Compassionate Deception: A Conceptual Analysis

Tan, Amil Kusain Jr. MSN, MHC, RN, PhDc
Assistant Director of Nursing, The Riverside Premiere Rehabilitation and Healing Center
PhD Nursing Student, The Graduate Center, City University of New York
Sigma Theta Tau Honors Society of Nursing

Correspondence: Tan, Amil Kusain Jr. MSN, MHC, RN, The Graduate Center, City University of New York
Address: 365 5th Ave, New York, NY 10016Email: amilkusainjr.tan@yahoo.com; atan@gradcenter.cuny.edu

Abstract

Background: A survey of healthcare providers shows that the use of deception has been a prevalent practice in healthcare settings. the concept of compassionate deception has not been clearly explored and defined in nursing literature. Moreover, the literature remains equivocal as to the effects of lying to patients. It is therefore imperative to study the phenomena to probe the appropriateness of its use.
Objective: The purpose of analysis was to examine, explore and clarify the meaning of compassionate deception.
Methods: A search review was conducted. Databases such as ERIC, PsychINFO, CINAHL Complete, MEDLINE Complete, and Health Source Nursing/Academic Edition from 2008 to 2018. Walker and Avant eight steps to analyze a concept was used.
Results: This analysis showed three overarching themes that are recurrent in concept. The defining attributes are deceptive strategy, person-centeredness, and benevolent intention. Thus, the operational definition of compassionate deception then is a person-centered approach that uses deceptive strategy to manipulate truth and reality with a benevolent intention to affect a positive outcome to the individual by alleviating distress and suffering.
Conclusion: The concept analysis of compassionate deception provides a clear operational definition of the phenomenon. This provides a standard language on how compassionate deception is characterized and can be communicated in the literature.

Keywords: compassionate deception, concept, analysis

Introduction

What constitutes good and evil in the practice of medicine and nursing remains in the domain of ethics. Telling the patients, the truth is a moral prerogative (Sokol, 2007). Lying can have positive and negative consequences. In some scholarly works, lying was found to reduce suffering and stress for dying patients (Foddy, 2009; Culley et al., 2013; Blanchar & Farber, 2016; James 2015; Meeuwse, 2017). On the other hand, lying can cause loss of trust and has the potential for abuse (Blanchar & Farber, 2016; Elvish, James & Milne, 2010; James, 2015; Meeuwse, 2017; Butkus, 2014). Lying and the tendency to lie have always been a part of the human condition. Nursing and medicine are not spared from this human tendency. The literature remains equivocal as to the effects of lying to patients. It is therefore imperative to study the phenomena to probe the appropriateness

of its use. Lying is defined as "giving factually incorrect statements." The word lying is often interchanged with the word deception in the literature. Deception is defined as "misleading without using factually incorrect information" (Elvish, James, and Milne, 2010). A survey of healthcare providers shows that the use of deception has been a prevalent practice in healthcare settings (Elvish, James & Milne, 2010). Subsequent work about deception has been reduced to various terms and related concepts. For example, the provision of the Declaration of Helsinki in 2000 made researchers explore the idea of placebo (Raz et al., 2009). Work on the compassionate deception also suffers from the fact that the very concept seems to now be lost from the literature. The very concept of compassionate deception seems be little studied until quite recently. Psychologists have long been interested in exploring the phenomena of lying and

deception (Blanchar & Farber, 2016). The surge of interest in therapeutic lying has reappeared after a decade. Nursing and medicine have resumed their interest in examining therapeutic lying (Culley et al., 2013). Researchers contend that the use of the word "therapeutic lying" is inherently contradictory (Sperber, 2014). There has been an effort to find a new word for the phenomenon. The word compassionate deception started to resurface in the work of Butkus (2014) among patients with dementia. Until now, the concept of compassionate deception has not been clearly explored and defined in nursing literature.

Concept Analysis Methodology: Walker and Avant (2011) identified eight steps to analyze a concept: (1) select a concept; (2) determine the aims or purpose of analysis; (3) identify all uses of concept; (4) determine defining attributes; (5) identify a model case; (6) identify borderline, related, and contrary cases; (7) identify antecedents and consequences; (8) define empirical referents.

Aims or Purpose of Analysis: The purpose of this concept analysis is to examine, explore, and clarify the meaning of compassionate deception. This study will add to the body of knowledge in healthcare and can be useful in developing instruments for psychometric testing. Additionally, this will increase the awareness of the characteristics of the phenomenon to provide an application in the practice setting.

Review of Literature: A search of the literature was conducted using the following search engines from 2008-2018: ERIC, PsychINFO, CINAHL Complete, MEDLINE Complete, and Health Source Nursing/Academic Edition. Key search terms used were "compassionate," "deception," "therapeutic lying," "lie." Also, search inclusion criteria included: "Full text," "peer-reviewed," "English language." The total search yielded 556 articles. After screening based on title and duplication, the articles were narrowed to 22 citations. Finally, there were 13 articles approved for extensive review. The other articles were excluded because they were not a related concept.

Uses or Definition of Compassionate Deception: It is essential to know the basic definition of the word "compassionate" and "deception" to understand the concept. In addition, identifying the uses of the concepts in the literature will support and validate the attributes of the concept (Walker and Avant, 2011).

Compassionate: The Merriam Webster dictionary defines compassion as "sympathetic consciousness of others' distress together with a desire to alleviate it." Compassionate, on the other hand, is an adjective which means "feeling or showing sympathy and concern for others" (Merriam Webster, n.d). This definition will serve as a premise on how we look at other uses of this word in different contexts.

Deception: On the other hand, deception is defined as "the act of causing someone to accept as true or valid what is false or invalid: the act of deceiving" (Merriam Webster, n.d.).

In Psychology: The field of psychology is the dominant discipline that has conceptually investigated deception and its related concepts. Lies and dishonesty were the common terms to describe deception (Elvish, James, and Milne, 2010). Psychologists were able to develop a taxonomic category of deception and classification of lies to examine the concept. Deception can be categorized as going along, not telling, little white lies, and tricks (Elvish, James, and Milne, 2010). In addition, lies can be classified as developed types of lies as white lies (told for reasons of politeness), gratuitous lies (told to establish psychological distance), omissions, secrets (a subtype of omissions that is conscious), outright lies (told deliberately to misled), and pseudologi fantastica (pathological lying and delusions) (Blanchard and Farber, 2016). On the other hand, clinical lies can be categorized as non-delusional clinical lies and calculated lies (Blachard and Farber, 2016). The word lying is often interchanged with the word deception in the literature. Some authors have claimed they are both similar. Others have contended that they are not identical. Several authors have tried to distinctively define the word between lying and deception to mitigate the negative association of the word lying. Lying is defined as "giving factually incorrect statements" while deception is defined as "misleading without using factually incorrect information" (Elvish, James, and Milne, 2010). The use of deception has been documented in psychology as a therapeutic tool for use in cognitive and interaction therapy. Therapists use lying as a non-confrontational skillful communication strategy to explore the patient's thoughts and feelings during patient-therapy interaction with the aim of achieving a cognitive and behavioral change (James, 2015). Furthermore, the use of lying was extended to manipulate the environment such as in dementia care to prevent

triggering negative emotional behaviors among older adults with cognitive impairment.

In Medicine: The use of deception in Medicine is associated with the use of placebo treatments and placebo effects. The purpose of a placebo can be divided into two, pharmacological and psychological placebos. The use of placebo was justified by the Declaration of Helsinki (2000). The declaration stated that there must be extreme care when using placebo-controlled trials. One of the requirements is the absence of proven therapy. If treatment is available, the researcher must show that there are compelling and scientifically sound methodological reasons that warrant using a placebo to ensure the efficacy and safety of the treatment. The second requirement stipulates that the subject who receives a placebo will not be subjected to the risk of serious or irreversible harm (Raz et al., 2009). Examples of placebo used in medicine include a subtherapeutic dose of psychiatric medication, supplements, vitamins, and experimental research sugar. Psychological placebos include manipulation of patient expectation by honest or dishonest means, re-assurance, giving a suggestion, and use of encouraging words from the physician (Foddy, 2009). Foddy (2009) is a staunch advocate of the use of placebos among physician and outlines several justifications. The published works were faced with a backlash from the medical community for ethical reasons particularly in the moral obligation of the physician to be truthful to the patient. Nonetheless, the work has been a landmark in discussions of the therapeutic use of deception in medicine. Medicine has recently recognized the used of deception beyond placebos. Therapeutic lying has been challenged in the field of medicine claiming that the use of it is unjustifiable given that physician have a moral responsibility to be truthful. Lastly, Sperber (2014) provided a definition of therapeutic lying in medicine: "Therapeutic lying is the practice of deliberately deceiving patients for reasons considered in their best interest."

In Nursing: Compassionate deception first appeared in the nursing literature in 1999, where Tuckett (1999) did an exploration of the phenomenon of deception in nursing practice. Nurses are prone to speaking half-truths, omission, misleading, partially telling the truth by means of a controlled release of information (Culley, 2013). Nursing is one of the healthcare professions that adheres to the highest ethical standard when providing patient care. This has been shown in a recent US poll conducted in 2018 where Americans choose nurses as the most trusted profession for 17 consecutive years in a row rating high and very high (84%) in terms of honesty and ethical standard (Brenan, 2018). The concept of therapeutic lying in nursing is defined as "a false statement or deception with the best interests of the patient" (Meeuwse, 2017).   Another definition provided by Culley et al. (2013) states that "it is a strategy to enhance patients well-being rather than an infringement of the fundamental rights." The use of therapeutic lying is acknowledged as a communication strategy in dementia care to distract or manipulate the person (Meeuwse, 2017). Other forms of deception used in the nursing practice are environmental manipulation: for example, a dementia village and using camouflage doors to deter escalating aggression in patients. The ultimate purpose is to maintain the quality of life of the elderly by creating compassionate, person-centered care, and empathy for a person with dementia to address feelings rather than facts (Meeuwse, 2017).

In Philosophy and Ethics: Compassionate deception exists at the intersection of health and ethics. Lying and deception use different strategies to create a false belief that can affect the provider and patient relationship (Schwab, 2019). Lying has positive and negative consequences and is a subject of contention whether there is a justification for its use and even a place in medicine and nursing. Wilson (2015) offered two concepts to justify the use of deception in patient care. First, counterfactual defeating deception argues that awareness of the deception would have caused the subject to refuse their consent to participate. Second, counterfactual compatible deception happens when an individual's knowledge of the deception will not make the individual withhold their permission. In addition to the debate about patient consent, the examination of the justification for engaging deception has been examined by ethicists. Butkus (2014) provided criteria for clinical situation when deception may be appropriate. First, deception is justified when the patient is not cognitively or emotionally prepared to decide or cope with the truth. Second, the use of deception can be used to a competent individual when there is a life-threatening situation when telling the truth can do more harm to the patient.

In Research: The concept of deception is associated with the word "placebo" and "informed consent" in the research discipline. Deception is highly discouraged in doing research. However, there are some situations in which withholding the truth to the respondents will elicit the results required to attain the research goals.

For example, the use of placebo in conducting research trials is a form of deception. Placebo can be in the form administering pills that contain vitamins and minerals or sugars randomly assigned to patients during an experimental drug trial. Another example of the use of deception in research setting is obtaining informed consent. Boynton, Portnoy, and Johnson (2013) explored two types of deception during disclosure of research information to participants. First, indirect deception happens when the individual consents to postpone full disclosure of the objectives of the study.

The goals are not entirely revealed to the participant. Full disclosure can occur during the debriefing session where the totality of the research project is discussed with the resident. Second, direct deception is the voluntary provision of wrong information to participants. Examples include deceptive study description, staged manipulations, and false feedback. There is a deliberate intention to mislead the participants which are not ethically justifiable. The use of deception whether in the form of research strategy or through obtaining and providing information is evident in the research discipline.
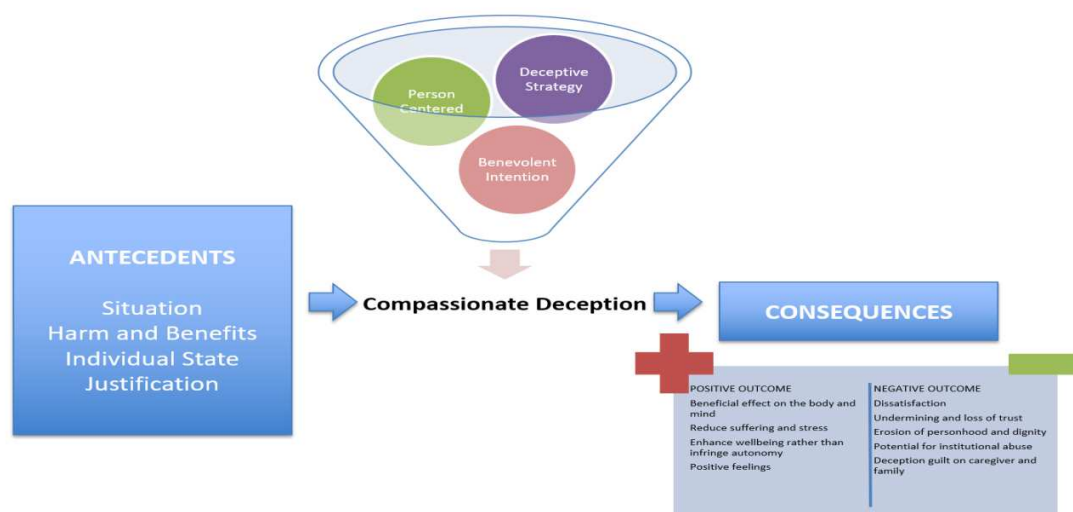
Figure 1. Compassionate deception conceptual framework

Defining Attributes: Identifying the attributes is central to the process of concept analysis. In this step, clustering the characteristics by determining similarities and differences will provide us with a general overview of the concept being explored (Walker and Avant, 2011). The overarching themes that are recurrent in the analysis include deceptive strategy, person-centeredness, and benevolent intention.

Deceptive Strategy: Compassionate deception requires creative thinking and skills to be able to persuade the person. It involves an assessment of the situation and careful planning to be able to have a successful outcome for the individual (Sokol, 2007). Deception can be in various forms. For example, it can be used as a communication tool during encounters like a therapy session, counseling or in a daily basis conversation (Culley et al., 2013; Elvish, James & Milne, 2010; James, 2015). Another approach would be manipulating

the environment to create an illusion of the reality for the person (James, 2015; Meeuwse, 2017). For instance, recreating a 1980's theme village or decorating the room or the ward to foster a familiar environment for the elderly. Lastly, administering pills can be a form to create a placebo effect both physiologically or psychologically in an individual can be a strategy (Foddy, 2009; Raz et al., 2009).

Person-Centeredness; Compassionate deception must be individualized. One strategy may work with one person but not with the other person. It is, therefore critical to determine the situation where the attempt to deceive the individual has the likelihood of success (Sokol, 2007; Butkus, 2014). Assessing the mental status, identifying what alleviates and exacerbates the agitation of a confused individual can be helpful. The literature has encouraged that all attempts must be made, and all available non-deceptive strategies or

interventions must be tried before resorting to deceptive strategy.

Benevolent Intention: Compassionate deception is a caring response of a nurse or a caregiver to alleviate the distress and suffering of the individual brought about by truth and reality (Tuckett, 1999; Butkus, 2014). The attribute refers to the caregiver's justification, motivation, and rationalization of why deceptive strategy is indicated to the person. It has been discussed widely in the literature that healthcare providers, such as nurses are ethically bound to tell the truth. However, this has been refuted by some researchers who are advocating that nurses should respond to the individual's situation and act in a reasonable and caring way to the suffering person rather than to adhere strictly to the principle of truth-telling (Tuckett, 1999). In this case, the nurse has the benevolent intention to use compassionate deception as an intervention.

Case Examples

Model Case: The model case is an example where all three defining attributes of compassionate deception are present. It is purely exemplary. Examples can be from a real-life scenario, found in the literature, or individually created (Walker and Avant, 2011). A model example from Rawley (1990) in Tuckett (1990) is a perfect model case of the attributes of a compassionate deception.

"Angela is a 48-year-old woman who is in the final stages of dying from metastatic cancer. The chemotherapy and radiation treatment had failed, resulting in cancer invading the bones and the brain. Angela slipped in and out of consciousness. On the last morning of her life, Angela opened her almost sightless eyes and struggled to speak: '[Susan (Registered Nurse)], are you here?' [Susan] took her hand. 'Yes, I'm here,' she answered. A few minutes later, Angela asked, '[Susan], am I dead yet?' [Susan] moved to the bed and stroked her arm. 'Angela,' she said, 'you are here with me.' Angela stirred again. 'Are we dead together, [Sue]?' There was a brief hesitation, then she spoke softly, 'Yes, Angela, we are together.'"

In this example, the nurse uses communication skill as a form of deceptive strategy. The nurse initially gives factually incorrect statements and does not acknowledge the imminence of death. Susan stated, "You are here with me" when asked by Angela if she is dead. She is stating the fact that she is present and deceptively avoiding the truth about the imminent dying condition. In the last statement when Angela asked if both are dead, Susan went along with her idea as a deceptive strategy. In this case, the approach was individualized to meet the needs of Susan. The plan was a person-centered. Lastly, the deceptive strategy was ultimately used to alleviate the distress of Angela about the imminence of death. In this scenario, Susan attempted to foster caring by being

present with Angela to decrease anxiety and fear of death.

Borderline Case; A borderline case is an example where most of the defining attributes of compassionate deception are present, but not all of them. This alternative case help clarify our thinking about the compassionate deception against the model case (Walker and Avant, 2011).

Robert is a 75 y.o., male, a war veteran resident with dementia in the memory care unit. During medication administration. Robert always and persistently asked nurse Anne where the post box was because he is waiting for a letter from his wife. The nurse was time-constrained in her task to administer medication in the 40-bed unit. Anne creatively crafted a faked mailbox and placed it in front of the nursing station. Anne told Robert that the post box was in the station and told the resident to wait for the postman in front of the station. Robert stopped pestering the nurse. Nurse Anne was able to seamlessly complete her job while Robert sits in the station quietly waiting for the postman to arrive.

In this example, two of the attributes of the concept are present. The first attribute is the deceptive strategy of manipulating the environment by crafting the post box and placing it in the nursing station. The idea was person-centered because the nurse considers the way Robert thinks about the post box. The deception was personally tailored to meet the patient's needs. The primary missing attribute of the scenario was the goal. The nurse did not assess the reason behind the patient's behavior. There was no intention of relieving the suffering of waiting for the letter to arrive. Instead, her plan perpetuated the longing for the item. The goal of the nurse for devising such a scheme was for her to complete her job. The nurse could have explored Robert's thought on what type of letter he was expecting and coming from whom. The nurse could have involved the family in retrieving notes handwritten by his wife for example and placed them in the post box to relieve Robert's longing for his wife for instance. The use of deception did not meet Robert's need.

Related Case: A related case is an example where one attribute of the concept pertains to compassionate deception but do not contain all the defining qualities. Related cases have names of their own and should be identified with their names in the analysis. Related cases are those examples that demonstrate ideas that are like the central concept, but that differ when scrutinized (Walker and Avant, 2011).

Dominick is a 65y.o. male resident diagnosed with Alzheimer's dementia. The nursing assistant always has a problem with his hygiene. Dominick has been refusing to take a bath. He still wears his favorite khaki long shirts and pants the whole day. There have been a lot of complaints about how disturbing Dominick smells from the other residents of the nursing home. One day, Dominick agreed to take a bath. After the shower, the nursing assistant confiscated the old clothes

and threw them away. When Dominick asked for the clothes, the nursing assistant told Dominick that they could not find the clothes and told him they were missing. Dominick was devastated and in distress about the loss.

In this scenario, this is called deliberate lying on the part of the caregiver without concern for the resident. There is only one attribute about the concept present in this example, and that is giving factually incorrect statements. The deception is not person-centered: instead, it is directed at the caregiver and the other patients' comfort. Although the intention was to improve his personal hygiene, there was no concern that by telling him that the clothes were missing this can make him very distressed, upset, and angry. The benevolent intention was absent. The caregiver could have explored more about the reason why he wore the same clothes by asking family for some information. The caregiver could have provided him with a pair of clean clothes that are similar to deceive him while buying time to wash the old clothes.

Contrary Case: Contrary case is a clear example of "not the concept" or the opposite of compassionate deception. In this instance, truth-telling will be the contrary case. The contrary case helps us analyze and see in what ways the concept being examined is different from the contrary case. This helps clarify the attributes (Walker and Avant, 2011). The following case example is adapted from Meeuwse (2017) and shows an example of the contrary case for the concept.

"Barb a 68y.o. female with dementia sits down to breakfast one sunny morning. She wonders aloud when her husband will be joining her and is looking forward to his company at the table. To Barb's absolute horror and dismay, the nurse says: "Honey, your husband has died, remember? It's ok: you're safe here with us." The sheer shock of the news overwhelms and bewilders Barb. The last she knew; her husband had gone out for his morning walk. She panics, tears in her eyes, her appetite wholly gone, wondering what on earth has happened to her husband. Dead? How? When? She sobs aloud, forcefully pushing the stranger's hand off her shoulder. Barb flings her arm free, briskly pushing away this woman. When she doesn't 't leave her side, Barb's sorrow now gives way to anger. Barb hits out with a fist in frustration."

The case example presented shows the absence of the three attributes of the concept. The caregiver provided the truth to Barb that her husband passed away. The intention was to re-orient her to reality and re-direct her thoughts. The caregiver has no reasonable consideration for the feeling of Barb about the truth and how Barb would respond to the information. Truth-telling, in some instances, is causing more harm to the patient instead of helping them. This example provides us with a contrary case of compassionate deception.

Antecedents and Consequences: Antecedents and consequences cannot be a defining attribute. Antecedents are the precursor of the concept.

Antecedents are useful in identifying underlying assumptions about the concept. Outcomes, on the other hand, are the result of the concept when applied. Recognizing the consequences are helpful in determining often-neglected ideas, variables, or relationships that may lead to new research directions (Walker and Avant, 2011).

There are several conditions that need to be considered before using compassionate deception with a patient. The situation, harm and benefits, individual state, and justification are the antecedents to compassionate deception. An assessment of the condition needs to be considered. What is the root cause of the problem? Why does the patient exhibit such behavior? Has an organic cause such as infection, acute illness has been ruled out? Are you identifying patterns of the response? An interview and history taking from the family about the patient's previous living conditions often elicit the reason for the repetitive actions among the elderly. The literature has provided us with a robust discussion about the harms and benefits of deceiving patients. The harms and advantages will be discussed in the consequence section. The primary consideration here is that identifying both harms and benefits will determine the likelihood of the success of the deceptive strategy. If harm is more significant than benefits, then there is no need to apply the deceptive strategy. The individual's state needs to be determined. Does the person have the cognitive capacity to decide? Is the patient suffering from an irreversible condition like Dementia? The deceptive strategy may be used among alert and cognitively intact patient especially during life and death situations (Butkus, 2014). Justifying the use of deception has been controversial. Ethical debate has provided us with a discussion about the moral acceptability of such action. This ambiguity and the thin line between right and wrong are challenged by the provider. On the other hand, there have been preliminary works that were done to develop guidelines. James (2006) in Culley et al. (2013) provided a 12-item set of instructions on the use of therapeutic lie, while Sokol (2007) provided a flowchart analysis to show when deceiving patients can be morally acceptable. The proposed deception chart might help clinicians make a better-informed decision making.

Compassionate deception can have positive and negative consequences. The beneficial effects of compassionate deception found in the literature are the following: compassionate deception can reduce suffering and stress, enhance body and mind wellbeing rather than infringe autonomy, provides positive feelings to the individual (Foddy, 2009; Culley et al., 2013; Blanchar & Farber, 2016; James 2015; Meeuwse, 2017). Adverse consequences are dissatisfaction, undermining, and loss of trust, erosion of personhood

and dignity, the potential for institutional abuse, deception guilt in caregiver and family (Blanchar & Farber, 2016; Elvish, James & Milne, 2010; James, 2015; Meeuwse, 2017; Butkus, 2014).

Empirical Referents: Identifying the empirical referents is the final step in the concept analysis. Empirical referents are not tools to measure the concept, but they are ways by which you can determine or measure the defining attributes of the concept. According to Walker and Avant (2011), empirical referents are categories of actual phenomena that by their existence, demonstrate the occurrence of the concept itself. The three main attributes of compassionate deception are a deceptive strategy, person-centeredness, and benevolent intention. The deceptive strategy can be measured by Paulhus Deception Scales [PDS (Paulhus-BIDR)], which was developed by Delroy L. Paulhus. The PDS (formerly known as the Balanced Inventory of Desirable Responding - BIDR) is a 40 item self-report inventory using a 5-point Likert scale that measures an individual's tendency to give socially desirable responses on self-report instruments. Two principal and relatively independent subscales are reported: Self-Deceptive Enhancement (SDE), the bias to provide accurate but inflated self-descriptions, and Impression Management (IM), the tendency to offer pretentious self-descriptions (Tully & Bailey, 2017). Person-centeredness of the deception can be measured by the attitudes. The Attitudes towards Lying to People with Dementia Questionnaire (ALPD) developed by Elvish, James, and Milne (2010). The ALPD has 16 item questions. All item-total correlations were above 0.5, and the Cronbach alpha value was 0.94. Benevolent intention can be measured by self-report of compassion. Kristin Neff developed the 26 items Self-Compassion Scale (SCS). The constructs of the scale are self-kindness, self-judgment, common humanity, isolation items, mindfulness item, and over-identified items (Neff, 2010).

Operational definition: A compassionate deception is a person-centered approach that uses deceptive strategy to manipulate truth and reality with a benevolent intention to affect a positive outcome to the individual by alleviating distress and suffering.

Conclusion: The concept analysis of compassionate deception provides a clear operational definition of the phenomenon. The operational definition can provide a standard language on how compassionate deception is characterized and can be communicated in the literature. With this completed conceptual analysis, we can continue the discussion of the appropriateness of the concept in the clinical setting as an alternative intervention. Further research can then be done to measure the effect of this intervention on the individual.

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