceptability, especially within the field of social work, where ethical decision-making is a central component of professional intervention (Banks, 2012).

Within this context, the present study examines the differential role of the *person-focused* and *lie-focused* dimensions of the ALPD in relation to the use and acceptability of therapeutic lying among social workers.

## 2. Methods

### *2.1 Study design*

A cross-sectional observational study was conducted using an online questionnaire. The study focuses on the analysis of professional attitudes and practices related to the use of therapeutic lying in the field of social work.

### *2.2 Participants and procedure*

The sample consisted of 253 practicing social workers who were working with older adults in Spain. Participants were recruited through professional networks, official professional associations and organizations related to social work and gerontology.

Inclusion criteria required participants to be actively practicing as social workers and to have experience working with older adults. Participation was voluntary, anonymous and unpaid.

The questionnaire was administered online, ensuring the confidentiality of responses. The study was approved by the Research Ethics Committee of the Complutense University of Madrid (Reference No. CE_20220217-05_SOC). All participants provided informed consent prior to participation.

### *2.3 Measures*

*2.3.1 Attitudes toward therapeutic lying.* Attitudes toward therapeutic lying were assessed using the *ALPD scale* (Elvish *et al.*, 2010). The Spanish version of the scale used in this study was previously validated in a sample of social workers, demonstrating adequate reliability and validity (Yusta-Tirado *et al.*, 2024). Consistent with previous research, the scale was conceptualized as a bidimensional measure, distinguishing between *person-focused* and *lie-focused* attitudes. The person-focused dimension reflects attitudes that justify therapeutic lying primarily on the basis of the well-being, emotional comfort and perceived best interests of the person with dementia. By contrast, the lie-focused dimension reflects broader attitudes toward the acceptability of lying as a professional strategy, regardless of the specific circumstances in which it is used. This distinction allows the assessment of whether support for therapeutic lying is grounded primarily in concern for the individual or in more general beliefs about the legitimacy of deception in care practice (Elvish *et al.*, 2010).

Scores for each dimension were calculated as the mean of the corresponding items, with higher scores indicating greater acceptance of therapeutic lying. Internal consistency for each dimension was assessed using Cronbach's alpha. Cronbach's alpha is a commonly

used indicator of scale reliability, with higher values reflecting greater consistency among the items included within a dimension.

*2.3.2 Use of therapeutic lying.* Use of therapeutic lying was assessed using a dichotomous variable (yes/no), in which participants indicated whether they had used this strategy in their professional practice.

*2.3.3 Frequency of use.* Frequency of use was assessed using a self-report measure indicating how often participants used therapeutic lying in their professional practice. This variable was treated as continuous in the analyses.

*2.3.4 Acceptability of therapeutic lying.* Acceptability was assessed using a self-report measure capturing the extent to which participants considered the use of therapeutic lying to be acceptable. This variable was treated as continuous in the analyses.

### *2.4 Data analysis*

Statistical analyses were conducted using IBM SPSS Statistics (Version 29).

First, descriptive statistics (means, standard deviations and minimum and maximum values) were calculated for all study variables. Internal consistency of the ALPD dimensions was assessed using Cronbach's alpha.

Second, the association between the *person-focused* and *lie-focused* dimensions was examined using Pearson correlation coefficients. Pearson correlations were used to examine the strength and direction of associations between variables, with larger coefficients indicating stronger relationships.

Third, bivariate analyses were conducted to explore the association between ALPD dimensions and the key study variables. Independent-samples *t*-tests were used to compare mean scores between participants who had and had not used therapeutic lying. In addition, Pearson correlations were calculated to examine the relationship between both dimensions and frequency of use and acceptability.

Finally, multivariate models were estimated to examine the independent contribution of each ALPD dimension. Binary logistic regression was used to predict the use of therapeutic lying (yes/no), and linear regression models were used to predict frequency of use and acceptability. In all models, *person-focused* and *lie-focused* dimensions were entered simultaneously as predictors to assess their independent effects.

Potential overlap between the two ALPD dimensions was assessed by examining their correlation before estimating the regression models. Although the dimensions were strongly correlated, the association was not considered sufficient to prevent their simultaneous inclusion as predictors. This approach allowed the independent contribution of each dimension to be examined within the same model.

The level of statistical significance was set at $p < 0.05$, indicating that there was less than a 5% probability that the observed findings occurred by chance.

## 3. Results

### *3.1 Descriptive statistics and reliability*

The sample consisted of 253 social workers. Regarding the ALPD scale, both dimensions showed adequate levels of internal consistency. Scores for both dimensions were calculated as the mean of the corresponding items.

The lie-focused dimension showed a Cronbach's alpha of 0.80, while the person-focused dimension demonstrated high internal consistency, with an alpha of 0.93.

Descriptive results indicated a moderate level of acceptance of therapeutic lying in both dimensions, with slightly higher scores observed for the person-focused dimension. The distribution of scores was appropriate, with no evidence of ceiling or floor effects. Descriptive statistics and internal consistency estimates are presented in Table 1.

### *3.2 Association between Attitudes toward Lying to People with Dementia dimensions*

The association between the person-focused and lie-focused dimensions of the ALPD was examined using Pearson correlation analysis.

Results showed a strong and statistically significant positive correlation between both dimensions ($r = 0.80$, $p < 0.001$), indicating that higher levels of acceptance in one dimension were associated with higher levels in the other.

However, although the correlation was high, it remained below commonly accepted thresholds for problematic multicollinearity, supporting the treatment of both dimensions as related but distinct constructs in subsequent analyses. The correlation coefficients are presented in Table 2.

### *3.3 Bivariate associations with key variables*

Bivariate associations between the ALPD dimensions (person-focused and lie-focused) and key study variables – use of therapeutic lying (yes/no), frequency of use and acceptability – were examined.

Regarding the use of therapeutic lying, independent-samples *t*-tests showed that professionals who reported having used this strategy had significantly higher scores on both ALPD dimensions compared to those who had not ($p < 0.001$ for both comparisons).

For frequency of use, both dimensions were positively and significantly correlated, with a slightly stronger association observed for the person-focused dimension.

Similarly, acceptability of therapeutic lying was positively and significantly associated with both ALPD dimensions, with a stronger relationship observed for the lie-focused dimension.

**Table 1** Descriptive statistics and internal consistency of ALPD dimensions

| *Variable* | N | *Mean* | *SD* | *Min.* | *Max.* | *Cronbach's α* |
|---|---|---|---|---|---|---|
| Lie-focused | 253 | 3.12 | 0.68 | 1.20 | 4.80 | 0.80 |
| Person-focused | 253 | 3.45 | 0.72 | 1.10 | 5.00 | 0.93 |

**Note(s):** ALPD = *Attitudes toward Lying to People with Dementia*; SD = standard deviation; α = Cronbach's alpha
**Source(s):** Author's own work

**Table 2** Correlation between ALPD dimensions

| *Variable* | *1* | *2* |
|---|---|---|
| 1. Lie-focused | – | |
| 2. Person-focused | 0.80*** | – |

**Note(s):** $n = 253$. ***$p < 0.001$
**Source(s):** Author's own work

Overall, while both dimensions were consistently associated with the variables examined, differences in the strength of these associations were observed, suggesting a potential differential role to be further explored in the multivariate analyses. The complete results of the bivariate analyses are shown in Table 3.

### 3.4 Multivariate models

To examine the differential role of the person-focused and lie-focused dimensions of the ALPD, multivariate models were estimated in which both dimensions were entered simultaneously as predictors to assess their independent effects.

*Use of therapeutic lying*. In the logistic regression model, the person-focused dimension was significantly associated with a higher likelihood of having used therapeutic lying ($B = 0.50$, $p < 0.001$), whereas the lie-focused dimension was not statistically significant ($p > 0.05$). This finding suggests that therapeutic lying may be more closely linked to concerns about the well-being of the person with dementia than to general beliefs about the acceptability of lying itself.

*Frequency of use*. In the linear regression model, the person-focused dimension remained a significant predictor of frequency of use ($B = 0.45$, $p < 0.001$), while the lie-focused dimension did not reach statistical significance ($B = 0.16$, $p = 0.151$). The model explained approximately 31% of the variance. In practical terms, professionals who were more likely to prioritize the perceived interests and emotional comfort of the person with dementia also reported using therapeutic lying more frequently.

*Acceptability of therapeutic lying*. In the linear regression model, both dimensions were significantly associated with acceptability. However, the lie-focused dimension showed a stronger association ($B = 0.60$, $p < 0.001$) compared to the person-focused dimension ($B = 0.34$, $p < 0.001$). This model explained approximately 64% of the variance. By contrast, judgments about whether therapeutic lying is generally acceptable appeared to be more strongly influenced by attitudes toward lying as a professional strategy than by person-centered considerations alone. The full results of the multivariate models are presented in Table 4.

## 4. Discussion

The present study aimed to examine the differential role of the *person-focused* and *lie-focused* dimensions of the ALPD in relation to the use and acceptability of therapeutic lying among social workers. The findings indicate that, although both dimensions are strongly correlated, they show distinct patterns of association with professional practice and with the moral evaluation of this strategy. This provides empirical support for a multidimensional conceptualization of attitudes toward therapeutic lying, with direct relevance for understanding professional decision-making.

**Table 3** Bivariate associations between ALPD dimensions and key variables

| *Variable* | *Lie-focused (mean/r)* | *Person-focused (mean/r)* | p-*value* |
|---|---|---|---|
| Use (No) | 2.85 | 3.10 | |
| Use (Yes) | 3.30 | 3.65 | |
| Use (comparison) | | | <0.001 |
| Frequency of use | 0.42*** | 0.51*** | <0.001 |
| Acceptability | 0.68*** | 0.55*** | <0.001 |

**Note(s):** Means are reported for dichotomous variables; Pearson correlations (r) are reported for continuous variables. ***$p < 0.001$

**Source(s):** Author's own work

**Table 4** Multivariate models predicting use, frequency and acceptability of therapeutic lying

| *Predictor* | *Use (B)* | *Frequency (B)* | *Acceptability (B)* |
|---|---|---|---|
| Lie-focused | 0.18 (ns) | 0.16 (ns) | 0.60*** |
| Person-focused | 0.50*** | 0.45*** | 0.34*** |
| $R^2$/Nagelkerke $R^2$ | 0.28 | 0.31 | 0.64 |

**Note(s):** B = unstandardized coefficient. Logistic regression was used for use (yes/no). Linear regression models were used for frequency and acceptability. ***$p < 0.001$
**Source(s):** Author's own work

First, the strong correlation observed between both dimensions is consistent with previous research suggesting that acceptance of therapeutic lying tends to operate as a global construct in practice (Elvish *et al.*, 2010; Mahieu *et al.*, 2016). However, more recent studies have emphasized the need to approach such constructs from more nuanced perspectives that account for the coexistence of different ethical reasoning frameworks in dementia-care contexts (Samsi *et al.*, 2020). In line with this, the present findings suggest that, although both dimensions share a common basis, they are not equivalent in terms of their explanatory role.

The multivariate analyses revealed a clear pattern: the *person-focused* dimension was consistently associated with both the use and frequency of therapeutic lying, whereas the *lie-focused* dimension showed a stronger association with its acceptability. This distinction suggests that attitudes grounded in the well-being of the person may be more directly linked to decision-making in everyday practice, while attitudes related to the legitimacy of lying reflect a more abstract or declarative stance.

This finding is consistent with research indicating that professionals often justify the use of non-truthful communication strategies based on contextual factors and their perceived emotional impact, rather than on rigid normative principles (Vernooij-Dassen *et al.*, 2020). From this perspective, therapeutic lying can be understood as a situated practice, in which decision-making is guided by the management of distress and the promotion of well-being, rather than strict adherence to truth-telling.

From a theoretical standpoint, these results align with the ethics of care framework, which emphasizes well-being, interdependence and context-sensitive responses in situations of vulnerability (Held, 2006; Tronto, 1993). Within this framework, the *person-focused* dimension may reflect care-oriented reasoning, whereas the *lie-focused* dimension appears more closely aligned with normative or deontological approaches (Baldwin, 2007; Spriggs, 2011).

In addition, the findings allow for a more refined interpretation of the ambivalence commonly reported in the literature (Culley and Gillett, 2016; Mahieu *et al.*, 2016). Rather than reflecting a generalized inconsistency, the results suggest the coexistence of distinct attitudinal dimensions that may be activated differently depending on whether the judgment is practical or evaluative. This interpretation helps explain why professionals may express reservations about therapeutic lying at an abstract level while still using it in practice.

From an applied perspective, these findings have important implications for social work education and practice. Specifically, they highlight the need to address ethical decision-making not only through the transmission of normative principles, but also through the analysis of complex, context-dependent situations. Incorporating deliberative and reflective approaches may help bridge the gap between evaluative and practice-based dimensions

of decision-making (Banks, 2012; Samsi *et al.*, 2020). More specifically, the findings suggest that ethical decision-making in dementia care cannot be fully understood through reference to abstract principles alone. Social workers are often required to make decisions in situations characterized by uncertainty, emotional distress and competing ethical considerations. In these contexts, decisions regarding therapeutic lying may depend not only on whether professionals consider deception acceptable in principle, but also on how they evaluate the immediate needs and well-being of the person with dementia. These findings highlight the potential value of reflective supervision, ethics-focused case discussions and practice-based training initiatives that encourage professionals to examine the reasoning underlying their decisions. Creating opportunities to critically reflect on situations involving therapeutic lying may help practitioners navigate ethical tensions more consistently and transparently, particularly when balancing concerns related to autonomy, dignity, emotional well-being and risk.

The findings also raise broader questions regarding the ethical challenges associated with therapeutic lying in contemporary dementia care. As person-centered approaches continue to shape policy and practice, professionals are increasingly required to balance competing values, including autonomy, dignity, emotional well-being and protection from harm. The present results suggest that these tensions may not be resolved solely through reference to universal ethical principles, but may instead, require careful consideration of the specific circumstances and needs of each individual.

From this perspective, therapeutic lying should not be understood simply as a technique or intervention but as part of a broader process of ethical decision-making. Greater attention to how professionals justify and evaluate these decisions may contribute to more transparent, accountable and person-centered practice in dementia-care settings.

From a methodological standpoint, the study underscores the importance of analyzing ALPD dimensions separately. Although the use of aggregated scores is common, it may obscure meaningful differences by assuming a level of homogeneity that is not supported by the data. The findings therefore support the use of more disaggregated approaches in future research.

Several limitations should be considered when interpreting these findings. First, the cross-sectional design precludes any causal inference regarding the relationships observed, and the directionality between attitudes and practice cannot be established. Second, all measures relied on self-report, which may be subject to social desirability bias, particularly given the ethically sensitive nature of therapeutic lying. Although anonymity was ensured, participants may still have underreported or overreported their use of this practice.

Third, the measurement of key variables such as frequency of use and acceptability was based on single self-report indicators, which may not fully capture the complexity of these constructs. More comprehensive or multi-item measures could provide a more nuanced assessment in future research.

Finally, the sample was obtained through non-probabilistic recruitment strategies, which may limit the generalizability of the findings. Participants may represent professionals with a particular interest or sensitivity toward ethical issues in dementia care, potentially introducing selection bias.

Future research could build on these findings through longitudinal designs or qualitative approaches aimed at gaining a deeper understanding of decision-making processes related to therapeutic lying. It would also be valuable to examine the role of contextual, organizational and cultural factors that may influence its use.

In conclusion, the findings of this study suggest that attitudes toward therapeutic lying are not adequately captured by a single, unidimensional construct. Distinguishing between

*person-focused* and *lie-focused* attitudes provides a more nuanced understanding of the phenomenon and offers relevant insights for both research and professional practice in social work.

## 5. Conclusion

The findings of this study indicate that attitudes toward therapeutic lying are not adequately captured as a unidimensional construct, but rather comprise distinct dimensions with different implications for professional practice. In particular, distinguishing between *person-focused* and *lie-focused* attitudes provides a clearer understanding of the relationship between the moral evaluation of therapeutic lying and its actual use in practice.

While *person-focused* attitudes were more directly associated with decision-making in everyday practice, *lie-focused* attitudes were more closely related to normative or evaluative positions. This distinction suggests that professionals do not rely solely on abstract principles, but instead make decisions based on contextual factors and their perceived impact on the well-being of the person.

From an applied perspective, these findings highlight the importance of addressing ethical decision-making in social work through approaches that integrate both normative reflection and the analysis of complex, context-dependent situations. From a methodological standpoint, the results also support the need to examine ALPD dimensions separately, as the use of aggregated scores may obscure meaningful differences.

Overall, this study contributes to a more precise understanding of therapeutic lying as a professional practice and identifies avenues for future research focused on decision-making processes in contexts of vulnerability.

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