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THE MEMORY HOUSE

Should the illusions of dementia be corrected or accepted?

BY LARISSA MACFARQUHAR

The large central room of the memory-care unit was designed to look like an old-fashioned American town square. There was a small fountain, surrounded by plants and a low stone wall; there were a couple of lamp-posts, and benches, tables, and chairs set about. The carpet was mottled with darker and lighter shades of green, to resemble grass growing and bending in different directions. Along the walls were the façades of what looked like clapboard houses, with wooden shutters and shingled pitched roofs and porches that extended into the room. Two long hallways, which led off from opposite sides of the central room, looked like streets in the same town, with more clapboard façades and porches on either side. These façades were not altogether fake: each front door opened onto a suite of small rooms—living room, bedroom, bathroom—that was a resident's home.

Some of the porches had rocking chairs that you could sit in and watch people go by. Many of the residents were quite restless, and there was nowhere else to go, so people did walk by fairly often. Daylight came in through high windows just below the ceiling, and the ceiling itself consisted of bright light panels painted to look like a blue sky dotted with clouds. In the evening, as it began to grow dark outside, lights on the porches came on. Sometime later, the street lamps were lit; and finally, around eight o'clock, the ceiling sky was switched off, so that the unit came to look like a small-town street at night.

The illusion was surprisingly effective. While the central area didn't feel like outdoors, exactly, it didn't feel like a room, either—it was halfway between the two, at once enclosed and public. People who spent time there found themselves referring to the hallways as streets, and the suites as houses. And although the unit was conceived as a kind of nostalgic stage set, a harkening back

to an America of eighty or ninety years ago, when many of its residents were children, in fact it looked much like the town outside: Chagrin Falls, Ohio, in the Chagrin Valley just east of Cleveland, a town of clapboard houses with wooden shutters and shingled pitched roofs and rocking chairs on the porches.

The impression that the unit was outdoors and public was all the stronger because the people who gathered each day in the central room had no common purpose or shared understanding of what they were doing there. Some knew that they had come to live in the memory-care unit because they could no longer manage living on their own: they could no longer drive, or they tended to forget their medication or leave the stove on, or if they went for a walk they might get lost. Some knew that they were in a memory-care unit but didn't believe they needed to be there and tried to get out. Others did not know where they were, or knew sometimes but not at other times, or else seemed to have reached a point at which the question of where they were was no longer important.

The staff tried to keep the residents busy. They played hangman and trivia and bingo and beanbag toss. They performed stretching exercises and cognitive exercises every morning. There was Bible study and crafts and manicures each week. They watched Indians games on TV in the summer, and Cavaliers and Browns games in the fall. Elsewhere in the facility, there was an artificial main street, with a library, a gift shop, a beauty salon, a chapel in which services were held on Sundays, and a couple of faux storefronts—an oil company, a hardware store. Sometimes the residents were taken on outings—picnics or fishing at a nearby lake—and sometimes relatives came to take them to lunch, but most of the time the clapboard streetscape of the memory-care unit was their world.

The streetscape at the Lantern, the

home at Chagrin Valley, is particularly encompassing and detailed, but comforting fictions—scenery, props, and other simulations—are employed in many homes for people with dementia. Some nursing homes offer their residents realistic vinyl baby dolls, along with diapers, bottles, and clothes. Some residents grow so attached to the dolls that it seems they believe they are real babies, although it is difficult to tell. Many people become visibly calmer when they are holding the dolls; but some relatives and staff find the dolls demeaning, and wonder whether it's possible not to infantilize a person who is cuddling a toy baby.

People with dementia often ask to go home. Some ask even if they're still in the house they've lived in for years; but people in institutions can ask many times a day. Telling a person in an institution that they live here now, that this is their permanent home, is usually neither comforting nor convincing, so, to address this problem, many nursing homes and hospitals have installed fake bus stops. When a person asks to go home, an aide takes them to the bus stop, where they sit and wait for a bus that never comes. At some point, when they are tired, and have forgotten what they are doing there, they are persuaded to go back.

Some years ago, a company in Boston began marketing Simulated Presence Therapy, which involved making a prerecorded audiotape to simulate one side of a phone conversation. A relative or someone close to the patient would put together an "asset inventory" of the patient's cherished memories, anecdotes, and subjects of special interest; a chatty script was developed from the inventory, and a tape was recorded according to the script, with pauses every now and then to allow time for replies. When the tape was ready, the patient was given headphones to listen to it and told that they were talking to the person over the



The memory-care unit in Ohio's Chagrin Valley is designed to look like an American town from its residents' childhoods.

phone. Because patients' memories were short, they could listen to the same tape over and over, even daily, and find it newly comforting each time. There was a séance-like quality to these sessions: they were designed to simulate the presence of someone who was merely not there, but they could, in principle, continue even after that person was dead.

In recent years, many more of these kinds of props and simulations have been devised: not just fake bus stops but fake buses, with screens for windows, on which footage of a passing scene gives the impression of movement; one home has made a simulated beach, with heat lamps, sand on the floor, and the sound of waves. There are versions of the Chagrin Valley streetscape in many countries around the world—in the Netherlands, Italy, Canada, Australia. Many homes have rooms that re-create, with period details and vintage artifacts, a past world that their residents remember from childhood: the Dutch countryside of the nineteen-forties; small-town California in the nineteen-fifties; East Germany under Communism. All these fantasies are conceived of as a means of soothing the misery, panic, and rage that sometimes accompany dementia: to convey to people in later stages

of the disease the impression that life is still as it was once, with children to take care of, and holidays at the seashore, and familiar homes to return to.

Fifty years ago, it was common in nursing homes to use physical restraints to tie a resident to a chair or a bed, to prevent them from causing trouble or coming to harm. Then, in 1987, a federal law was passed that limited the use of physical restraints to situations where the safety of the resident or someone else was at stake—they were not to be used for punishment or for the convenience of the staff. The physical restraints were then often replaced by chemical ones, and residents were tranquilized with powerful antipsychotics such as Haldol. Many people thought the use of such drugs was a terrible thing, so they began searching for non-pharmaceutical alternatives to quelling troublesome behaviors, and psychological placebos such as fake bus stops proved to be quite effective. One patient who had been given Haldol every night to stop him from screaming was so calmed by Simulated Presence Therapy that he no longer had to be tranquilized at all.

But psychological placebos, like any placebos, are a form of deception, and

so they make people uncomfortable. They seem like a throwback to a time, not long ago, when it was normal and acceptable for a doctor to lie to a patient. Until recently, for instance, it was thought that telling the truth about a fatal illness was pointless and cruel. The Hippocratic oath said nothing about lying—it only proscribed doctors from doing harm. And what was harmful if not delivering a death sentence and destroying hope? Lying to most patients in this way now seems obviously wrong; but when it comes to people with dementia there is no consensus. To lie is to violate the respect that one person owes another; but lying to a person with dementia can protect them from awful truths that they have no power to alter. If a woman asks for her husband, having forgotten that he is dead, should you tell her the truth and cause her terrible grief, knowing that this fresh bereavement will likely repeat itself, over and over, day after day? Or should you just tell her that he is at the office? And is direct lying different from various forms of passive lying—encouraging delusions, or allowing existing delusions to persist? What is more important—dignity or happiness?

In Chagrin Valley one evening in early summer, Rachel and Jane sat eating dinner together at a small table by the window. (Some names have been changed to insure privacy.) Rachel had a bob of curly gray hair, and wore little metal-framed spectacles. Every now and again she made an anxious, high-pitched squeaking sound. "What's that noise you're making?" Jane asked. "Are you O.K.?" Jane wore a red hoodie and a red-and-white gingham shirt. Rachel didn't answer. For a while, they ate without talking.

"Sweetheart, you're making noises," Jane said.

"I know," Rachel said. "I can't help it."

"Yes, you can."

"How?"

Becky sat by herself in the opposite corner. She had a strong face with vivid blue eyes; her cheeks were ruddy and her wild gray hair was escaping from a loose bun, as though she had just come in from a walk across a windy moor. Every so often she tried to stand up, but bumped against the table and fell



back down into her wheelchair. Becky was married to another resident, Cal, but she no longer knew him, although sometimes his presence distressed her, which the nurses thought might be a sign of recognition. Cal sometimes seemed to recognize her—sometimes he would sit next to her and stroke the back of her head—but at other times he did not. Becky could not speak anymore, and spent most of her time being cared for by an aide.

George, Angela, and Carmen sat together at a long table in the middle of the dining room. Eleanore came into the room, wheeling her walker, and went up to the table. “O.K., ladies, what would you want for dinner tonight?” she asked. Eleanore had been a Girl Scout troop leader for many years, so she was used to taking care of people. Her hair was short and fine and colored a pale brown, and she wore round glasses. She had trouble with her memory and sometimes grew confused, but she knew that she was living in a nursing home and was still very much herself.

“I didn’t bring anything for dinner tonight,” Angela told her.

“I didn’t think you would bring anything,” Eleanore said. “I want to know if we can make anything for you.”

“Who is that back here?” George cried out, clutching the arms of his wheelchair and twisting around, trying to see behind him. “Why are you back there? Why aren’t you talking to me?” There was nobody there just then, but sometimes aides came up behind him and started wheeling his chair away without alerting him first, so he knew that someone might be lurking at his back where he couldn’t see them.

“I am talking to you,” Eleanore said. “I’m trying to ask you what you want for dinner.”

“What are you doing?” George said. “What’s going on back there?”

“Will you tell us what you want to eat?” Eleanore repeated. “Do you like spaghetti? Do you like macaroni or spaghetti?”

“I don’t know what to do,” George said. “What the hell am I supposed to do?”

“Tell me yes or no, do you like macaroni?” Eleanore asked him patiently.

“What is she talking about?” Carmen asked Angela.

“She’s talking too much,” Angela said.

“You eat things, you drink things, you don’t have a goddam thing,” George said.

“Don’t swear,” Angela said.

An aide told Eleanore that there was a set menu for dinner, so she went to sit at her customary table by the door with Dr. Joe, a retired dentist. Dr. Joe did not talk much, so they usually ate together in silence. But at other times Eleanore would muse aloud about the course of her life. During the Second World War, she had worked as a switchboard operator for the military. She then stayed home to raise her children and never worked for pay again, but she had loved that job and still talked about it.

Later that month, she was going to turn one hundred, and she was trying to figure out how to think about this strange event. “I mean, that’s ridiculous,” she said cheerfully. “Who lives a hundred years? So I never believed it. If they have a party for me at a hundred, then I’ll be a hundred. I’m not objecting. But I’m not going to stay that way. After all, the year keeps going, and I’ll keep going along with it, and next year’s going to be a hundred and one, and then a hundred and two, and pretty soon I’ll be a hundred and five, and then what are they going to do with me? They’ll put me on a fence post and say, Look at that lovely lady, she lived a hundred and five years and nobody knows why, so we’re trying to find out why. What’s the point in living all that long if you can’t *live* it? And I don’t think I’ve been living it. I’m just existing. And when the time goes by and I say, Yeah, another year passed, and I’m a hundred and two, a hundred and three, a hundred and four, and then what? What number do I have to reach before something changes? Do I have to go to a hundred and ten, and then be something else? Or what? What’s it all for? That’s the question I’m asking, and I can’t get any answers.”

Jim Beitel was too upset to sit down for dinner. He had come to Chagrin Valley only a couple of days before; for the first forty-eight hours his wife, Sondra, had stayed with him all the time, both of them miserable. A little while

earlier, Sondra had forced herself to leave. Jim was fifty-eight; he had been given a diagnosis of Alzheimer’s at fifty-three. Now he barely spoke. He was a big, athletic man, six feet two, two hundred and twenty-five pounds. He was wearing a Led Zeppelin T-shirt, a rope necklace, black surf shorts, flip-flops, and a pair of sunglasses on his head. He had short, bristly gray hair and a short

gray beard. He paced continuously, up and down the corridors, in and out of the dining room, into doorways and out again. Every now and then, he stopped suddenly and threw his arms out wide in a gesture of utter bewilderment.

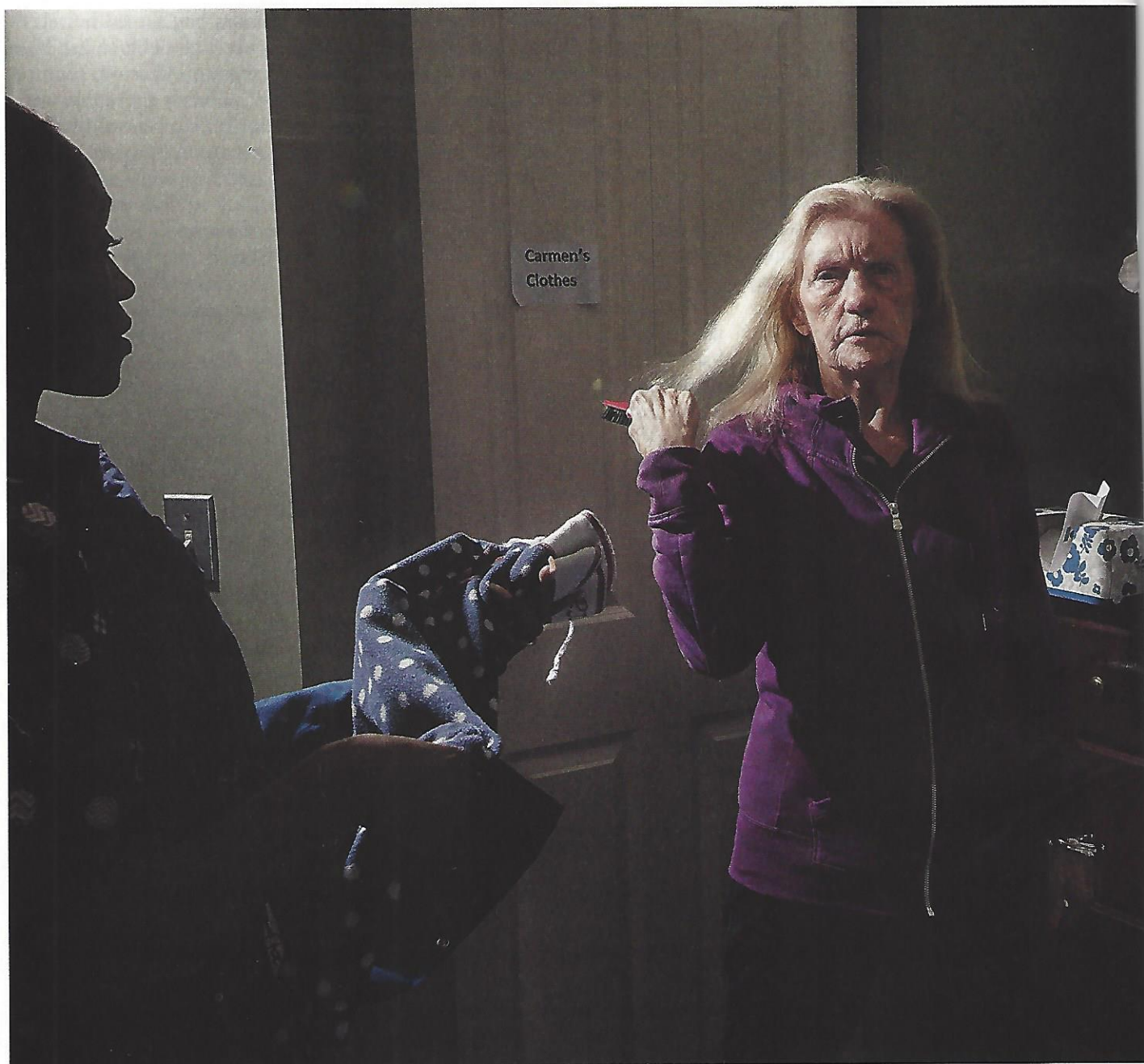
Later in the evening, Sondra came back. She was a tiny woman in her late

forties, with short blond hair. She stood with Jim in the central room and demonstrated how to throw a rubber ball into a toy basketball hoop. Then she gave the ball to him. Jim looked up at the hoop as though he didn’t know what it was. He hugged the ball to his chest and began to cry.

Jim and Sondra had both worked as engineers in the Columbus, Ohio, office of a multibillion-dollar construction company. Jim oversaw big commercial projects—convention centers, hospitals, ballparks. They had met twenty years earlier, playing on a local soccer team. In 2009, Jim’s brother, to whom he was very close, died of kidney cancer in his early fifties, and Sondra thought that might have triggered something in Jim, because his symptoms started soon afterward.

The first thing she noticed was his reaction time: one day she said, while they were working on the computer together, “Close that window and open another,” and she noticed that it took him time to process what she had said. She then saw that in meetings he had begun asking people to repeat things and writing down what they said. Then one day he had an appointment with a doctor he’d been seeing for twenty-five years and he couldn’t remember how to get there. Because he was so young, nobody thought of dementia. Doctors tested him for inflammation and hepatitis and mad-cow disease and autoimmune diseases; they gave him spinal taps and put





The residents' homes consist of suites of small rooms—living room, bedroom, bathroom—and have front porches that make the

him on steroids. Finally, they ordered a PET scan of his brain and diagnosed Alzheimer's.

Jim went on disability, and Sondra bought a trained English setter to keep him company while she was at the office. The dog brought Jim's medication to him at the sound of an alarm. When Jim was still able to drive but grew disoriented in large parking lots, he could tell the dog, "Truck," and the dog would find his truck. If he got lost walking in the neighborhood, the dog tracked him down. The dog enabled Sondra to keep working awhile longer. But after a year it took so much out of

Jim just to manage simple tasks like finding his coffee cup that he was exhausted by the end of the day, and she stopped working so that they could spend time together while he was still aware of it. They decided to check off some items on their bucket list. They took money out of Jim's retirement account and travelled to New Zealand and Italy and Hawaii.

Sondra decided that if Jim did something weird, or said something that wasn't true, she wouldn't correct him. If he put on four baseball caps at once, or put a flip-flop on one foot and a sneaker on the other, she would just go with it.

Then again, he had always been a pretty obstinate person, so this wasn't a big change in their relationship. "Everyone knew if Jim says the grass is blue it's not worth trying to talk him out of it," she said. "And that just rolled right into when he was sick."

Eventually, things got to the point where Sondra couldn't manage taking care of him alone anymore, so she began looking into nursing homes. Chagrin Valley was much nicer than other places she saw—no funeral-home carpeting, no grim hallways with wall protectors and handrails—but it cost about the same. She dreaded leaving him there, but she



hallways look like streets.

home they were no longer a husband or a child—just a nurse.

Jim mostly lost his ability to speak early on, but he could still recognize faces, and he could show emotion. Oddly enough, while many people with dementia grow angry and difficult, Jim was the opposite. “He got a lot nicer,” Sondra said. “Not that he was mean before, but he was always very businesslike, very serious and by the book. The disease changed his personality. People would ask, *Who is this guy?*—he was just so kind, and there was a softer side to him that they hadn’t seen before.” Before, when he was frustrated he would get angry; now he was more likely to cry.

In losing his language so early but remembering faces, Jim was unusual. Most people with dementia start to become confused long before they stop speaking. Many people mistake one relative for another—mistake their daughter for their mother, or their son for their husband—and many forget that their spouse or their parents are dead. It is common to imagine that you are somewhere else, such as a hotel or a prison or a ship, and to believe, therefore, that those who tell you you’re in a nursing home are trying to trick you. Some people believe that dramas on television are real. People with Lewy body dementia often experience visual and auditory hallucinations, and people with dementia of all sorts have problems with depth perception and find it difficult to distinguish dark patches on the ground from holes. Many imagine themselves to be living through an earlier time, when they had an office to go to or small children to pick up from school, or even earlier, when they themselves were small and dependent on their parents. Doctors have observed that there seems to be a “reminiscence bump”: that people whose memories are failing tend to remember the period of their late childhood and early adulthood more vividly than other stages of their life.

It is because of these characteristic confusions that dementia care has developed its characteristic lies. “I think for the most part it’s kinder to just go with the moment,” Jennifer Karp, the former acting director of nursing at Chagrin Valley, says. “Because the chances are within the next few minutes they’re not going to remember what just occurred anyway. To tell them repeatedly that their spouse

has passed away, or when they’re crying out for their mother to say, ‘You’re ninety-four years old, where do you *think* your mother is?’ That’s just cruel. So we say, ‘Hey, maybe they’re at the store.’ Someone asked me yesterday, ‘Where do you think all the kids went?’ And instead of saying, ‘What kids?’ I said, ‘I think they’re playing—it’s a beautiful day outside.’ And she said, ‘That’s good, they can go play.’ That was all she needed to hear.”

In dementia care, everybody lies. Although some nursing homes have strict rules about being truthful, a recent survey found that close to a hundred per cent of care staff admitted to lying to patients, as did seventy per cent of doctors. In most places, as in Chagrin Valley, there is no firm policy one way or another, but the rule of thumb among the staff is that compassionate deception is often the wisest course. “I believe that deep down, they know that it is better to lie,” Barry B. Zeltzer, an elder-care administrator, wrote in the *American Journal of Alzheimer’s Disease & Other Dementias*. “Once the caregiver masters the art of being a good liar and understands that the act of being dishonest is an ethical way of being, he or she can control the patient’s behaviors in a way that promotes security and peace of mind.” Family members and care staff lie all the time, and can’t imagine getting through the day without doing so, but, at the same time, lying makes many of them uncomfortable. To ease this “deception guilt,” lying in dementia care has been given euphemistic names, such as “therapeutic fibbing,” or “brief reassurances,” or “stepping into their reality.”

The current prevalence of lying is in part a reaction to the opposite approach, which was favored in the middle of the last century. Oddly, at the time when doctors routinely lied to ordinary patients about their diagnoses, experts in dementia care advocated confronting confused patients with facts and truth. In the early nineteen-sixties, Lucille Taulbee and James Folsom, a nurse and a doctor working with a range of geriatric psychiatric patients, including some with dementia, at the V.A. hospital in Tuscaloosa, developed a program they called “reality orientation.” Small groups of patients were taught by an instructor standing at the front of a classroom with a pointer, which

also hoped that finding someone else to help with daily tasks would allow them to be close again. “I spent so much time taking care of him that I had no time to be his wife anymore,” she said. “By the time where I can sit down on the couch and hold his hand, I’m so completely drained mentally and physically that I can’t even go through a photo album with him. I’m hoping now I can hold his hand and go for a walk and just have that husband-wife relationship. We still have it; it’s just that we haven’t been able to really experience it in a long time.” Many people said this: that while they were taking care of their wife or their father at

he used to indicate various props: a clock, a calendar, a picture, a map, plastic numbers, and, most important, a “reality-orientation board,” on which were listed such things as the name and location of the hospital; the year, month, and day of the week; the name of the next meal; the next national holiday; and the day’s weather. In the class, the teacher told each patient his name, where he was, and the date. The teacher rehearsed these facts over and over until the patient managed to retain them, at least for the moment, at which point the teacher moved on to a new set of facts, such as the patient’s age, home town, and former occupation. These lessons were not confined to the classroom but reinforced continually throughout the day. Each patient wore a nametag at all times; there was another nametag attached to their bed, and a third tag identified their seat in the dining room. Before the patient ate each meal, they were reminded of what time it was.

Taulbee and Folsom claimed considerable success as a result of this program. Mr. R., for instance, who had lived in a psychiatric hospital since 1923, and at the time of his entry into the program had not spoken a word for fifteen years, could after seven and a half months not only read the entire reality-orientation board out loud but had begun to chat with staff outside the classroom. The core of the program was not giving up hope that even the most bewildered, isolated patient could, with enough training, return to the world. And the key was facts: these were the handles that the patients would cling to, to pull themselves back in. “When they arrived, they all were frightened, unhappy, and uncomfortable people,” Taulbee and Folsom wrote. “But their look of hopelessness soon changed to hopefulness when we told them their names, where they were, and what date and day of the week it was.”

For decades, reality orientation was extraordinarily influential—even now, it is a rare nursing home that does not have a reality-orientation board somewhere on display. R.O. was one of the first efforts not only to halt but actually to reverse the cognitive symptoms of dementia, and as such it gave the staff of nursing homes something to do that felt more hopeful than the endless round of washing, dressing, and feeding. But, even

as reality orientation became mandatory in many places, its rigid methods were resisted and mocked by patients and staff. A pair of sociologists who spent time in some Midwestern nursing homes in the early nineteen-seventies discovered that reality-orientation training had degenerated into farce:

Aide [pointing to the weather on the R.O. board, which reads “raining”]: What’s the weather like today, Emma?

Emma turns her head slightly and quickly looks out the window.

Emma: Well, it looks like the sun is shining kinda bright.

The sun happens to be shining at the moment.

Aide: Are you sure? It says it’s raining. Doesn’t it? [finger still pointing to board]

Emma: Well, it doesn’t look like it from here.

Aide: What does it say here, Emma? [directing Emma’s attention to the board].

Emma: It says it’s raining.

Aide: [warmly] That’s correct. Very good.

In some cases, the training seemed worse than pointless, forcing patients to confront realities that might have been better left unchallenged. One patient the sociologists encountered had been relatively calm until she started R.O. training, during which she was continually reminded that she lived in a nursing facility. Once this sank in, she began to cry all the time and pace around the ward, saying that she wanted to go home. It was far from clear that R.O.’s version of reality was relevant or helpful for long-term patients. Keeping track of the weather seemed unnecessary when a patient was rarely allowed outside a locked ward. And keeping track of calendar and clock time only drew attention to the dreariness of nursing-home life, where each day was more or less like the last. The kind of reality most relevant to dementia patients was not the kind that would be represented on an R.O. board: not “Today is Monday/Tuesday, the weather is rain/sun” but “Your spouse’s name is _____. He/she is alive/dead.”

In the early nineteen-eighties, a social worker from Cleveland named Naomi Feil began to practice what she called validation therapy, which rejected R.O.’s absolutist position on truth. She believed that it was wrong to lie outright, but also wrong to correct: the thing to do was to enter into the emotional world of the person with dementia and validate their

feelings, because feelings were more important than facts. To many people working with patients, the idea that rigorous truthfulness was unnecessary and even harmful came as an enormous relief.

To advocates of reality orientation, Feil’s validation therapy seemed not empathy so much as collusion. But the validation approach grew more and more popular, to the point where the idea of sticking to the truth came to be an unconventional position. Then, in the nineteen-nineties, an Englishwoman named Penny Garner came up with an approach to dementia care that was considerably more radical in its rejection of truth-telling, and aroused considerably more hostility.

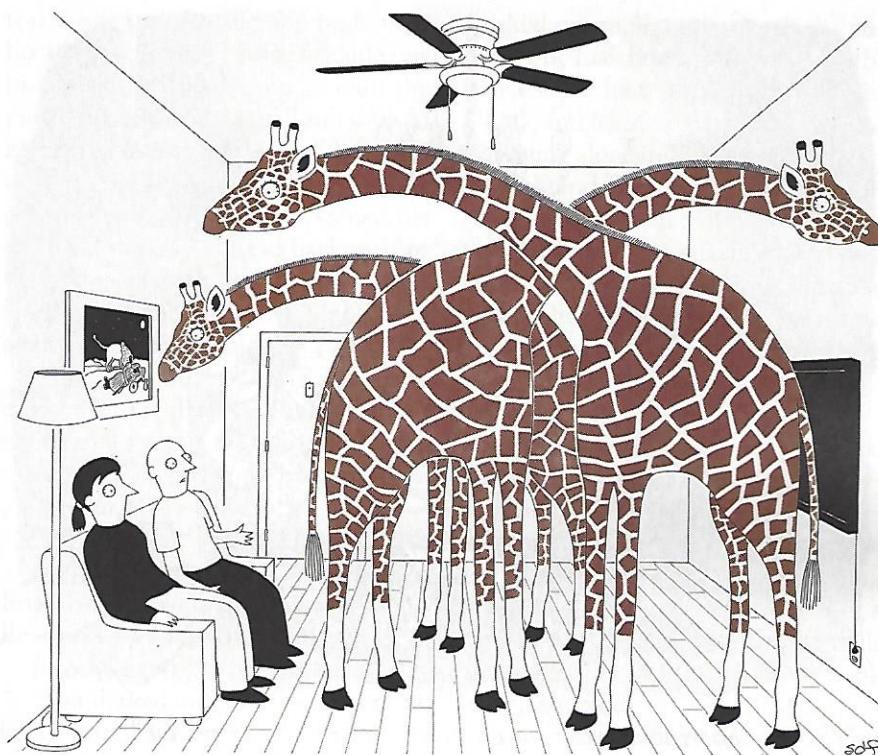
Garner’s mother, Dorothy, began to notice, in her late fifties, that her memory was failing and she was getting confused, and she grew sufficiently worried that she insisted on a brain scan. The scan revealed extensive atrophy, but her husband, a doctor, thinking it best, didn’t tell her. He told her only that she didn’t have a tumor, and not to worry; if she wanted to remember things, she should just try harder. Dorothy grew disturbed when confronted with her mistakes, so Garner found that the best way to keep her mother happy was to go along with everything she said, no matter how peculiar. Dorothy had travelled a lot, and Garner saw that, when surrounded by strangers, in a line at the supermarket, or in a doctor’s waiting room, she often guessed that she was at the airport, happily anticipating boarding a flight. Garner always went with it. Her father couldn’t adjust to this strategy at all—he insisted on setting Dorothy straight—but Garner discovered that she quite enjoyed the Alice in Wonderland quality of those days with her mother.

After Dorothy died, Garner decided that she ought to use what she’d learned taking care of her. She had no medical training—she was a stay-at-home mother living in the Cotswolds, a bucolic region just west of Oxford—but in the early nineteen-nineties she started volunteering with dementia patients at her local hospital, in Burford. During the next ten years, she refined her ideas into a system. First among her rules: Never ask questions. Questions, she thought, put you on the spot: they could cause a person with dementia to panic by demanding

an answer that they might not be able to give. Instead, she learned to start a conversation by rambling on about something boring—usually the weather—in order to ease her way into the person’s attention in an unthreatening manner. Once they started talking, she would use words they had used, mirror their gestures, and declare herself fascinated by what they said, to create a sense that at last they were with someone who really understood them.

Another of her rules was: Never contradict anything the person said, no matter how distant from reality, in order to spare them a distressing confrontation with their own decline. But it wasn’t enough simply to avoid correcting; to keep the person truly happy, she thought, you had to identify the roles in which they were happiest and which fit common situations—as Dorothy was happy, while waiting for something, to believe she was a traveller at the airport—and then you had to keep them playing those roles as much as possible. Garner instructed each person’s family to figure out what those roles might be. For instance, one woman in the hospital, Alice, had been a crack bridge player. Garner arranged for two bridge novices to ask Alice to teach them. After a while, she could not play very well anymore, but she no longer needed to: Garner found that all it took to trigger Alice’s sense that bridge was being played was a certain velour tablecloth. “As time went by, most of Alice’s waking life revolved around Bridge,” Oliver James, a psychologist and Garner’s son-in-law, wrote in “Contented Dementia,” his book about her technique. “Penny created a loop for her in which a large part of every day consisted of waiting to play, playing, having tea while playing, recovering from having played and discussing plans for playing tomorrow—like a happy version of the film *Groundhog Day*.”

Alice was not unusual, Garner found: often, a single prop or gesture was all that was needed to keep a person feeling that they were playing their accustomed role in a beloved activity—that, and a caregiver who could keep the scene going. The requirements were few enough that Garner found she could keep several scenes going at once. “You might have ten or twelve people with dementia in the same room, but they’d all think



“If we get a bigger place, we’ll just accumulate more giraffes.”

it was something else,” Jan Dewing, who was the director of the Burford hospital in the nineteen-nineties and is now a professor of nursing at Queen Margaret University, in Edinburgh, says. “One guy who used to work in London, in the City, years ago thought it was his club. Someone else thought it was a church hall where they came to practice the piano. There was an ironing board there, and someone thought it was an offshoot of the laundry where she used to work. One used to be a Wren in the Royal Navy and thought she was having a reunion with her Wren friends.”

In order to keep a person safely inside their world, it was necessary to figure out the boundaries and contents of that world—who lived in it, what activities took place there, and in what era—so that there would be as little dissonance as possible when the person used information from that past world to interpret the present. If there was someone missing from the present, for instance—because that person had moved away, or died—it was necessary to arrive at an explanation for this absence that the person with dementia would accept. This had to be done by

a careful process of trial and error. If, for example, the person asked often where their son was, it was necessary to find out, by experimenting with answers and watching their reactions, how old they believed their son to be at that moment. If they believed him to be a small child, then telling them truthfully that he was out of town at a medical conference, say, would cause bewilderment or suspicion; but if they believed their son to be a college student, telling them that he was playing in the garden would also be a mistake. Continuity was essential. Even a momentary glimpse of another reality that led patients to doubt their understanding of things could be horribly traumatic; all the more so because they would not remember exactly what they had been traumatized by, and so would be left only with a feeling that something was threatening and incomprehensible.

Garner’s method had much in common with improv comedy, following the same rules: Never say no to the reality you’re given; say “Yes, and,” building on whatever the other person said; don’t ask questions. It also called on the same skills—quick thinking, refusal to



"Sacrificing your queen pretty cavalierly, aren't we?"

be embarrassed, delight in the absurd. The best preparation for caring for a person with dementia, Garner thought, was learning such techniques at drama school. And, indeed, professional actors elsewhere were making that connection. Northwestern University's medical school was working with the Looking-glass Theatre Company, in Chicago, and Karen Stobbe and Mondy Carter, improv artists, were travelling around the U.S. giving workshops on the uses of improv in dementia care.

Some relatives worried that they couldn't make Garner's method work because they weren't good actors. They found the constant manipulation upsetting, and feared that their deceptions would be detected. Garner recognized that sticking to her method with the necessary consistency required a certain emotional remove. She concluded that in order to put her method properly into effect it was necessary for the relative to stop thinking of the person with dementia as their mother or father or husband or wife; they must start thinking of them, instead, as their client.

Other relatives worried that to lie was to betray a trust. To them, Garner said, "Grow up." To insist on the truth seemed to her immature and selfish when a vul-

nerable person's happiness was at stake. Having witnessed the desperate anxiety that could make life with dementia a hell for both the sufferer and their family, she felt that to worry that lying was bad was to miss the whole point.

Some dementia experts felt that Garner's method was unethical, because it encouraged delusions. The British Alzheimer's Society felt strongly enough about this that it issued a formal statement on the subject: "We struggle to see how systematically deceiving someone with dementia can be part of an authentic trusting relationship in which the person's voice is heard and their rights promoted." But to Garner the reality of people with dementia was not a delusion in the way that a belief that they were Queen Victoria or Napoleon would be: it was not a delusion but a *memory*. Her clients were living in reality—they were just using the reality of the past to understand the present. Besides, she wasn't promoting delusions; she was just refusing to correct them. "You're not actively *reinforcing* the idea that Fred is alive when you know he's died," she said. "You are simply *not disturbing* the idea that Fred is alive that the person with dementia already *has*. Imagine a conversation between two people in which one

says, 'Fred is so good at tennis,' and the other person says, 'Yes, Fred is good at tennis, but we can't forget that he's dead!'"

Garner was an outsider with no medical training, which made experts suspicious, but some were sufficiently impressed by what they saw at Burford to conduct studies. Positive results were published in *Aging & Mental Health* and in the *Journal of Social Work Practice*, and, more recently, Niall McCrae, a senior lecturer in mental health who specializes in the elderly at King's College London, embarked on a multiyear study of Garner's technique—both its effectiveness in improving patients' well-being and the feasibility of putting it into practice in places larger than Burford. "In a textbook of mental-health care, you will not see advice that you should meet the person with delusions halfway," McCrae says. "But, in reality, the best nurses, the best carers, do that." Garner's method allowed many people with dementia to avoid panic and misery and to live out their last years in a state of happy delusion—how could that be wrong?

Years ago, the philosopher Robert Nozick proposed a thought experiment: a person could be hooked up to an Experience Machine, which would provide any experiences the person chose, for the rest of their life, and which the person would experience *as* their life—the only catch being that it wouldn't be real. Would people want that? Nozick thought that they would not, because, as the medical ethicist Maartje Schermer puts it, people "not only want to experience certain things but also to *do* things, to *be* a certain kind of person and to live in *contact with reality*." Schermer believes that deceptive treatments of dementia patients have something in common with the Experience Machine, and to that extent they are suspect. But she feels that dementia changes a person in a way that makes the calculation different.

"The Experience Machine shows that there is more to the good life than merely experiences," she writes. "Well-being comprises more than just 'feeling good.' But this does not necessarily show us that illusory pleasant experiences have no value at all." To reject happy delusion on principle seems to her too puritanical, too rigid. Besides, she believes, once a person with dementia has lost the capacity to tell the difference between truth

and falsehood, or, really, to hold beliefs at all, that person has also lost the capacity to be lied to. "When there is only pain and no capacity left to deal with that pain, to really understand or come to grips with it, nor even to remember it for very long, then the truth cannot contribute to a good life."

In the memory-care unit at Chagrin Valley, it was time for the Tuesday-morning cognitive exercises. Kelly, a nurse, handed out pieces of paper on which the letters of the alphabet were written with dotted lines, so that they could be traced. Some of the residents could trace them easily; others could not do it at all. Rachel traced the letters carefully, with intense concentration, but she saw only the letters on the left side of the paper. "Jimmy, write me a sentence, any sentence," Kelly said, and held out a pencil. Jimmy Carter was one of the abler residents, in his mid-seventies—too able for tracing letters. He took the pencil from Kelly and wrote, "I Jim Carter would like to get out of this mud, out of hope."

Jimmy Carter was always cracking jokes, but he was also very unhappy that he couldn't leave. "I don't understand how I got here," he said. "They didn't tell me, they just dropped me off. The patients, some of them are bad. It's not for me, to be in a place like this." Kelly looked over Jimmy Carter's shoulder and read his sentence. "Why don't you tell me something about your company?" she suggested. He wrote, "My wife and I started our business forms company along with our 3 daughters. We have been for 4 years." A resident named Paul sat opposite Jimmy Carter and sketched him. The sketch was very good. George, who had been dozing, woke up and started singing "Yankee Doodle Dandy" in a rich bass voice, beating time on the arms of his chair.

Jim Beitel continued to wander, but his mood was very different from what it had been the day before. He no longer seemed distressed, just restless. When he tried to open a locked door, which set off an alarm, he raised his hands in mock fright, giggled, and moved on. Entering the dining room, he nearly walked into Carmen, and he shifted rapidly from side to side, as though joking that they couldn't figure out how to pass each other. Carmen was not amused, and waited for him to stop. He arrived back in the cen-

tral room and spotted the basketball hoop and the rubber balls. An aide saw him holding a small orange ball; she picked up a giant beach ball and showed it to him. He couldn't think of the words to say in response, but he knew the expression to substitute: he widened his eyes and tipped his head back as if to say, Whoa, that is a *huge* ball. A minute later, he remembered the words. "That's a big one, huh?" he said.

Later on, in the evening, Jim wandered over to Jimmy Carter, who was sitting in a rocking chair.

"How d'you get here?" Jimmy Carter asked Jim.

"I don't know!" Jim said.

Jimmy Carter pointed to the Abbey Road T-shirt that Jim was wearing. "The Beatles!" he said. "A great group."

Jim shrugged. "What the hell?"

"You figured out a way to get out of here?" Jimmy Carter asked him.

"No," Jim said.

"Me, either." They both laughed.

Some people in the dementia field, notably members of the Bradford Dementia Group founded, in 1992, by the late psychologist Tom Kitwood, believe that to think of the disease as a terrible harm is to think slightly of people who are living with it. They argue that, with proper care, a person can live as good a life with dementia as without—in some ways and in some cases even better. Sometimes relationships between a person with dementia and their family grow more emotional and intimate as talking falls away. Kitwood believed not only that a happy life is possible with dementia but that such lives could be instructive to the rest of us. "People who have dementia, for whom the life of the emotions is often intense, and without the ordinary forms of inhibition," he wrote, are "inviting us to return to aspects of our being that are much older in evolutionary terms: more in tune with the body and its functions, closer to the life of instinct."

One resident of Chagrin Valley who rarely came out of his room to participate in the activities was an electrical engineer from Mississippi named Ed Magee. Ed was eighty-four; he had

worked on nuclear-power-plants, and his work had taken him all over the world—he had lived in Indonesia, China, and Mexico. After he retired, he was living alone in Florida—he was divorced, and then his ex-wife, Anne, died—when his daughter, Linda, noticed that when they talked on the phone he asked the same questions again and again. Then one day he fell and hit his head and was found unconscious in his front yard. He was given a diagnosis of dementia and later moved to Chagrin, not far from Linda's home. Linda liked that Chagrin had what she felt were activities appropriate for male residents—a basketball hoop and a Ping-Pong table and a carpet with a miniature putting green. "My dad wasn't going to sit at a table making bunnies with cotton balls for tails, or glue beads to coloring-book pages," she said.

Linda did not lie to her father. This was not a moral position for her but a practical one: she wanted her father to understand the reality of his life for as long as possible, so she reinforced this every way she could think of. She hung family photographs on the wall of his living room and labelled them with the names of the people depicted. She hung up a whiteboard on which she wrote messages that pertained to his current anxieties and mistakes: "Always eat dinner!"; "Wear hearing aids every day! Turn ON!"; "If it's written on the calendar, it's correct." For a while, Ed had been preoccupied with the thought that he needed

to attend to a house he had owned in Alabama, so she wrote, "No need to move or go to Huntsville. You stay right here . . . permanently."

She emphasized that he was going to be in Chagrin Valley forever, because, while he understood that he was in a facility, he seemed to think it was a kind of rehab, from which he would eventually

be discharged and sent home. Often, Ed thought that he needed to go to his office, and he would call Linda or her brothers and ask them to pick him up. One of Linda's brothers sometimes went along and promised to take him, but Linda refused to do this. She believed he could still handle the truth. "There was one time when he was



getting upset that we weren't picking him up, and I told him, 'No, Dad, you've been retired since 1998, you don't work anymore,'" she said. "And he said, 'Yes, I do,' and I said, 'No, you don't,' and he said, 'Yes, I do,' and so I said, 'Where are the time cards?' He said, 'They're on my computer,' and I said, 'O.K., show me.'" As he turned to his computer and tried to find the time sheets, she began filming him. She wanted him to remember this moment. "After a long time, he realized there were no time sheets on the computer. And he turned to me and said, 'Wow, I've got to get with the real world.'"

Her father often called her many times in the middle of the night, and it got to the point where she wasn't sleeping, so she set up her phone so that after she went to bed only calls from the staff would ring through—the rest went to voice mail. One morning, she woke to see that he had called her twenty times between 1 A.M. and 4 A.M. "The first one started with a voice mail to the effect of 'Hey, Linda, it's Dad, I just wanted to let you know your mother isn't here, I can't find her, I don't know where she is, I'm going to go to the front desk and get them to call the police.' Then he left messages—'Hey, where are you, are you in the hospital, are you drunk, are you in jail?' Then the messages went to 'Hey, Annie, it's Edward.' My mother's name was Annie."

Her father had called her many times before, wondering where her mother was. He had forgotten that they had divorced, he had forgotten she had died. To Linda, it seemed that if he no longer understood these basic facts about his life he was lost, and she wanted fiercely for him not to be lost yet. So she called him back that morning and told him over and over, Mom is dead. Mom is dead. Mom is dead. Mom is dead. No matter how many times she said it, though, she sensed that it somehow wasn't getting through to him. Then the thought occurred to her that she needed to go back further. "I finally said, 'Anne is dead.' And he got real quiet for a moment. And then he said, 'You're right. I forgot about that.'"

For Linda, giving up trying to pull her father back into reality did not seem like a kindness, even if the truth was distressing. And many people with dementia, those who are still able to ex-

press an opinion on the subject, agree with her. A few years ago, Graham Stokes, a British expert on dementia care, chaired a study on ethical issues in the field, and included on his panel several people with the disease. "All of them said, Why do you lie to us when we are at our most vulnerable? Would you wish your relationships with others to be based on deceit? Why do you create fake worlds for people with dementia? Why do you convert care homes to look like pubs or cinemas? For me," he says, "that was a light-bulb moment. It shouldn't be about deceiving people. It should be about giving them meaningful lives in the present, rather than trying to keep them in nostalgic themes from the past."

Stokes was one of the people who pushed the British Alzheimer's Society to issue its statement condemning Penny Garner's method. To him, even passive lies—artificial worlds and fake bus stops—were just a lazy short-term solution that avoided deeper problems and engendered problems of their own. "It just creates confusion," he says. "You're standing in the hallway of a building and there's a bus stop. It's not easy—it's challenging when someone wants to go home. But that gives you an opportunity to talk about the desire to go home, because home represents something they're not getting in the present. I think that's a far more meaningful way of working than sticking up a bus stop when you know it's nothing more than a blazing lie."

There are practical problems with lying, too. Dementia doesn't proceed in a steady, systematic fashion; in most people, at least in the early and middle stages, periods of confusion alternate unpredictably with periods of lucidity. So if you tell someone their mother is coming to pick them up, and at that moment they remember that their mother has been dead for thirty years, they will know that you are untrustworthy, and might justifiably be suspicious of other people as well. Even if they forget the reason they don't trust you, the feeling may linger. (A study published in *Cognitive and Behavioral Neurology* in 2014 found that Alzheimer's patients feel emotions long after they remember their cause.) And, even if the person never glimpses, in an awful moment of lucidity, how they are being manipulated, still

they have lost something in the relationship, whether they know it or not.

Then there is the issue of inconsistency among all the people with whom the person comes in contact. What if a person with dementia asks for his mother, and one person says, "She's out shopping," another says, "I'm afraid she's dead," and a third says, "Are you feeling sad?" This problem is not a minor one. Many people with dementia are already suspicious of those around them. Some suspect that people are lying to them (and, of course, they are often right), or that someone who claims to be a relative is actually an impostor. Some suspect that their belongings have been taken (they may be right about this, too—residents of nursing homes often wander into one another's rooms and pick things up), or that they're going to be attacked. Some believe that the care staff have abducted their children. Even if they don't suffer from these more extreme fears, they will likely be aware that, since their diagnosis, other people suspect them of being confused whether they are or not, and so may be second-guessing what they say, or making decisions without consulting them. So the risk of arousing suspicion is a big risk to take, especially if the whole idea is to ease a patient's anxiety.

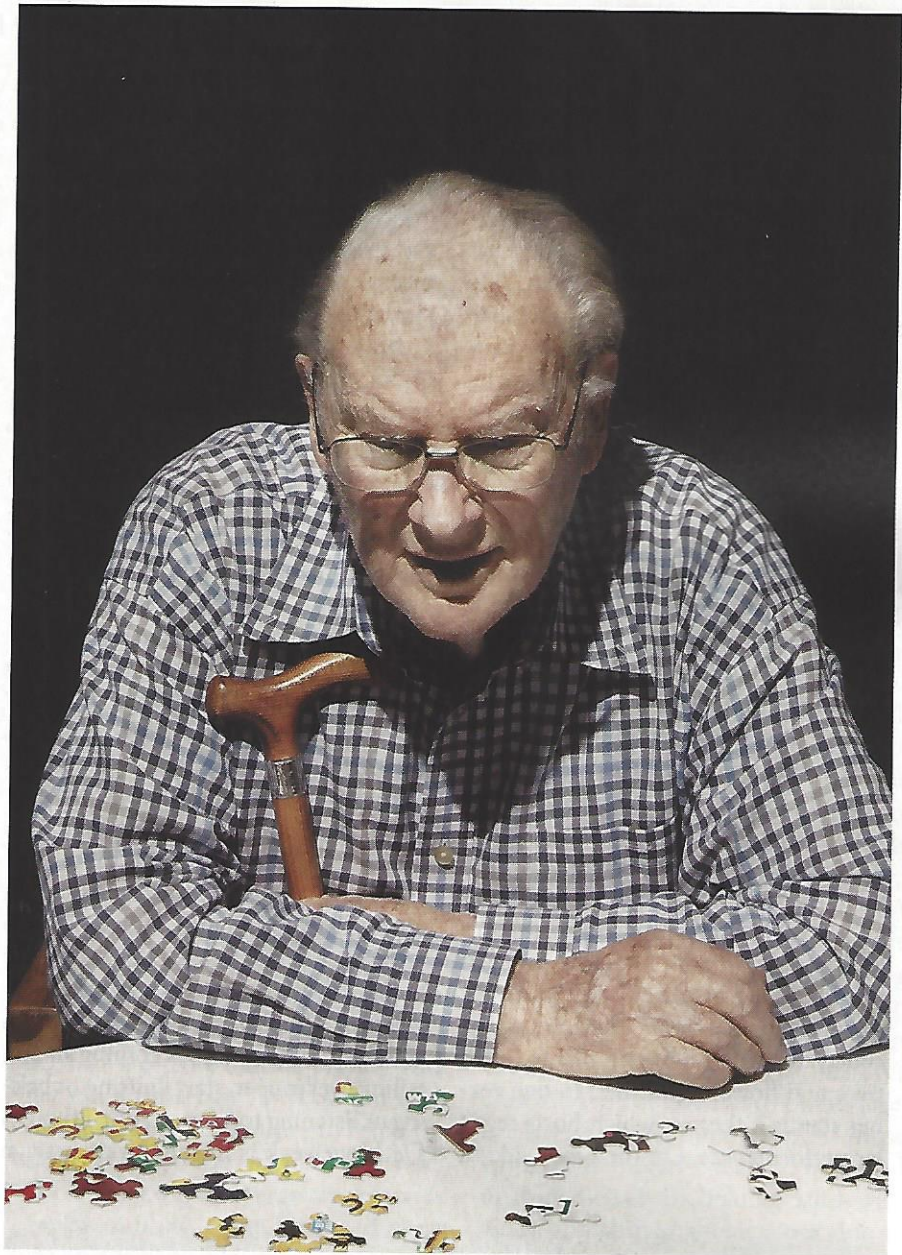
There is also the problem that, since lying implies a lack of respect, its acceptance can lead to disrespect of other sorts. "Most of the caring workforce is quite transient and not very educated, and you want to convey to them the value of the person they're working with," Graham Stokes says. "But, if they see you lying to patients, you're saying, They're not *really* people. And then you see other parts of the care changing: they might leave the door to the toilet open, while you wouldn't do that with real people."

It might be possible to deal with the problem of lying and dementia by means of advance directives. People already specify what sorts of medical treatment they want and don't want in the future, in case they later lose the capacity to make those decisions; could they not also specify how they want to be treated in other ways? Someone who most values happiness, however simple, might choose lies and medicine; someone who feels that life with late-stage dementia, without a certain degree of awareness, is not worth living might choose truth and death. The

trouble is, advance directives themselves bring up all kinds of problems in the context of dementia. Suppose a woman signs a directive that she is not to be lied to but, at a later stage of the disease, suffers terrible bereavement each day as a consequence—should her family feel obliged to respect her wishes? Or suppose a man believes that life with late-stage dementia is not worth living, and signs an advance directive to have all medical treatment withheld, even antibiotics, once he reaches that point; but then, when he does reach it, he seems very happy with his life—he still enjoys visits (even if he can't identify the visitor), his meals, beloved music, walks in the sun. Should his directive be respected, ending his life?

The late philosopher Ronald Dworkin believed such advance directives should be respected. People don't just live for pleasure, he argued; they also want to preserve their dignity, and to feel that their life as a whole has integrity and coherence. When people dread the total dependency of late-stage dementia, they don't just dread its effect on others; they dread the way it warps the shape and story of their life. For some, the prospect that they might live their last years content with childlike pleasures, kept happy with benevolent lies, would not be a relief but a horror. In the case of such a person, Dworkin believed, it is no more legitimate or kind to contradict their advance directive in late-stage dementia than it would be if they were in a permanent vegetative state.

Dworkin assumed that the man who dreaded late-stage dementia and the one who is perfectly happy are the same person. But what if the happy person can no longer remember anything about the man he once was—is he still the same person in any meaningful sense? And, if not, is it right to end his happy life in order to preserve the dignity of, in effect, somebody else? Also, does it make a difference what his family thinks about this? Whether they feel, in the later stages, that the person they loved is gone; or whether they feel that that person, though much changed, is still there—still recognizable in his body, in his smell, in his eyes, in his hands when held, in some of the things he appears still to delight in? Why should a person be defined by thoughts and memories? Aren't emotions and bodies enough?



The staff gives residents cognitive exercises, such as puzzles, tracing, and hangman.

Those who advocate lying to people with dementia are usually thinking chiefly, sometimes exclusively, of the short-term happiness of the person with the disease. They ask themselves, Will a lie prevent misery right now? Does it seem like the kindest thing to do? But, as the philosopher Sissela Bok, the author of the 1978 book "Lying," points out, the person with dementia is not the only person involved, or the only one who matters; and no lie is an isolated event. "You need to be very careful," Bok says. "What other kinds of harm might there be? The most important effect is on yourself. What am I doing to myself if I do this over and over? If lying becomes a habit? Will I start doing it when I don't need to? And, if I

start doing it with one relative, why not with others?" It is easy to imagine a white lie as a kindness that does no harm, Bok believes, but most lies do harm to someone. Lying resembles violence, she says, because it can coerce people to act against their will. Even lying for benevolent reasons risks a coercive kind of paternalism, and can be corrupting, like any other unchecked exercise of power.

Moreover, it is not only the liar's character that is at stake but also that of people around them who see and hear what they're doing. "Let's say it's a family with children listening in," Bok says. "There is so much lying in families anyway—how will children distinguish this from other kinds of lies?" A child hearing a

parent lie will be particularly affected, but so will anyone who hears another person lying without compunction—lying, in fact, in a spirit of kindness. The commitment to truth is very fragile, Bok believes. It can be preserved only if we believe that other people are also committed to it. “The veneer of social trust is often thin,” she wrote in “Lying.” “As lies spread—by imitation, or in retaliation, or to forestall suspected detection—trust is damaged. Yet trust is a social good to be protected just as much as the air we breathe or the water we drink. . . . When it is destroyed, societies falter and collapse.”

A few miles southeast of Amsterdam, in the small town of Weesp, is De Hogeweyk: a nursing home for people with advanced dementia which is both the source and the most fully realized version of many of the ideas in dementia care that are now being experimented with in Chagrin Valley and around the world. De Hogeweyk, which was founded in 2008, is far more elaborate than the Chagrin Valley streetscape: it is a three-and-a-half-acre campus of two-story buildings which looks like a modern neighborhood in a Dutch city. The front entrance opens onto a large outdoor courtyard with a fountain planted with trees and flowering bushes. In one corner stands a theatre, which hosts regular performances. On the other side of

the courtyard, a glass door leads into a small indoor mall that houses a restaurant; a pub, the Café de Hogeweyk; a room for art and cookery classes; and a little supermarket. From the main courtyard, a passage leads past more storefronts—a physiotherapy center; the Mozart room, where the classical-music club meets—to other courtyards, where the residences are.

Staff at De Hogeweyk refer to the places where residents gather, and which are designed to look like normal homes or shops or courtyards, as “onstage.” “Backstage”—the administrative and medical infrastructure of the nursing home, the charts and the records, the medications and the stretchers—is kept out of sight. Everywhere in De Hogeweyk, the physical and psychological atmosphere is curated with attention to the tiniest detail. The Mozart room, for instance, is decorated with chandeliers, gilt mirrors, and busts of well-known composers, so as to create a setting congenial to aficionados of classical music. Activities, it is thought, are more convincingly enjoyable if they take place in appropriate surroundings, and it is also important, if the houses are to feel like homes, that club activities take place elsewhere. After all, in a normal living room you don’t have strangers coming in and telling everyone to start knitting or baking or listening to Mozart. But although De Hogeweyk is in some ways a stage

set, to call it fake would be too simple. The supermarket, for instance, is part real, part fake: there are few price tags, and most transactions don’t involve money, but the store stocks real food that is needed to cook real meals in the houses, and, when the aides bring residents to shop there, their purchases are tallied at the checkout.

Spread across the complex, there are twenty-seven housing units, divided among four different “life styles.” De Hogeweyk’s founders wanted life there to feel normal, which to them meant that you lived in a small, family-size group—no more than seven—consisting of people like yourself in matters of background, taste, and ideas. At the haute-bourgeois “Gooise” houses, for example (named for Het Gooi, a prosperous region in the middle of the Netherlands), classical music is played, apéritifs and wine are drunk, and manners are formal; residents eat on tablecloths under a chandelier, and dinner is served on individual plates, as in a restaurant, rather than family style, on platters. The “urban” life style denotes informal, gregarious manners, brightly colored décor, popular music, and beer. In the “homey” houses, décor is plain, the residents listen to folk music, and meals are traditional, involving lots of potatoes and avoiding anything too foreign, such as pasta. There used to be houses for other lifestyles, too: a Christian house and a house for the inhabitants of the former Dutch East Indies, whose rooms were kept warmer and more humid than those in the other units.

Once a person has dementia, the time for novelty and cosmopolitanism is past, the staff thought. The guiding principles at De Hogeweyk are familiarity, comfort, like-mindedness. And although some houses are more materially luxurious—the linens and the glassware in the Gooise houses are of a finer quality than those in the other houses, for instance—the cost to the resident is the same: the life styles are not supposed to be aspirational. Before a new resident arrives, their family is interviewed to determine the life style that seems most appropriate, which means the one that they are used to.

In an effort to make the houses feel as homelike as possible, the domestic tasks are not centralized but performed



Kanin

“Quit hogging the covers!”

house by house, as they are in a normal neighborhood. In the morning, an aide from each house, often accompanied by a resident, goes to the supermarket to pick up supplies for the day. Each of the houses has its own kitchen where the meals are made. The residents can help to prepare the meals, chopping vegetables and washing dishes, all of which breaks up the monotony of the days. Even if they don't want to help (and in the Gooise houses they rarely do), they smell the meals as they are cooking, in the way that you do in a normal home, and so they are less likely to be taken by surprise when a plate of food appears in front of them and they are invited to eat.

The staff of De Hogeweyk wanted to get away from traditional institutions, Eloy van Hal, one of the founders, says—"where you're locked up indoors, where you are living in a big group with nice nurses running around in white uniforms saying, 'Please be seated, please be seated.'" In a traditional nursing home, residents sit around on chairs in large, clattery dayrooms, the television turned up loud, surrounded by noisy crowds of odd-seeming people and nurses bustling about. The lights are too bright, the furniture and pictures are ugly. There is nothing to do other than some childish crafts, and nowhere to walk to. The residents almost never go outdoors. Small wonder, van Hal and his colleagues thought, that they began acting in ways that staff found difficult to deal with—banging on tables, shouting, kicking at doors, trying to get out.

The door from De Hogeweyk to the outside world has to be locked. Many people with dementia wander and become lost, so they can't go outside on their own. But within De Hogeweyk residents who can get about by themselves are allowed to wander where they like—along the brick paths, through the indoor mall, up and down in elevators. The staff were told by experts that it was too dangerous to allow such a thing, that unsupervised residents would climb into the fountain or eat the leaves off the bushes. But the founders believed that it was better to accept some risk for the sake of freedom, and that Dutch people didn't eat bushes or climb into fountains, and, in fact, in all the years that De Hogeweyk has been open only one resident has ever climbed into the

fountain, and she did it on purpose, to annoy the staff, because she was angry that she couldn't leave. So the residents walk about freely and sit around in the courtyards, watching people go by.

Early in the morning, aides and some residents came from the houses to shop at the supermarket. Members of the baking club turned up for their meeting at the cookery room. Aides gathered for a morning coffee at the table outside the pub. It was pleasantly noisy in the indoor mall—supermarket carts rattling along the brick floor, aides calling to one another as they walked by, jazz audible through the open door of the Café de Hogeweyk. An elderly woman wearing a lilac scarf and a hot-pink jacket scooted past in a motorized wheelchair. Another woman, in red jeans and a purple fleece, strode rapidly through the mall, carrying a large zippered bag, and soon afterward strode equally rapidly back in the other direction. A woman with a long gray braid and a stricken look wandered slowly around, murmuring to herself.

In the late morning, a group of young mothers and their toddlers began to gather at the tables in the main courtyard. Some weeks earlier, a staff member had spotted a mother playing with her child on a tiny lawn on a nearby street, and had invited her to bring the child to play in the spacious courtyards of De Hogeweyk. Now groups of ten or twelve mothers came for lunch every Wednesday, and their toddlers ran about with their toys. Since the residents of De Hogeweyk can't go outside, the staff tried to cultivate a more normal atmosphere by bringing the outside in. The restaurant was designed to emulate a chic urban establishment, with statement ceiling lamps and a fifteen-foot-high backlit bar, in order to attract people from the town to eat there. At midday, two coroners, a man and a woman, both wearing black suits, walked quickly through the mall to the residences on the other side. Sometime later, they returned, wheeling a coffin out through the courtyard, past the mothers and children.

After lunch, the mothers packed up and left. A little later, an elderly man in a beige windbreaker who had been walking restlessly around all morning came upon their now empty tables and chairs.

He picked up the chairs one by one and rearranged them by type; then he moved about the area, picking up dead leaves and tiny bits of rubbish from the ground and depositing them in a trash can.

At two-thirty, there was to be a piano-and-harp concert in De Hogeweyk's indoor mall. Two rows of chairs were lined up to face the piano, and each resident was guided to a seat. Before the performance, an aide wheeled a cart around, offering wineglasses filled with *advocaat*, a traditional Dutch alcoholic drink resembling thickened egg-nog, which isn't drunk much anymore but used to be served at special events by older generations.

The pianist played and sang old songs that everybody knew—"Edelweiss," "O Sole Mio," "The Blue Danube," "Moon River." Many in the audience sang along: some people with dementia who can no longer speak can still find the words to sing. Then the harpist took her turn, and she, too, played well-loved music that was deeply familiar—"Jesu, Joy of Man's Desiring," "Ode to Joy," Brahms's "Lullaby." A woman in a blue cardigan knew the words to Brahms's "Lullaby," and sang along in a strong alto voice. A man in a wheelchair wearing a pale-gray blazer beat time to the music with his eyes closed, a look of intense joy on his face.

After a while, some people—those who could—began to dance. They stood up from their chairs, holding hands with aides, and shifted slowly from side to side. The woman with the gray braid and the stricken expression walked to the middle of the floor but then stopped to listen to the piano. The harpist, standing there while the pianist played, smiled at her and offered her hands; the woman smiled back and accepted her hands and began to sway to the music. The man in the beige windbreaker, who had not stopped moving all morning, had stopped now, and sat in the back row. The music was neither fake nor true. It was both past and present, and could be understood without fear of mistakes or forgetting.

The harpist played "Greensleeves." The pianist played "Für Elise." Administrative staff emerging from a meeting on the second floor of the mall leaned on the railing of the balcony outside and stood with the residents to listen. ♦