The Senior Center and the Dying*

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The Senior Center and the Dying

A community based, multi-service system whose stated purpose is to provide a program that will enhance the quality of independent living can also play a supportive role for the dying. When we opened our Senior Center five years ago we did not anticipate nor plan for the fact that some of our dying members would spend their final days in our midst. Denial was operating from the inception of the program. Nevertheless our dying members made their needs known, bringing their own agenda to our program in the hope that their peers and the Center staff would provide the help that was needed at a crucial period in their lives.

Gradually the participants and staff of the Senior Center became aware that they were being asked to provide a supportive relationship for those who seemed to sense their approaching death. Frequently the request was a covert message from a marginal member of the group with poor social skills who could not verbalize his need for help nor tolerate the structured intimacy of the casework relationship. The message was often expressed in behavioral changes such as confusion, disorientation, agitation and increased dependency. These are the kinds of changes that can precede or accompany a major physical change that is experienced as a narcissistic injury. By his continued steadfast presence in the face of major deterioration, the member demonstrated the need to remain among the living; the wish to be seen and acknowledged; and the need to be nurtured. These individuals publicly acted out their need to deny and the wish to postpone death. The members of the Center responded as a supportive surrogate family, providing a refuge from the isolation of preparing for death alone. They joined their failing member in expressing disbelief, denial and anger; in turn projecting their feelings to staff.

The program described here is jointly sponsored and staffed by three separate agencies: Council for Jewish Elderly, Jewish Community Centers, and Jewish Family and Community Service. It represents a pioneer effort to combine supportive and adjunctive service, group service, and individual treatment into a single service system. Staff from the three agencies function as a team. Our facilities consist of a small neighborhood drop-in center, and a senior adult center that offers a five-day program of recreational, educational activities, and a daily hot lunch which is staffed and partially funded by the Chicago Office for Senior Citizens and Handicapped. Casework service is available to the Center members and the community at large on a fee basis or subsidy. Service includes outreach and assessment, advocacy, crisis intervention, and long-term counseling. The population served is representative of the urban community where it is located, near

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a large university. It includes a broad range of socio-economic, ethnic, and religious groups.

This article will deal with the evolution of the supportive role played by the Center for its dying members. This function of the Center was not part of a formal service plan. Rather, it emerged as a response to the unique way that our members were using their relationship with the Center. We now realize that the gradual growth of a cohesive Center population capable of providing peer support during a crisis is an essential component for the successful performance of this role, much as a family system develops its nurturing role around the changing needs of its members.

The Center Population

The concept of creating unity out of diversity was a major theme that permeated all of our early efforts to launch the Senior Center. The goal of developing a unified service system soon expanded to include the goal of helping the participants grow together into a group with a strong sense of Center identification that could allow for expression of diverse personal needs. Shortly after the Center opened, we became aware of the wide range of differences represented in the members. In addition to the diverse socio-economic backgrounds represented, there were marked variations in level of functioning, which appeared to divide the members into three broad groups with mutually incompatible needs. The amount of deterioration evidenced was a significant factor in this disparity. For the purpose of this paper the groups are described in terms of level of function. They are referred to as the frail, or least able group, the intermediate, and the able group.

The Frail Group

Staff attention quickly focussed on the presence of a number of people readily identified by their shabby personal appearance, poor social skills, and lack of interest in program. Most of them are over the age of seventy, with some physical, mental or emotional impairment. However, the group includes a number of younger, more affluent, verbal people as well. They function as a number of individuals engaged in the parallel process of gratifying intense personal needs. Their one common interest lies in the daily hot lunch. Their affect is passively depressed or overtly demanding and hostile. They are highly sensitive to personal slights and changes in procedure, and are capable of acting out when they feel threatened. Their dependency needs are demonstrated in the way they form relationships with the staff who fulfill the role of care-giver, such as the bus driver, the receptionist, and dining room staff.

Mrs. N. is an example of this group. She was a lady in her eighties who lived in a hotel sleeping room with no cooking facilities. She used her multiple physical problems to dramatize her demands for help. Mrs. N. delayed seeing her doctor until she was in crisis. She was alienated from her daughter, who lived in a distant city. Mrs. N. was referred to us by a relative who could not deal with her frantic telephone calls demanding to be rescued from harassment by fellow tenants who were intent on stealing her valuables. She carried two large shopping bags, presumably containing her worldly goods. Mrs. N. quickly became one of the regular early arrivals, aggressively demanding her morning coffee and cookie. The rest of the morning was devoted to negotiating the purchase of her meal ticket, checking the menu and impatiently inquiring when the food would be served. In spite of her need for instant gratification and special attention, she was coy and seductive in a charming way that enabled the staff to relate to her. She created havoc in the dining room, insisting on being first and clamoring for special service. After consuming her meal in zealous silence, Mrs. N. retreated to the lobby to await the afternoon bus pick-up. No amount of urging could persuade her to linger for program in the dining room.

Staff felt powerless to deal with her energetic displays of temper. Our stance was alterna-

tively confronting or permissive, reflecting the split in the attitude of the peer group. Mrs. N. actively resisted any involvement with the social worker. My role was to help staff recognize her need for nurturing, admiration and structure. Staff was helped to sort out their feelings about their role as professionals to serve as models responsible for setting limits which the group felt unable to impose themselves. They learned to develop effective ways to cope with Mrs. N.'s acting out and to find creative approaches to meet her needs. They adopted a firm, consistent manner, while responding to Mrs. N.'s wish to be pampered. A volunteer was assigned to escort her on special shopping trips. She responded with a show of grace and charm as she came to feel valued as a member of the group.

As Mrs. N.'s health deteriorated, she became increasingly confused and agitated, trying the patience of her peers, who soon began to express the view that she belonged in a home. Following major surgery, Mrs. N. remained firm in her refusal to enter a home. She was provided with a home-health-aide following her release from the hospital, whom she quickly dismissed in order to return to the Center. When a second medical crisis erupted, the doctor insisted that Mrs. N. enter a home, where she died within a few months.

For Mrs. N. the structured atmosphere of the Center and the recognition she received from the staff, increased her sense of self and provided a sense of continuity which she had been unable to sustain alone in her cluttered living quarters. Our ability to set limits on her chaotic behavior enabled her to experience some level of control.

The Intermediate Group

This group consists of a number of solid, self-assured individuals with good social skills, and/or leadership ability, who are capable of assisting with planning and implementing program. These people are strongly identified with the Center. They are involved with classes, recreational activities, volunteerism and the hot lunch program.

Mrs. P. is representative of the intermediate group. She was a volunteer who developed a long-term relationship with the social worker as a result of her volunteer work. Mrs. P. was a strikingly attractive, dynamic lady in her late eighties, a survivor of the holocaust, who had recently retired from a career as a bookkeeper. She was a proud perfectionist who was very selective in her choice of friends, preferring intellectual men to frivolous women. The need to deny her aging and the impact of retirement intensified her loneliness and the pain of alienation from her only son, whose wife was unacceptable to her.

Mrs. P. had grown up in an orphanage. She had two unrewarding marriages, both ending in divorce. Her initial reluctance to become involved with the Center was overcome when she was offered a job as a volunteer-receptionist, which enabled her to enjoy the prestige of identifying with staff. She achieved status when she was awarded a plaque as volunteer of the year. Mrs. P. maintained a steadfast avoidance of program, preferring solitary pursuits. In the Center she enjoyed a brief relationship with a handsome gentleman who shared her appreciation of art.

Mrs. P. frequently sought me out to express her loneliness and conflicted feelings about her relationship with her son. She demonstrated a need to ventilate but was not available for close scrutiny or any ongoing sessions. Her need to be loved and her inability to say no was played out as she assumed a caretaker role for some of the very needy members. When this role became overwhelming because of her tendency to overextend herself, she came to me to rescue her.

As failing health and advanced age affected her memory, her performance as a receptionist deteriorated. Staff was conflicted about relieving her of this position, aware of her vulnerability. The professional team designated a special volunteer assignment for Mrs. P., utilizing the caretaker role she had developed on her own. She was assigned to assist one needy individual at a time, frequently a different one each day. Mrs. P's most significant relationship in this new assignment was with a confused, partially aphasic former professional man who responded warmly to her. In my role as consultant to volunteers, I became Mrs. P's supervisor; thus providing an opportunity to develop a relationship as co-worker therapist.

Periodic flare-ups of chronic physical problems precipitated a stormy period of medical crises, culminating in placement in a Home for the Aged at the insistence of Mrs. P's son and physician. Her desperate need to deny the imminence of death, which she perceived within herself and observed in her fellow patients, led to an angry and hasty self-discharge. She returned to the Center, which she called her home, frequently feeling quite ill. When she became homebound, I provided support through weekly visits, enabling her to share the fear she experienced alone at night. Mrs. P. seemed to have made a conscious choice to endure this anxiety, sustained by the benefits of remaining in her own surroundings with some help from a neighbor. She reviewed her early life experience, expressing personal goals and values that guided her life; and reflected on the meaning of her relationships at the Center, where she felt appreciated and loved. She described a period of disorientation that she exprerienced in the hospital, when she felt she had been kidnapped by a gang of murderers. Mrs. P. was ashamed of this sign of mental deterioration but found comfort in recognizing it as a transitory experience. A few days later she was found by a neighbor, after she collapsed in her apartment.

Mrs. P's volunteer assignments at the Center as an office worker and a care-giver helped her deal with the loss of status she experienced in her retirement. Her need to feel special was fulfilled through her recognition as volunteer of the year. Within the informal atmosphere in the Center she was able to pursue her interest in men on a selective basis that enabled her to maintain the distance she needed. The opportunity gradually to develop a close relationship with the social worker was a new and meaningful one for her.

Mrs. P's son remained aloof during most of my contact with his mother. During the last six months of her life he consulted me by telephone, usually asking for my support in urging his mother to enter a home or accept a part-time companion after one of her hospitalizations. My role with him was to help him understand his mother's need to struggle alone. When Mrs. P's son telephoned me at home on the weekend to inform me of his mother's death, we spent some time reviewing the events of the past few months in terms of Mrs. P's intensified need to maintain her super-independent stance. Her son seemed to recognize that he had not failed her when he allowed her to take the risk of dying alone, much as she had lived most of her life.

The Able Group

The large number of able, sophisticated elderly in the community at large are not well represented in the Center population. They use the Center to pursue selective special interests, seldom lingering for the socializing which might lead to closer involvement. These people are still actively engaged in pursuing goal-directed lives. They find it painful to contemplate the deterioration of the frail group, who seem to have no sense of meaning or purpose in life. Many of these able people are quite vocal in expressing their negative feelings about the Center. They cannot identify with the presence of the frail nor what they perceive as the "soup kitchen" atmosphere of the Center.

Role of the Social Worker

The role of the social worker in this setting is unique in terms of the quality of the worker-client relationships that develop. The social worker serves as a teacher-consultant for other staff and volunteers. There is an opportunity to observe the operation of group dynamics within the Center population and in their relationships with staff.

Visibility and proximity provide opportunities to develop informal relationships with resistant clients who need to maintain some distance. Some people are able to actively seek me out for help. Others will find their way into my office to ask for help for a friend or for themselves when they are feeling overwhelmed by the friend's needs. Proximity is a factor that enables me to respond quickly to crisis situations. These contacts may be brief and transitory; or they may lead to a more lasting relationship. Crisis intervention is more meaningful to the client when the worker is a familiar member of the Center staff. There are opportunities to monitor client func-

tioning and interaction with the peer group and with other staff. Changes in physical and mental conditions are more readily apparent when there is frequent contact. In this respect, input from the Center members and other staff is useful and valuable.

Many of these people do not become formal clients of the agency. When they present management problems for staff who are directly involved with them, my role as a teacher-consultant enables me to provide guidance and support, as in the case of Mrs. N. The role of teacher-consultant is further developed in my relationships as supervisor of volunteer friendly visitors. In this respect I am frequently called upon to present material for in-service training for volunteers and for staff.

As a representative of a family casework agency, I serve on the professional team along with staff from the other sponsoring agencies. In our staff meetings, program, services and individual needs are evaluated. In this respect the social worker's role is similar to a team member in a residential setting. This experience provides an additional opportunity to observe and experience group dynamics at work within our staff group as the members of each agency reflect their own viewpoint as well as the professional goals and approaches of their agency. Working in an outpost creates a sense of isolation for each of us. In spite of the diversity of agency policies and the tug exerted on us by dual loyalties, we have developed a sense of professional autonomy that is stimulating and rewarding. Each of us has benefitted from the individual professional growth that results from this kind of experience. We have developed into a cohesive group capable of providing support and direction for each other. This enables us to approach the task of integrating the different member groups into a cohesive Center population.

The Struggle for Cohesion: Impact on Staff

The disparity among the member groups presents a challenge for staff, whose goal is to provide program and services for as large and diverse a group as possible. Their efforts to meet the variety of needs represented are a reflection of peer group attitudes; professional self-image and goals, and interface issues around deterioration. We are aware that the groups feel threatened in each other's presence. The able group can verbalize their fear of the deterioration that they perceive in the marginal group. The frail group acts out when they feel threatened by the presence of more able people. They become competitive and more demanding. Staff feels responsible for promoting indigenous leadership, self determination and harmony. We are uncomfortable with conflict but willing to accept the challenge of its presence. At times our need to achieve our goals exceeds our awareness of the amount of time and effort required to fulfill them.

The predominant theme in our staff meetings was one of impatience and frustration. In our role as authority figures we resembled young parents engaged in the task of developing a strong family unit capable of sustained harmonious function. We too experienced the effect of the massive apathy and overwhelming depression transmitted by the frail group. The challenge represented by this group lies not in the level of their involvement, which is intense, but in the quality, which is narrow and limited. Their unresponsiveness to program leaves group workers feeling discouraged, unable to achieve their goal of enriching the quality of life. The challenge of the able group lies in their resistance, which stems from the fear of their own aging. Their uninvolved stance stirs up a sense of failure on a different level. Staff's need to deny or postpone their own aging evokes a sense of shared values and needs with these able

people. The group worker longs for the stimulation and rewards of working with this so-called normal population. These are the people who are able to respond to creative program with vigorous participation and enthusiasm. These are the people with some capacity for leadership and self-determination. Constructive involvement of this group could have a positive effect in resolving some of the fears of their own aging.

For the caseworker, whose goal is to facilitate adjustment to life stage issues, intense preoccupation with dependency needs is viewed as a means of warding off fragmentation and deterioration. I am accustomed to working with clients who are struggling to hold themselves together. My goal for these people is to sustain the level of function they have been able to maintain. I am familiar with death, as several of my clients die each year. I view the frail group as highly vulnerable. I feel a need to protect them, to reach out to them.

I am well aware of the challenge of working with resistant clients from the able group who are faced with adjustment problems that arise around aging. Many of them have well-functioning defenses which can be reinforced. They usually do not come for counseling until their defenses are no longer functioning. The number of clients from this group is a small proportion of my caseload. I too feel a need to reach out, to do some preventive work with them. I too yearn for the stimulation of working with people who are available for self-scrutiny and insight; people who can work actively to achieve growth in their final stage of life.

Staff's approach to these problems reflects the influence of administrative requirement of monthly statistics showing the number of participants. There is a sense of urgency to achieve, in order to justify the existence of the program and the need for additional funds. The burden of diversity makes the task more complex. Staff is periodically pulled to focus on the larger, more homogeneous able group as the target population. They hope that a sophisticated, charismatic session worker will attract the able group to her weekly sessions, exposing them to the rest of the program. The able intellectuals appear for this program only and abandon the site when the session worker's contract is not renewed because of lack of funds.

Staff feels frustrated by the makeshift, inadequate facility we operate in a residential hotel. The rooms we use are available only until 3:00 P.M. and are shared with the hotel caterer. We compare our site with modern, well-equipped centers in suburban areas that attract a large, homogeneous population. We seek out alternative sites to hold special classes for the able group. A building group formed in a high rise, where many of the able reside, is disbanded after two years due to waning interest and inadequate meeting space.

Periodically the focus is on the nutrition site, which occupies a disproportionate amount of our space. We consider replacing the subsidized meal program with a self-supporting snack bar manned by members, a model which works well in other areas. Staff attempts to design programs to appeal to the limited interests of the marginal group meet with minimal success. I conduct a discussion group on life stage issues and reminiscing as part of my agency's Family Life Education program. After two years the series is not repeated due to small attendance and pressure for time and meeting space in the program schedule. Group work staff are assigned to the lobby for an hour after lunch to stimulate an expression of topics of interest to the lobby sitters. They make it quite clear their needs have been met when they find a comfortable chair.

Eventually our members made themselves heard, as they spontaneously sorted themselves out and began the process of forming a Center population based on mutual needs

and continuity. The sophisticated able, with more choices available in the Jewish community, remain aloof or minimally involved. The intermediate group slowly expands. They find the Center atmosphere sufficiently rewarding to enable them to tolerate individual differences, deviant behavior and deterioration. Many of them serve as role models for their peers or they assume leadership in the operation of Center programs. The frail group, with less choices available, remain firmly attached, many of them quite comfortable in the role of lobby sitter. The needs of the group, attitudes and feelings transmitted by staff, and the passage of time resulted in the emergence of a Center population with a sense of cohesion and loyalty..

The group uses the Center to transact the daily business of living much in the pattern of a surrogate family in gratification of individual and group needs, role relationships, behavior and communication patterns, issues of control and authority. Heinz Kohut views late mid-life as a period when deficits of the self are intensified. He describes this period as a time of hopelessness, lethargy and depression. In old age there is the added loss of sources of narcissistic gratification. Identification with the Center as a source of recognition, nurturing and support enables our members to experience some enhanced sense of self. Through this experience they are better able to participate together in "the struggle of the threatened self under the impact of old age, physical decline, and the imminence of death."[1]

Mr. D. is an example of a member with a diagnosed terminal illness. My relationship with him spanned a period of three years. His illness developed in the early part of the third year.

Mr. D. was a seventy-five year-old bachelor who became known to me around problems with his landlady, which prompted him to become intensely involved in the Center, where he frequently played a disruptive role. He was a scholarly Orthodox Jew with a poor work record, who lived with his mother until she died when he was fifty-five. He lived a miserly existence in the low rent district of the area, hoarding huge quantitites of food which he purchased on sale. His only relative was a married sister, from whom he was alienated. Mr. D. was an argumentative, suspicious, sensitive man with a deep sense of personal deprivation and low self-esteem. Unable to tolerate close relationships, he antagonized his peers by introducing conflict into every encounter. In spite of these qualities, he had a reverence for life, a sense of humor and a colorful style of self-expression typical of the *shtetl* Jew. He was an enthusiastic participant in programs of Jewish content. He gained a heightened sense of self-esteem through his contributions to discussions and his role in reciting the Sabbath Prayer. He demonstrated creative talent in the Yiddish poetry writing class.

Over the years I became a significant person for Mr. D., functioning in the dual role of advocate and adversary in terms of imposing limits. I served as a role model for staff, who were engaged in ongoing struggles with Mr. D. around issues of control played out in his need for instant gratification and special service. When he became ill with an incurable cancer, he became depressed and secretive, absenting himself from the Center. The information about the nature of his illness came from his sister, who could not deal with his frantic pleas for help. His chaotic behavior in the hospital had prompted a hasty discharge with a recommendation for placement, which he refused. The sister wished to enlist my help in persuading her brother to accept placement.

When Mr. D. returned to the Center, he responded to my efforts to reach out to him by sharing the secret of his terminal illness. He was enraged with the treatment in the hospital, which he perceived as punitive and dehumanizing. His distrust of the doctor assigned by the hospital complicated treatment. I supported his wish to remain in his own home as well as his decision to discontinue chemotherapy, when side effects developed. Mr. D.

[1] Heinz Kohut, *The Restoration of the Self.* New York: International University Press, Inc., 1977, p. 289.

was seen regularly, providing an opportunity to express his disbelief and anguish.

Eventually he remobilized his role as a tragic victim, one that served him well thoughout his lifetime. Mr. D. used the casework relationship to articulate his ambivalence about death, recognizing the inevitability, while hoping for extra time. His fear of pain and the unknown was expressed in a wish that death would come quickly. Mr. D. came to realize that dying is a long, difficult, lonely experience. His wish to avoid placement was tempered by the fear of dying alone. My conviction that he would recognize when the time came that he could no longer remain alone gave him courage. Mr. D. continued his regular attendance at the Center, seeking me out to share the anxiety that accompanied each change he experienced. He felt intense shame about his physical deterioration, angrily brushing aside the concern expressed by his peers, for fear that they would find pleasure from the knowledge of the seriousness of his illness. As his neediness and demands for service increased, staff and volunteers provided extra help. He found comfort in the knowledge that the Jewish agency was taking care of him. Following a sudden change in his condition over a weekend, Mr. D. called the Center to report a new cluster of symptoms. Mr. D. was admitted in the midst of a heated argument about the ambulance fee. He died in his sleep that night.

Elizabeth Kubler-Ross describes the need of the dying patient to be surrounded by familiar objects, sights and sounds; the smell of food cooking to be a part of the daily routine. The Senior Center provided this opportunity for Mr. D., who felt more secure there than in his own apartment, where the threat of dying alone was ever present. "We can keep it a secret or we can share the struggle . . . thereby not only giving us an opportunity to grow, but giving the ones with whom we share it an opportunity to grow through the turmoil."[2] Although Mr. D. could not openly acknowledge his illness to his peers, they were aware of his deterioration and were able to be supportive. His courage and determination provided a unique example for all of us who now realize that it is possible to embrace life while awaiting death. The fulfillment of this goal which he set for himself was a growth experience for Mr. D. in his final stage of life. My relationship with him during this period was the impetus for a spurt of professional growth which I continue to integrate in his absence.

Impact of Deterioration on the Center Members

The reaction of Center members to the increased deterioration of one of the group reflects a variety of coping mechanisms and defenses. Disbelief and denial are displayed by those who seem unconcerned with and unaware of the change that is occurring. They are angry that the sick one needs more help and special attention, and surprised when the sick one dies. Others can express their sense of vulnerability. Others respond with solicitous nurturing behavior. When they feel overwhelmed by the task they look to staff for relief while endeavoring to control the level of our intervention. They question whether the sick one should be encouraged to stay home, coerced to seek medical care or consider placement. Anger toward adult children who seem to abdicate responsibility by allowing their parents to take risks is displaced to staff, with the implication that staff is not sufficiently concerned. Their feelings about parent-child relationships and their own wish to be cared for become evident. The predominant theme is a wish to postpone or avert death. Following the death of a Center member, there is a great deal of rationalizing in the peer group about their inability to attend the funeral. Staff are contronted with their failure to attend and are accused of cold indifference.

[2] Elizabeth Kubler-Ross, *To Live Until We Say Goodbye.* Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1978, p. 14.

Impact of Deterioration on Staff and Implications For Program and Treatment

When one of the group begins to fail, the anxiety level in the group is quickly felt by staff, who experience a need to protect them from witnessing the decline of one of their members. The bus driver feels uneasy when the sick one stumbles as he alights from the bus near his home. The social worker is assigned to explore needs for help and provide support. Staff is well aware of the availability of paramedics in emergencies. Over the years staff has come to recognize the kinds of choices and risks that people choose to take. They function as role models for the rest of the group in providing reassurance and acceptance of the feelings expressed.

The expectations and demands of the group around the issues of death prompted staff to evaluate the way they were reacting to group pressure. Staff's response to the angry criticism by one member had been alternately defensive and reassuring in an effort to relieve what they perceived as their own feelings of guilt. A parallel process of defensive projection emerged as we found ourselves focussing on the reluctance of the members to attend funerals. Historically we have questioned their behavior and viewed it as indifference in much the same way as our members had viewed us. We were able to translate the anger of our members as an expression of fear and their own death. They were able to express their discomfort in witnessing and responding to expressions of pain or sorrow from the bereaved. Implicit in this discomfort is a sense of obligation to relieve the pain we witness, which stirs up feelings of helplessness. Our personal fear of experiencing this kind of pain became apparent. We explored attitudes about staff attendance at funerals, an unresolved issue which we struggle with periodically. Some of us were firm in our conviction that funeral attendance should not be mandatory or routine. Others felt an obligation based on the need to demonstrate to the living that we care. There was agreement that selective attendance at funerals might be interpreted as favoritism. We remained united in our need to maintain the freedom to exercise individual clinical judgment about funeral attendance based on the nature of our relationship with the deceased, availability of family, or the need to provide a supportive presence for survivors.

Early this year we developed a staff in-service series on death and dying using selected readings and personal experience as a basis for our discussions. Rabbi Gary Gerson's article on the Psychology of Grief and Mourning in Judaism[3] was particularly significant as he highlighted the Jewish view of death as a natural and acceptable experience to be shared by community and family. "The sense of reality of death is encouraged from the moment of death itself; it is to be witnessed."[4] The insights into human needs and behavior that underlie Jewish customs of mourning enabled us to understand our own reactions during periods of grief and the validity of Jewish mourning practices.

The Center continues to acknowledge the death of a member by written condolences to family. We agreed on a new policy of announcing the death of members along with daily announcements in the dining room. Notice of funeral arrangements is posted on the bulletin board. Members are aware that staff is available to make plans for transportation if a small group wish to attend a funeral. We continue to maintain a low profile, allowing our members to make their own choices about funeral attendance and encouraging them to feel comfortable with their decisions. We are planning a yearly memorial service for deceased members.

[3] Gary S. Gerson, "The Psychology of Grief and Mourning in Judaism," *Journal of Religion and Health,* Vol. 16, No. 4 (1977).

[4] *Ibid.,* p. 264.

As staff have become more aware of their own unresolved feelings about death, they are able to empathize with the reactions of our members. This helps them to deal with the members' anger and criticism more constructively. The initial wish to shield members and ourselves from the intrusion of deterioration and death is evolving into an acceptance of this experience as a positive integrative episode in the human life cycle. Our members have demonstrated their ability to participate in this experience. All of us have developed new perspectives and achieved growth through this encounter with death.

Our task now lies in utilizing this episode as a basis for creative programming and individual treatment around the issues of autonomy, control and growth in the final stage of life. By interpreting to our members the value of this experience on this level, we can further enhance the quality of their lives as they prepare for their own death.