

DINING, MEMORY AND AGING: FOOD FOR THOUGHT

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“Human existence is defined by the choices people make” – Barry Schwartz, *The paradox of choice*.

The purpose of this paper is to help you to think differently about some of the issues that attend dining, choice and well being in elders living in long term care settings. I have taken ideas from neuroscience, psychology and literature that can be used as tools to help build alternate approaches to choice and dining in nursing homes. They are offered so that you may keep them in mind as you think about how to address the dining experiences in nursing homes to make them more like home.

Proust, *madeleines* , and memory

“It is impossible to get out of a problem by using the same kind of thinking that got you into it.”

Albert Einstein

Guided by Einstein’s insight, I want to begin by considering the French author Marcel Proust (1871-1922) and his famous *madeleine*. For those of you who have never seen or tasted one, even a good image fails to communicate the essence of Proust’s experience with this sea-shell shaped, buttery cookie flavored with lemon zest. Ask anyone raised in France about the intense, complex memories they experience when eating one. I asked a French friend about *madeleines* and he said: “I had one this morning. You cannot have the same experience that I do when eating one. You just can’t have the same memories.”

Proust’s great genius was not how well, how thoroughly, and in how much detail he described his memory of the taste of the *madeleine*, but how in doing this he found how the mind works. What is so important to us is that Proust’s experience, captured in his work *In Search of Lost Time*, provided us with a new way to look at peoples’ memories and through memories, their lives. He was inspired by the idea that art (subjective) and scientific (objective) evidence both deal in facts, but only the artist is able to describe how reality is actually experienced (Lehrer, 2007). That is, reality is subjective. So, though we can analyze the chemistry of the *madeleine* to know its composition, we cannot know its taste without eating it. This last point is worth remembering as we think about dining, memory and aging. You will never know how the *madeleine* tastes to me, and I will not know how it tastes to you, even though we know both know the ingredients and can describe our experiences to each other eloquently and at length. We can be certain that knowing the chemistry will not enable either of us to experience our own unique past as a simultaneous part of our present existence, which was Proust’s great genius and

neuropsychological insight. By the same token, knowing the nutrients in an elder's diet doesn't allow us to know her experience of eating the meal that contains them.

Some of the facts of Proust's life at the time he wrote *In Search of Lost Time* resonate with the lives and circumstances of elders living in nursing homes and so may provide us some insight into their shared experiences. Proust was a sickly man who, starting in 1910 when he was in his thirties, was stuck in his bedroom for the rest of his life due to his asthma. Like many of our elders living in nursing homes, he had too much time on his hands that was devoid of novelty. His life to that point had amounted to nothing, and he spent a great deal of his time writing self-pitying letters to his mother (Lehrer, 2007). With only his memory as resource material, he sought immortality to counteract the experience of his life slipping away. His chosen path to immortality was to become a novelist. "He made art out of the only thing he had: his memory" (Lehrer, 2007, p.76). He hoped that through his writing he could stop the helpless feeling of his life slipping away and make time stand still by finding the space where time stops. By recalling his experience in Combray while sipping tea and tasting the *madeleine* he dipped into it, he realized that by remembering all the details of how the *madeleine* tasted he found that he could use his memory to explore his favorite subject – himself. He discovered (in 1911) something that neuroscientists wouldn't know until recently; our senses of taste and smell bear a unique burden of memory (Lehrer, 2007).

Why do these senses bear that unique burden, and how is that relevant to our work here? Research by Rachel Herz (2003) shows how these senses are "uniquely sentimental" (Lehrer, 2007, p.80). Taste and smell are the only senses that connect directly with the hippocampus, the center of memory consolidation in our brains and the key to long-term memory. These sensory memories are with us forever and linked to emotional responses (think perfume, fresh baked cookies and how an image comes up in your mind without using words to recall it). All of the other basic senses (touch, vision and hearing) are first processed by the thalamus, the source of language and "front door to consciousness" (Lehrer, 2007, p. 80). As a result, these senses are much less efficient in summoning up our past and can in fact obscure memory because they rely on words and conscious activity which, as we shall see below, can change memories by the very act of remembering. When it comes to the memory of a great meal, words can get in the way.

Once Proust remembered the past during his recollection of the taste of the *madeleine*, he lost all interest in the cookie and became obsessed with how he felt about it, and what it meant to him (Lehrer, 2007, p.81). Proust followed his associations wherever they led him, and intuitively understood that idiosyncrasy was the essence of personality. The specific pattern of connections between neurons in each of our brains is unique, so that even if we share an identical experience, the memory and meaning of that experience will be different for each of us. To know that our experiences, while perhaps similar, are not identical to others, is to understand how we experience ourselves. It is how we understand what an experience – in this case, eating a cookie – means, and why no two people have the same exact memory of eating the same thing.

Proust also believed that our memories were fabricated, not objective. They are modified to fit our ongoing life story, or personal narrative. He thought that we bend the facts to fit our story, as our minds

rework the stories to fit it into our autobiographies (the stories we tell ourselves about our lives). This is why the meaning of events is subjective – it is understood as part of, and contributes to, each individual’s personal narrative. I can’t fit the experience of tasting a *madeleine* into your narrative. Only you can and will do that. My experience is limited to knowing that you ate one as it is recorded in my self-narrative.

Science has discovered that Proust was right about memory fabrication too. Memory in the most cognitively intact brain is fallible, because in the act of remembering we change the memory from what it had been before we retrieved it. Every time we recall an event, an experience, or an idea, the neuronal structure (the connected group of nerve cells that are firing when we remember it) of the memory is delicately changed. This process, called **consolidation**, takes place in the absence of the original stimulus (think *madeleine*) so the memory of it becomes less about what you remember eating and more about you (Lehrer, 2007, p.87). The margins, or small details, of the memory are modified to fit what you know now, not what you experienced the first time you ate a *madeleine*. Proust knew that the past is never the past. “As long as we are alive, our memories remain wonderfully volatile” (Lehrer, 2007, P. 95). The more remote an unused memory gets, or the more you retrieve it without strengthening it by real experience, the more it changes to conform to contemporary experiences. The same thing occurs with regard to memories of the self; the margins of memory of self are constantly changing with our experience (Feinberg, 2000). If the major activity that our memories of self gets is reminiscing, rather than doing and storing new experiences, then memories of self become less and less about the person and more about the memories.

Food, feelings and decisions

This brings us to the issue of how important experiences about food, dining and choice are in the daily experiences of elders, and how these experiences evoke meaningful lifelong memories of foods and its emotional value.

From infancy, food and food intake are at the core of a rich set of fundamental sensory and emotional memories about our world. The alimentary canal is far more than a tube with input and output functions; it contains every class of neurotransmitter that is found in the brain (Wilson, 2004), so it is where a great deal of emotional information that is sent to the brain and other organs originates. It lives up to its characterization as the “second brain” (Wilson, p.34). But while trusting your gut is a valuable source of guidance when making decisions, it is not foolproof (Lehrer, 2009).

Erik Erikson (1963) observed that the infant develops a sense of Basic trust vs. Mistrust, a global impression about the world that results from how well the infant is nourished with food and the emotional atmosphere with which sustenance is delivered. As infants develop into young children, food and emotions increasingly become intertwined in an increasingly complex set of conscious and unconscious ways. These experiences color the relationships we have with ourselves (self-esteem, conscience) and others. Food becomes linked with feelings in many ways as children interact with family, friends and peers around daily meals, celebratory religious and seasonal rituals. Food may

promote comfort due to its association with nurturing people and activities so that it takes on an acquired positive emotional valence. Food is used as a reward or punishment (“do more math problems and I will give you a piece of blueberry pie” or “no dessert until you eat your lima beans”) and as emotional leverage (“Eat your spinach; there are people starving in Europe” or Africa, China, the Balkans – pick your era; “Don’t you like the fried liver dinner? I spent the whole day preparing it for you”). These scenarios are all fraught with overt and covert (unstated) agreements with food as the reward or penalty, and they serve to set up emotional contingencies that pivot around autonomy, freedom, dependability and safety.

These associations happen automatically. All memories for events include the emotion felt at the time the experience was encoded. That is one way our minds are unlike computers; silicon is singularly unsentimental. This has survival value for us as a species (it was valuable for our ancestors to remember the nausea and dizziness they felt when they smelled that spoiled piece of sabre-toothed tiger meat, so that they would avoid it in the future and not risk death) and as individuals (the sense of discomfort I may feel when I smell garlic, which I used to like but to which I became terribly allergic). Emotions are a strong influence on which aspects of memories we may want to and are able to recall, and which we want to forget.

Novelty

As children continue to develop, maturity leads to better emotional control and greater opportunity to make considered choices. Our brains are essentially choice makers and novelty seekers built to make ever finer distinctions among responses when confronted with events in the environment. We quickly and automatically remember qualities of an experience so that we respond and respond quickly without mulling over the details of every situation. This is called *expectation*, and is how the advertising industry makes us believe that people like Coke better than Pepsi even though research shows that in blind taste tests (in unlabeled glasses), more people like the taste of Pepsi when they compare the two. Expectations grow out of the brain’s ability to predict the potential results of choices on an envisioned future self. The brain uses this ability to value its options (Montague, 2006). We will look at the idea of a future self and choices below.

Knowing that decision making is complex (Lehrer, 2009) and is central to enjoying food (Wansink, 2006), we have to consider how to integrate novelty, choice and expectation if we are to promote greater pleasure in dining for elders in nursing homes. But we must recognize a couple of factors to achieve this goal. First, since people typically eat several times a day, a certain amount of novelty has to be sacrificed for the sake of convenience. This is an especially thorny issue in congregate settings, where people are typically divided into preparers/servers and consumers/eaters. Culture models and related operational practices conflict about whose convenience is more important, the preparers’ or the eaters’. Second, people differ widely as to how much novelty they seek and how much convenience and reduced novelty they will accept in return for a sure thing. Some of us eat the same lunch every day though we can afford a wide variety of meals while others crave variety; the need for novelty is not equal in everyone.

We must remember this when we try to imagine the impact of choice in dining in nursing homes; not everyone will want to have unlimited options or uniform sameness. We have established a range for any group of elders, and it will probably turn out to be in the middle of the extremes. Third, even if you seek high novelty by pursuing many options when you choose what to eat, things are not as intensely pleasurable as they are the first time you experience them. In light of that, we need to acknowledge that repetition (which is a typical experience in and outside of nursing homes) has positive value in making choices about food. Repetition serves two purposes. It lets us refine our predictions of how pleasurable a food will be, so that we can develop *favorites* and limit the search for novelty to a small number of occasions where we crave something different, and second, we *habituate* to a sensation and reduce our likelihood of responding to a taste – setting off a renewed quest for novelty (Berns, 2005). Each instance requires that we imagine the results of our options and decide if the energy needed to pursue a different meal, i.e. novelty – will produce an outcome significantly better than sticking with what we currently have (Montague, 2007).

As a result of the balance between seeking novel sensations and relying on convenience, the essential choice for elders in nursing homes, just as for you and me “lies in *what you eat and when you eat it*” (Berns, p.72, emphasis added). This is, of course, the topic of the Creating Home II symposium, and is the point around which person centered care in dining (and other aspects of life in nursing homes) pivots. The knot of difficult issues we confront about eating and choice characterizes other fundamental issues with which we must wrestle when considering the person at the center of care in a nursing home. We can understand more clearly the universal importance of this issue, and why it illustrates the adaptive value of choice in promoting mental wellness, when we realize that the ability to exercise choices and imagine their results increases with experience and as a result of our encounters with novelty. This is the outcome of our brains doing what they optimally do to keep developing knowledge. Contrast this idea to the historical paucity of choices in the world of nursing homes, the routine of “doing it like we have always done it” that values sameness over novelty and so provides the brain with a sub-optimal menu of challenges to promote growth. We, as a society, accept the belief that elders, especially those in nursing homes, are unlike the rest of us and don’t need and/or are unable to appreciate novelty, and that they are unable to learn from having made choices that will inform future decisions. This persists despite all the research about the strengths of the aging brain (see, e.g. Cohen, 2005; Goldberg, 2005), and anecdotes about the positive effects of novel experiences – the exceptions to routine – on the lives of elders in nursing homes (“their eyes lit up when the kids came to visit”).

Engaging in ritual and pursuing novelty lie at the extreme ends of a continuum. Both have their proper places in social activity and human development. When people are in the process of learning new skills or practicing traditions, for example, repeatedly engaging in a practice in the same way with others creates a feeling of solidarity and group identity. Ritual evokes implicit, automatic, well-rehearsed, high conformity patterns such as are found in institutional routines. Novelty evokes explicit, planned, individualized responses, as are found in spontaneous behavior. It appears that too many meals in nursing homes are anchored in ritual rather than novelty, and that this deprives elders of the psychological benefits – chiefly awareness of his/her individuality and self-memory - that encounters

with novelty bring.

Food, novelty and choice: how to make time stop

But let's get back to food, novelty and choice, and the place where time stops. In their book *The Elements of Taste* (2001), Kunz and Kaminsky identify a key element that creates novelty when it comes to food, an element that also figured in Proust's work. "Time", they say, "is very important in the dining experience" – as important as the food's ingredients in creating novelty (Kunz and Kaminsky in Berns, 2005). Why? A meal as being like a story, says Kaminsky; it has a beginning, middle, and an end. "You spend time looking over the menu, deciding what you want, and imagining what it will be like. Then, after you place an order, anticipation builds, until it is delivered and you experience it. And then you remember" (Kaminsky in Berns, 2005, p.77). Both Proust and Kaminsky found that eating the right thing at the right time can transport us to a moment in time. When we eat something that puts us in touch with the purely personal, pleasurable experience of the self in action, the sense of time vanishes. We are savoring the moment, and time has stopped.

Why is novelty such an important concept for our understanding of how we enjoy food? As new information flows into the part of the brain where the person and environment occurs (the striatum), the neurotransmitter *dopamine* is released. Dopamine stimulates the brain to get ready to act on the new information (motivation) and at the same time creates a feeling of satisfaction while you get ready to pursue that novel stimulation. So when some novel food appears and we are motivated to act in response, we feel satisfied. Kaminsky says of his choice of meal at a sushi restaurant: "I never order the tasting menu, because I find the dining experience much more enjoyable when I order myself" (in Berns, 2005, p.77). Food and choices around it are where novelty can be incorporated into the nursing home culture to produce heightened pleasure and activity. Novelty and choice in food is a way to stop time by promoting pleasure and knowing the self through our own actions by using memory and memory stimulation to combat sameness. We can stop time by sameness and lack of novelty (leading to boredom) or we can stop time by promoting novelty. Our brains want us to do the latter.

Choices for persons in nursing homes

I have observed that choices for elders are not the way of life in the typical nursing home setting. In fact, one of the cardinal characteristics found in the culture of total institutions as first described by Goffman (1961) and later scaled on a continuum by Bennett (1963) is that, in these institutions, only the management is, to use Morris's term (2000) authorized to make choices. In light of our look at novelty, choice and pleasure, you will not be surprised to hear that I think that the lack of choices around what and when, not to mention in whose company, elders eat is bad for their emotional and cognitive well-being. Lack of novelty would appear to be a recipe for excess disability and suppressing normal brain function. This can result in sadness, cognitive inertia and reduced mental alertness that may develop into so-called minor depression and, if left untreated, the geriatric syndrome of depression (Kennedy, 1995). This group of difficulties significantly compromises an elder's ability to function at the highest

possible level, and often presents with memory loss that is written off as normal for an older person in a nursing home. As a result it may likely be unidentified and untreated. I further think that this cultural value is the result of an ageist view that still presumes, in spite of evidence to the contrary, that aging brains cannot develop and learn (Goldberg, 2005; Cohen, 2005).

Let me share an instructive example of how even a basic choice became self-affirming and promoted improved mental wellness. I met Bob over 30 years ago; he was one of the first people I was asked to help when I went into practice. He had come to live in a nursing home following an above-the-knee amputation of his right leg, and was “being difficult” (hence the referral to me) when it was time to dispense medications. His “difficult behavior” consisted of throwing any object at hand, usually a shoe, at the nurse who came into his room to say: “Hi Bob, it’s time to take your medicine.” Bob could be a charming person; a former truck driver and devotee of alcoholic beverages in excess, he was a life-long bachelor who had conveniently chosen to live in small apartment above a liquor store in town. When we spoke, his principal complaint was that “these women are always telling me what to do.” I asked specifically about the medicines, and whether he objected to taking them for any reason. He responded that he just didn’t like being told what to do by “these women” (the nurses and aides). It struck me that Bob had lost control of his life and choice-making. The story Bob told me about his life prior to his admission confirmed my suspicion that he was out of place in an environment where others, especially strangers, told him how to live.

I asked him if he would agree to a solution where he would refrain from throwing things if he had 10 minutes after being told it was medication time to ring his call bell to request the nurse to come in and dispense them to him. He agreed. When I told the charge nurse about this plan she looked at me as though I had lost my mind and said (the expected): “If we do it for Bob we will have to do it for everyone.” I replied by asking who else was throwing things at the nurses’ heads. As nobody else responded in this particular way to medication time, I didn’t think it would become an issue. (As I look back on this response I wonder if it meant that she believed all old people were alike and would want the same thing, or if she felt at some level that to individualize a caregiving process would be tacit admission that everything they were doing by uniform procedures was wrong.) I also explained that Bob had told me what the problem was: he was not in control of anything here and was not used to having his life run by anyone, especially the well meaning but (to Bob) intrusive women. The procedure was changed. I timed how long it was between when a nurse knocked on Bob’s door to announce medication time and when Bob chose to ring his call bell to signal his readiness. It took Bob 20 seconds to ring the bell, a response he consistently maintained until he was discharged. There was no more throwing of shoes and other objects, and in fact it was reported to me that he turned on the charm every time the nurse went in. He needed to know that he had a choice that would be respected, and it took him one time with the new order of things to trust that this respect was there.

Choice: a relationship with your future self

A choice creates a relationship with your future self. It is a commitment to a future action, like when you order a meal from a menu and experience waiting and anticipating how your choice turns out. This is also a form of forward modeling (Montague 2007)), since you as you order and then wait you evaluate your options and hope you have selected the best among them for your future self to enjoy (or not!). Choices make use of *diachronic vision*, or looking at one's self across time. These relationships can be characterized by *diachronic cooperation* or *diachronic competition*. Whether we know it or not, when we make a choice, we are always creating relationships with our future selves. Using a credit card is a good example of diachronic competition; you spend money your future self will have to pay back. Working for culture change is an example of diachronic cooperation. You are creating a relationship with your future self to work in, or perhaps live as an elder in, a nursing home whose culture shares your values.

Making choices between seeking novelty or the routine, and then seeing how well or poorly the choices work out, is the way we constantly provide meaning to and write the stories of our lives. It is in this autobiographical narrative, the stories we tell ourselves about our lives, that the memory of self resides. That is why memory is so important for our knowledge of self: autobiography is a plan made real and its consequences appreciated – though not always factually. Memory is bent to fit our ongoing self narrative, as when we appraise the results of the sequence of events that embodies the “I prefer; I will; I did; I learned” cycle of experience. Here is where the emotional channel of memory is so useful. “Emotion” says Lehrer, “turns mistakes into educational events” (2009, p.249). And since emotional regulation becomes better in aging persons due to improved left brain – right brain integration (Goldberg, 2005; Cohen, 2005), we could posit that the ability to learn from good and bad choices might, in the absence of dementia, get better with advancing age. Some would call that wisdom.

Making choices and mental wellness

I suggest that making choices is a mental wellness or low-tech brain fitness activity that would engage the brain's intrinsic novelty seeking and memory-making ability of our elders. The wonderful thing about this is that choosing is something our brains are already motivated to do. Our responsibility in this wellness activity is not to get in its way. Making choices and evaluating outcomes adds to a person's self narrative and enriches the meaning derived by each person's life story. Conventional, task-oriented care practices offer few, if any, meaningful choices and will act to dilute personal identity. The tradition of “we are here to help so we will decide for you” is based on, and reinforces, ageist stereotypes that elders in nursing homes are all somewhat cognitively compromised, have poor judgment, and are missing the ability to make good choices -- especially if they are functionally dependent.

Elders who live where they can't make choices may struggle to keep the motivation to do so. If their choices are not sought out, respected, are punished or go unrewarded, their ability to select from or even care about their options may atrophy. When, on the rare occasions they assert their decision-making prerogative in an unauthorized way, their decisions may be deemed as lacking judgment, written up in a formal record as impulsivity, “non-compliant,” or otherwise deemed wrong because they are counter to the institutional culture as enforced by authorized choosers. Choice -- what constitutes a good one and bad one -- and relative risk involved exists on a continuum of wisdom and safety, and

should be seen in the context of each individual elder's skills and experience. Ordering a particular dish from a menu of choices probably does not carry the same degree of risk as does deciding to run away with the circus again at age 93, like Jacob Jankowski does in *Water for Elephants* (Gruen, 2006). The author illustrates the impact of what happens when meaningful choices are lacking in conventional nursing homes by juxtaposing how people in the nursing home view Jacob's desire to decide when to wake up or whether to pull up the window shade to be as unauthorized and portraying a similar degree of folly as is his desire to run off to rejoin the circus, where he expects to find the novelty and relationships he knew as a young man await him. Jacob and Bob are but two examples that illustrate the problem how elders in nursing homes are by virtue of conventional practices cut off from making decisions. Because of this norm, even genuine opportunities to make meaningful choices may be responded to by passive non-compliance, by choosing not to choose, or as Melville's *Bartleby the Scrivener* did, by becoming depressed and replying to every request to do anything, even eat, by saying "I prefer not to."

Fortunately, the consequences of a narrative of non-efficacy or, in more contemporary terms, *learned helplessness* (Seligman, 1975) may be reversed when this narrative is replaced with what Langer (1989) has termed *mindfulness* or meaningful choice. These classic studies (Langer and Rodin, 1976; Rodin and Langer, 1977) demonstrated that a group of residents in a nursing home who heard a lecture promoting their responsibility for themselves (responsibility-induced group), and were then given the freedom to make choices and the responsibility for caring for a plant they were given, showed significant improvement in alertness, active participation and general sense of well-being when compared to a similar group of their fellow residents (comparison group) who heard a lecture about how the staff would take good care of them and would water a plant that they would be given. Follow up data obtained 18 months later (Rodin and Langer, 1977) showed that the responsibility-induced group "showed higher health and activity patterns, mood and sociability which did not decline as greatly, and they had a mortality rate that was lower" (15%) than the comparison group (30%) (compared to a 25% mortality rate for the entire nursing home during that 18 same month period).

These results are encouraging and suggest that we still need to find ways to extend the finding of this research in our practices. They suggest that actual control of events in one's life (vs. illusory or sham control) such as when making meaningful choices from available options, and being seen and treated as capable of making good decisions for your future, makes it possible to mobilize sometimes dormant or underused abilities to promote wellness.

Surplus safety and the lure of novelty

Why are there so few opportunities for meaningful choices in nursing homes? Anyone familiar with the Pioneer Network and culture change movement is aware that this is one of the most fundamentally disempowering and distressing aspects of traditional nursing home cultures (Lustbader, 1994; Thomas, 2004). I think it represents one of the more malignant (Kitwood, 1997) signs of how elders (especially the dependent and cognitively compromised) have been viewed in this society. It is a part of the legacy

of practices left by the public policy foundations, care philosophies and socially devalued roles (Wolfensberger, 1985) ascribed to those who lived in the antecedents of the modern nursing home, the public acute care hospital and the large state psychiatric hospital (see Penney and Stastny, 2008; Sachs in Payne, 2009; Rosenberg, 1987; Ronch, 2003). Because an in-depth look at this history is worth more than the brief treatment it can receive in the limited space available to me here, I will look at one of the more significant pieces of this legacy. That component is what Bill Thomas and I (Thomas and Ronch, 2008) have called *surplus safety*. This refers to conditions which prevent autonomous thinking or action and the satisfaction that decision-making brings because of an exaggerated fear that harm will come to the elder. This prevents the consequent cognitive, motor, emotional or other adaptive growth and development that would result if novelty had been pursued. *Surplus safety* assumes that the person will not be able to recover from the error or restore homeostatic balance if she makes a bad choice, and further that an elder does not have the developmental readiness to take the risk that the novel stimulus presents and to learn from the experience. Treating a class of people according to this approach, in this case elders in a nursing home, assumes that any member of that class by definition needs surplus safety to remain free from harm. This assumption is the operating default value and therefore preventing class members from making (by definition unsafe) choices in the pursuit of novelty is forbidden. People managing an environment must create this condition intentionally; people are always looking for novelty in the most creative ways and therefore this impulse must be squelched in the name of keeping people safe.

Surplus safety, and the way it works to deprive elders of novelty, contributes to the condition called “excess disability;” functional impairment greater than would be expected as a result of the individual’s medical, emotional or other difficulties. Excess disability could be the result of not using one’s brain as a choice maker and future modeler. In these circumstances, the person is prevented from the pursuit of novelty and of enjoying the relationship with the future self that results from making a choice, looking forward to future events to see what will be, and enhancing life’s meaning through making new memories. This excess disability is a consequence of interfering with how the brain makes meaning in life. It is a classic case of thwarting the “use it or lose it” principle. Staff in this scenario become what Morris (2000) called “observers of chronicity” instead of participants in creating an evolving narrative. Our challenge is not to stop time for elders by forestalling their relationship with their future selves, but instead to make time stop by finding ways to provide choices in dining so that intense pleasure happens and time stops as it did for Proust or Kaminsky.

Framing choices

Choices that have value are those that are offered with a genuine commitment to be both available and honored. One outcome that we would want to prevent arises when staff is caught between organizational aspirations to look like a culture change environment though they lack the requisite organizational or operational wherewithal to follow through on choices that elders make. The way to optimize choice is to be sure that the question is posed so as not to bias the response and to guard against encouraging the elder to decline the chance to choose. A common way to discourage the elder’s

actual preference from being stated is to ask in a way that suggests that something about them (i.e. their age and/or associated “questionable” cognitive abilities) will make them not give good or the appropriate answers. This is readily communicated in subtle ways, such as through tone of voice or in the way the question is posed (e.g. “you don’t like that food, do you?”). Called *stereotype threat*, it invokes stereotypes about a group in the way the challenge is phrased and has been shown to have an effect on how well elders do on tests of memory. When told that their memories will be tested they do worse than when they are instead told that they will be asked some questions. It is important to make sure that even subtle cues, whether by intonation, facial expression, or other body language, not undermine the elder’s self confidence and potential preference for expressing an unusual or idiosyncratic selection.

A positive way to influence decisions around food choices is to offer them as a routine part of dining and probe for reasons why a resident is reluctant to decide. This approach can help elders balance their need for novelty with the benefits of routine and to decide how much energy they wish to invest in any particular opportunity for future modeling posed by making dining choices. Think of how menus in nursing homes are presented (the meal-cycle driven menu on the wall), and ask yourself where novelty is to be found and how that precludes choice and the satisfaction that results. Here is one setting where we would be able to present elders with opportunities to thrive on attractive novelty and optimistic future modeling in their lives that reinforces their memory of self, of being in control, and of having their preferences respected.

A traditional view and stakeholder safety

As I indicated above, the tradition of surplus safety rests on declinist, stereotyped assumptions (most of which are ageist and/or ableist) about what elders, especially if they are functionally dependent or memory impaired, can and cannot decide about. This is especially so for elders living with dementia who try to choose, only to then have the choice ignored because the diagnosis of dementia has expelled them from the hypercognitive world (Post, 1995) populated by people without the diagnosis whose choices are therefore valid. One inference we might draw from this is that practices like this one are based in the belief that because people are old and/or dependent and/or have cognitive challenges, all people residing in nursing homes are unable to learn or make important, meaningful, responsible decisions that benefit their own interests and well-being. This stereotype distracts us from learning to gauge the total pattern of individual choices in dining that a group of elders may prefer, their demonstrated and historic need for novelty, and their ability to make and learn from the choices they make as they adjust to the nursing home environment. The field needs research that addresses the practical and therapeutic effects of choice in dining (and other activities like it) on the safety, mental and other related wellness benefits on elders and staff, and the impact of choice on management and business realities. Choice is often opposed as being an additional expense, but studies of family style dining, for example, indicate that there are nutritional benefits as well as cost savings.

But this opposition may be related to another core issue when considering the issue of choice in dining and safety (surplus or not) and that is whether there are other stakeholders whose safety is at issue here as well but that have been inadequately addressed.

We will not, in my opinion, be able to develop practical approaches to reduce the culture of surplus safety and enhanced choice in nursing homes until we address and solve the real issues faced by stakeholders who can be sued or are otherwise at risk when an elder in a nursing home exercises a choice. We live in a litigious society, where billboard and TV advertising in many states invites people to consider whether their loved one has had any one of a number of negative events and, if so, to call the law firm who raised this question. I do not have an answer, but think that it is critical that all stakeholders who are at risk have a role in conversation about solutions to this problem. I believe that this and the previous symposium sponsored by The Pioneer Network and CMS are blazing the trail in this regard, and I applaud the organizers for taking this step. Collaborative solutions don't happen when significant and powerful stakeholder groups are left out of solution-focused conversations. These symposia are models of how all of the stakeholders whose concerns limit or facilitate more choice and variety in the daily lives of those who live and work in nursing homes can be part of the solution team.

Research agenda for stakeholder concerns

Nursing homes are businesses, and whether for profit or not for profit, no matter the culture they represent, their business success is critical to their survival. A program of translational research on this and related topics of interest to and developed by all stakeholders would help to address their diverse and often competing safety concerns. A common data set and success measures to study this and related topics in changing the culture of nursing homes could be developed to link the business case for choices in dining and other aspects of life in nursing homes to the regulatory and humanistic ones, as well as to provide guidance on data collection to adopters of the various culture change models. This is a huge challenge, both for economic reasons and because operating models that would be introduced at initial expense (but with possible savings after the transition) have traditionally relied on ritual, routine and predictability (with rare exceptions at holiday times, for example) to control costs and create efficiencies in a task-oriented work model.

From nutrition to dining: an organizational model

These observations about dining and choice can be viewed in a practical way that organizes and integrates them into an operational approach arranged in a hierarchic system of goal satisfaction. This tool looks at dining and choice along a model of need satisfaction that is true for all of us, and that offers a pathway to change operations from feeding to dining. We (Bradley, Ronch and Pohlmann, 1999) have previously applied the BASICS model to various care concerns. It represents a practical way to move beyond reductionist views of dining as food intake merely to satisfy the body's nutritional needs and incorporates the other important needs discussed in this paper. It also provides us with a way to look at

the many levels of dining as an experience with multiple effects on wellness. I include it here so that other creative solutions might have a model to work with and modify, not necessarily to adopt as a whole.

BASICS HIERARCHY MODEL OF RESIDENT NEEDS IN LONG TERM CARE	
Need Satisfied	Fosters
Biological Basic needs for food, water, oxygen, safety, rest, human stimulation.	self-preservation Resident physically cared for and safe.
Activities of Daily Living Personal needs that support life style (eating, mobility, dressing, toileting, personal hygiene).	self-dependence Environment provides supplies and assistance to foster self-performance.
Societal Need for unique personal identity, privacy, resident's place in society).	self-identity Environment provides for privacy affiliation with groups, culture, family customs, education, resident selection of associations with individuals and groups.
Inter-personal Need for connection with others (love and belonging).	self-esteem Environment fosters social role expression, supports interpersonal, and social abilities, promotes social confidence and an atmosphere of caring and being cared about.
Creative Need for personal expression, problem solving opportunities, and meaningful activity. Need for the activity in the resident's life that brings joy (face lights up- "the spark of life" is there, if even for a fleeting moment).	self-expression Environment supports independent activity, humor, creativity, and encourages use of talents and skills. Environment identifies and fosters the activity that brings that " spark of life " to the resident. It also, supports the resident to continue to problem-solve and make decisions in his/her everyday life.
Symbolic Need for expression of: beliefs, hopes, dreams, values and autonomy (ability to control important aspects of life). Sense of peace in the universe according to the individual resident's belief of the meaning of life.	self-actualization Environment encourages hopefulness and self-fulfillment: (" Being all you can be ") Environment respects and encourages expression of the spiritual dimension of the resident and supports spiritual ministry from outside sources as requested by the resident or family.
Adapted for EDGE from Vickers, R. (1977). Originally modified with permission in J.L. Ronch, (July/August 1987). Specialized Alzheimer's unit in nursing homes: Pros and Cons. <i>American Journal of Alzheimer's Care and Related Disorders & Research</i> , 2, 10-19.	

We can approach the levels of experience as follows, with the benefits of choice in dining being are fully realized when all levels of BASICS are satisfied for each elder:

Self preservation The nursing home can, at a minimum, satisfy the biological need for food to sustain life, but we might call that eating, not dining. The resident is physically cared for and safe, but the elder's optimal autonomy and self-performance are not a goal that is achieved.
Self dependence The environment supplies the supplies (food, clean utensils and dishes, tables and chairs, etc.) and any needed assistance to eat. The elder may or may not participate in preparing, serving and cleaning up after a meal. Optimizing self-performance and maximum self-dependence when eating is a goal.
Self-identity The elder eats with others of his/her choosing or privately, and the food served reinforces self-identity because it is tied to family, ethnic or other personal memories.
Self-esteem Food is part of a larger social context, where elders' choices of food dining partners are part of everyday life. Choice is encouraged and elders gain self-respect and the respect of others through successfully exercising these choices.
Self-expression Food choices and preparation are meaningful activity such that solving problems (what to choose, dining partners, and when to eat) in individual novelty/routine preferences are balanced as the elder wishes according to agree upon practices. Emotional and cognitive benefit is derived from dining as new memories are made.
Self-actualization The environment encourages mindfulness in choice making as a way for elders to achieve a positive relationship with their future selves through having hopes fulfilled, individual values of individuality/mutually fulfilled, and dining is an experience where residents realize an affirmation of their sense of self in relation to the universe; life, even when there are challenges, has meaning. The encouragement and support of elders regularly making meaningful choices from among options that they value promotes wellness, social integration, and longevity.

Conclusion

When elders have choices in dining, they should find, like Proust did, that place where time stops as they enjoy a meal that provides a pathway to find themselves and make their memories.

Future Considerations

1. Frame dining and choice in nursing homes as a key ingredient that synthesizes quality of life and quality of care. Dining is about more than food; it creates meaning and invites memories.
2. Use stories and reports of practice innovations (with outcome results) to “normalize the exceptions” that run counter to prevailing biases about elders’ ability to make reasonable choice as regards dining.
3. Develop approaches to dining that reflect a view of elders as capable of making choices and deciding what, when, and with whom to dine as a mental wellness activity because it “exercises” the decision making circuitry of the brain, enhances pleasure, and strengthens memory encoding and retrieval.
4. Review survey findings and identify a range of harmful outcomes found when choices are denied or invalidated with no or only perfunctory attempts made to satisfy the choices that are consistent with the elder’s decision making history and style, and a range of beneficial outcomes when choices are encouraged and made available.
5. Develop a tool that captures and projects forward in time the elder’s decision making history and style, with regard to food as well as other aspects of living, as applied to the current living situation (See Helen Kivnik’s *Life-Strengths Interview Guide* as an example). What are the foods that “make time stop” and provide unique pleasure through memories of self for the elder? How can they be made available on a routine basis?
6. Establish behaviorally based examples of passive compliance to use as examples which illustrate situations in which a choice is offered in a negatively framed way (“you don’t want X, do you?”; “nobody expects anyone to want to eat ...”), or is offered but is not honored, or not offered (“she has dementia; she can’t tell you what she wants so we give her what we have”), that the “reasonable person” would not tolerate.
7. Identify patterns of verbal or other interaction by staff with elders that encourage dependency to expedite task completion.
8. Identify examples of harm occurring in patterns of elder’s responses where most or all chances to exercise a choice or make a decision about one’s life are politely declined (The Bartleby the Scrivener reply: “I prefer not to”), or the presence of a consistent pattern of passive compliance with choices made for the elder that either differs from historical patterns, or where the reasonable person would state a choice. Elders who are reluctant to make choices known may have this as a historical pattern but can be helped to learn to trust themselves and their environment should they choose to want to do this.

9. Continue to apply research findings about diet, health and dining so that we increasingly close the gap between our view of what “should” motivate elders as regards food preferences and what really motivates them (and the rest of us). This will help to normalize explanations and expectations about elders and their food preferences and de-medicalize policies and procedures around food.
10. Develop strengths-based methods to assess elders’ abilities to exercise choices in dining (and other domains of life) that do not reflect the norms found in low choice environments. These environments may produce artificially low estimates of how well elders can learn and create artificially low expectations for interventions. Elders need to be in environments that have the complexity necessary to challenge them to learn as a result of their choices, as we all do.
11. Educate staff about how to understand the ways (past and present) that individual elders think when making decisions. By observing how an elder approaches choices and makes decisions, what their decision making strategy and risk tolerance are, they can come to know how the elder “forward models” their preparation for possible outcomes of their intended activities. Good caregivers typically do this already; the skill needs to be made a universal competency.
12. Launch a coordinated program of translational research (ethnographic, clinical trials, and meta-analyses) to inform policy and practice, starting with current state of the art innovations, which evaluate creative approaches to choice in dining and yield measures of primary physical and mental health outcomes, cost data, longevity figures and happiness indices in the short, medium and long terms. Start by replicating Langer and Rodin’s studies and extend them to multiple sites with multiple sub-populations, including elders living with dementia. Develop practice-informing research programs that identify and evaluate ways to gauge the decision making abilities around food – either verbal or non-verbal behavioral, that can guide practice and honor their decisions.
13. Enhance the availability of choice in dining by expanding opportunities for elders to dine with staff and other elders so that prompting and modeling may be used to support and re-train requisite skills that would support and normalize the dining experience.
14. Create dining experiences where salutary aspects of the physical, social, psychological and cultural environments are identified to plan a part in providing positive emotional experiences at every meal.
15. Start innovation by brainstorming with residents and asking the “miracle question”: “If by a miracle you could eat anything you wanted at any time with anyone, how would that look?”
16. Develop a guide to discussing choices with elders , families and staff as part of the elder’s life at the nursing home that is collaborative, holistic and, through the use of simulations and discussion guides, standardizes the approach to choice in dining given the elder’s needs and strengths.
17. Apply the relevant recommendations of the other presenters to systematically review and eliminate instances where “surplus safety” does not improve, or may interfere with, the health, wellbeing, function and quality of life of elders.
18. Establish guidelines that define an elder’s right to make an unpopular or ill-advised decision in view of all available information about the impact of the decision on his/her future self (“the right to folly”) versus cognitive, emotional or other conditions that render him/her vulnerable to exploitation, abuse or neglect. This should be based on imagining future scenarios that result from the decision and how the elder appreciates and plans for the impact on his/her well being.

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