Aging, Spirituality and Palliative Care

Elizabeth MacKinlay, PhD, RN • Editor

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Aging Spiruality and Pallative Care, edited by Elizabeth MacKinlay, PhD, RN (vol. 18, No. 2/3 and 4, 2006). *A collection of presentation papers from the Third International Conference on Ageing and Spirituality in Adelaide, Australia in 2004.*

Ministering to Older Adults: The Building Blocks, edited by Donald R. Koepke, MDiv, BCC (Vol. 17, No. 3/4, 2005). *A step-by-step guide for the development of an older adult ministry that focuses on the unique needs of each congregation and uses the unique resources found within that congregation.*

Spiritual Assessment and Intervention with Older Adults: Current Directions and Applications, edited by Mark Brennan, PhD, and Deborah Heiser, PhD (Vol. 17, No. 1/2, 2004). *"OUTSTANDING. . . . Provides readers with the most up-to-date and authoritative perspectives on spiritual assessment and intervention in the field of aging. Editors Brennan and Heiser offer an introduction in which they deftly and concisely summarize current trends and practical applications in this sub-specialty. The chapters on elder abuse, Alzheimer's disease, and intergenerational programs are all rich with illustrations that will help clinicians develop new applications for reaching target populations. I was particularly impressed by Heiser, Brennan, and Redic's discussion of the 'CARE Cabinet' collection of intervention techniques. What the editors have done is to strike an exemplary balance between theory and practice. This is a book that will be helpful to many readers for years to come." (Harry R. Moody, PhD, Director of Academic Affairs, AARP).*

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Aging Spirituality and Pastoral Care: A Multi-National Perspective, edited by Rev. Elizabeth MacKinlay, RN, PhD, Rev. James W. Ellor, PhD, DMin, DCSW, and Rev. Stephen Pickard, PhD* (Vol. 12, No. 3/4, 2001). *"Comprehensive . . . The authors are not just thinkers and scholars. They speak from decades of practical expertise with the aged, demented, and dying." (Bishop Tom Frame, PhD, Lecturer in Public Theology, St. Mark's National Theological Centre, Canberra, Australia)*

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and spiritual insights into the aging process." (Dennis R. Myers, LMSW-ACP, Director, Baccalaureate Studies in Social Work, Baylor University, Waco, Texas)

Aging in Chinese Society: A Holistic Approach to the Experience of Aging in Taiwan and Singapore, edited by Homer Jernigan and Margaret Jernigan* (Vol. 8, No. 3, 1992). *"A vivid introduction to aging in these societies. . . . Case studies illustrate the interaction of religion, personality, immigration, modernization, and aging."* (*Clinical Gerontologist*)

Spiritual Maturity in the Later Years, edited by James J. Seeber* (Vol. 7, No. 1/2, 1991). *"An excellent introduction to the burgeoning field of gerontology and religion."* (*Southwestern Journal of Theology*)

Gerontology in Theological Education: Local Program Development, edited by Barbara Payne and Earl D. C. Brewer** (Vol. 6, No. 3/4, 1989). *"Directly relevant to gerontological education in other contexts and to applications in the educational programs and other work of church congregations and community agencies for the aging."* (*The Newsletter of the Christian Sociological Society*)

Gerontology in Theological Education, edited by Barbara Payne and Earl D. C. Brewer** (Vol. 6, No. 1/2, 1989). *"An excellent resource for seminaries and anyone interested in the role of the church in the lives of older persons . . . must for all libraries."* (*David Maldonado, DSW, Associate Professor of Church & Society, Southern Methodist University, Perkins School of Theology*)

Religion, Aging and Health: A Global Perspective, compiled by the World Health Organization, edited by William M. Clements** (Vol. 4, No. 3/4, 1989). *"Fills a long-standing gap in gerontological literature. This book presents an overview of the interrelationship of religion, aging, and health from the perspective of the world's major faith traditions that is not available elsewhere . . . "* (*Stephen Sapp, PhD, Associate Professor of Religious Studies, University of Miami, Coral Gables, Florida*)

New Directions in Religion and Aging, edited by David B. Oliver** (Vol. 3, No. 1/2, 1987). *"This book is a telescope enabling us to see the future. The data of the present provides a solid foundation for seeing the future."* (*Dr. Nathan Kollar, Professor of Religious Studies and Founding Chair, Department of Gerontology, St. John Fisher College; Adjunct Professor of Ministerial Theology, St. Bernard's Institute*)

The Role of the Church in Aging, Volume 3: Programs and Services for Seniors, edited by Michael C. Hendrickson** (Vol. 2, No. 4, 1987). *Experts explore an array of successful programs for the elderly that have been implemented throughout the United States in order to meet the social, emotional, religious, and health needs of the elderly.*

The Role of the Church in Aging, Volume 2: Implications for Practice and Service, edited by Michael C. Hendrickson** (Vol. 2, No. 3, 1986). *Filled with important insight and state-of-the-art concepts that reflect the cutting edge of thinking among religion and aging professionals.* (*Rev. James W. Ellor, DMin, AM, CSW, ACSW, Associate Professor, Department Chair, Human Service Department, National College of Education, Lombard, Illinois*)

The Role of the Church in Aging, Volume 1: Implications for Policy and Action, edited by Michael C. Hendrickson** (Vol. 2, No. 1/2, 1986). *Reviews the current status of the religious sector's involvement in the field of aging and identifies a series of strategic responses for future policy and action.*

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ABOUT THE EDITOR

Elizabeth MacKinlay, PhD, RN, is a registered nurse and an ordained priest in the Anglican Church of Australia, Associate Professor in the School of Theology at Charles Sturt University, and Director for the Centre for Ageing and Pastoral Studies. In addition, she is a member of the Anglican Retirement Community Services Board of Management for the diocese of Canberra and Goulburn. Dr. MacKinlay is a co-editor of *Aging, Spirituality, and Pastoral Care: A Multinational Perspective*, and editor of *Mental Health and Spirituality in Later Life*, and *Spirituality of Later Life: On Humor and Despair* (all from Haworth). Currently she is Principal Researcher in the research center of the Public and Contextual Theology (PACT) at Charles Sturt University.

Foreword

Palliative care in modern society offers a rich new frontier where things that are old are new and those that are new are often actually quite old. Care for persons with chronic illness and/or who are dying has taken place since the beginning of time. For thousands of years, spiritual caregivers were the only persons who were available for support. Yet, in more recent times, medicine and science have taken over this process, shifting the emphasis to physical comfort away from religious and spiritual care. Advances in medicine are important in their contributions to the quality of life in these times. However, emotional and spiritual care is still needed.

For chaplains in hospitals, one of the very clear roles is at the time of death. In the emergency room, the chaplain offers comfort to families and to patients, but they also need to stay out of the way of medical teams as they do their work to preserve life. However, if the person dies, then the chaplain is generally in charge of the intervention, not the physician. Once a patient has died, the chaplain's role becomes clearly to offer comfort to the family and to support decision-making in terms of funeral homes and the disposition of the body. Indeed at times the chaplain is the guardian of the body to be sure that it is treated respectfully and in concert with the belief system of the patient and their family. When possible, chaplains prefer to be a presence to both patient and family in advance of a death; however, this is the role of palliative care, not the emergency room.

Hospice care is another element of palliative care. Designed to be in-patient as with so many of the new medical innovations of the 1960s and 1970s and yet today it has become more of a home-based intervention. For chaplains, nurses and other spiritual caregivers, hospice offers a unique format to be able to listen to the patient and their family, understand their beliefs and spiritual needs, and then to offer support as

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needed. Hospice, while relatively new, brings the patient back to focus on the dying process and comfort, rather than the more medically driven acute care models.

Life should not be reduced to the significance of the list days, yet in the last days we often tell the story of a life lived. When queried about death, older adults talk about a fear of how they will die, not in death itself. Older adults no longer experience the kind of death that is dramatically shown in the media where one knows that she or he is dying and turns to a trusted friend to say something profound, before gasping one last time and dying. Modern healthcare has altered these stereotypes, rendering most seniors helpless and speechless in the dying process. Too often chronic illness and the dying process is experienced alone. Not because families have abandoned them, but because the transition to medical care can inhibit the kind of surrounded family care that is closer to the memorialized ideal from years gone by. Whether in an institution or at home, whether the patient is able to speak for her or himself or not, spiritual care clearly involves getting in touch with the story of the person and finding the meaning of a life lived.

Spiritual care is not new. It is as old as the religions themselves. In early times it provided the majority of the care given to persons at times of chronic illness or who are dying. While at times it seems like modern society has strayed away from spiritual care at times of death, chaplains, hospice staff and volunteers, and numerous other key caregivers are still there surrounding the individual and family as appropriate. Spiritual care has moved from being the primary caregiver, to being a member of a team. Yet, whenever possible the individual is still surrounded by those who care and can work toward supportive care. In the pages of this volume, the stories of this team and the many voices that can be heard working together can be heard. It is an important topic that reflects both that which is old and yet that which is still new and in many ways underaddressed in the current literature.

James W. Ellor, PhD, DMin, DCSW

Preface

There are both opportunities and challenges as we face our own ageing and the ageing of societies. How people care for the older members of their society tells much of the values held by that society. Care and compassion, and respect for the weak and vulnerable of a society are important measures of the physical and moral well being of that society.

In many parts of the world advances in public health, medicine and technology have led to increased levels of health in later life; the positive ageing movement spells out the need for physical health for a better quality of life in ageing. But there is yet more.

If life is to be worth living, there must also be meaning in that life. The fulfillment of longer life cannot be just added years, but also the need to find meaning in those years. The burden of chronic illness and suffering still challenge us. But there is something more, the spark of life, the yearning of the human spirit, of the soul. For humans have the capacity to hope and to transcend the most difficult of times and experiences, the capacity to thrive and flourish. It is of the spiritual dimension of ageing that this publication is concerned.

This collection of papers is based on presentations made at the Third International Conference on Ageing and Spirituality. The first conference on ageing and spirituality took the focus of ageing, spirituality, and pastoral care, the second, ageing, spirituality, and well-being; this third conference includes a perspective on palliative care. Western societies largely deny ageing and death and this book seeks to bring themes of ageing, spirituality, and palliative care together to intentionally reclaim the final career of life. This seems timely; in an ageing society with low levels of mortality in early life, few people experience death first hand until much later in life. Research shows that many older people do not fear death, but do fear the process of dying. It is a journey that is new to each one of us, as we come to our own final career–the process of dying.

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It is a career that we would want to make well, for ourselves and for our loved ones.

The aims of this conference were to, first, explore the growing knowledge and practice base of ageing and spirituality; second, bring researchers and practitioners together to examine spirituality in later life, ways of growing spiritually in later life and strategies for providing best practice in aged care. The final aim of the conference was to examine the latest developments in palliative care and ageing.

Part I of the book begins with articles that reflect the state of the art in ageing and spirituality. First, Harriet Mowat's paper explores Scottish health care and the spiritual imperative. Dr. Mowat alerts us to three possible discourses of ageing: first, a problem to be solved, second, or the counter argument that ageing is not a problem, and third, ageing is a spiritual exploration. Robert Atchley's paper addresses aspects of continuity theory and spiritual development, with threads and spirals of continuity within a framework of reference points that constantly evolve throughout life.

Bruce Rumbold's paper considers the spirituality of compassion, touching on the importance of relationship and community. Rosalie Hudson explores spirituality as fragmentation, asking questions of the concept of person as an 'ensouled body' and 'embodied soul.' Issues of definition of spirituality emerged in a number of papers, and spiritual assessment was the topic of the paper by Elizabeth MacKinlay. John Killick shares wonderful images of people living with dementia, highlighted in the poem of the dying candle, where the flame burns just as brightly, even when much of the candle has already burned.

The article by Corinne Trevitt and Elizabeth MacKinlay reports findings of a study of spiritual reminiscence work with frail older people with dementia. Paul Winks' article examines fear of death, religiousness, and spirituality in later life. Michael Barbato's paper focused on the pain of dying, and how we mostly experience death as outsiders, unless it is the death of someone very close to us. David Currow and Meg Hegarty address concepts of suffering in palliative care, while both sorrow and joy are explored in the paper by Jenny Thompson-Richards (Dr. Wooops) on being a clown doctor.

The conference was attended by people from a number of religious and faith perspectives. Increasingly, Western countries are becoming multicultural and multifaith societies. As we discover more on this journey of ageing, we are mindful both of our Christian roots, but also of the presence of other faith and cultural traditions among us. In an ageing society it is important that our elders are able to practice their faith in free-

dom according to their beliefs and practices. Thus those of us who work with older people must be sensitive to the variety of need. The paper by Ruwan Palapathwala explores Buddhist and Christian perspectives on dying. The importance of relationship with others and love as agape in dying patients is emphasized in Ann Harrington's paper.

All people should have the opportunity to share their final journey with others. In a death denying society this final career needs to be reclaimed. Perhaps a midwife is needed to walk with those who are dying. Part II of this publication focuses on providing appropriate care for older people who are dying, with important papers by Linda Kristjanson, Laurie Grealish, and Margaret O'Connor and Susan Lee. These papers challenge the reader to look at experiences of dying, to change practices, consider ways of learning to provide appropriate care to older adults.

I wish to acknowledge and thank Karen Woodward for her valuable assistance in editing, and Graham Lindsay for his work on the figures.

Elizabeth MacKinlay, PhD, RN

PART I

Ageing Health Care and the Spiritual Imperative: A View from Scotland

Harriet Mowat, PhD

SUMMARY. This paper, given as a keynote presentation at the third international conference on Ageing and Spirituality 2004 in Adelaide, Australia, offers a perspective on ageing that makes central and fundamental the spiritual journey. Ageing is not confined to the old. We are all ageing all the time and whilst the imperative of ego integration (Erikson, 1986, 1982) is more pressing in old age, the march of time makes no exceptions. The paper starts with a consideration of the Scottish context and the current interest in Scotland in spirituality and health. Borrowing from the human developmental ideas of Frankl, Jung, Erikson, and Klein, the paper takes the view that we are all spiritual beings, and we are all trying to be successful, integrated reconciled and mature individuals. Ageing and spirituality is relevant to every individual. Successful ageing

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is fundamentally concerned with the successful self. The spiritual journey is bound up with the search for meaning. Ageing is part of the task of being human and it involves decline and loss. The spiritual journey–search for meaning–is unique to each one of us. The spiritual journey is made evident in the search for the ultimate destination of giving up self, transcending self. Remembrance and routine are methods by which the ageing and the spiritual journey can be facilitated. A successful ageing, according to this perspective, is therefore one that embraces and self-consciously embarks upon a spiritual journey. To take it further–the spiritual journey is bound up with ageing–and further still–ageing is a spiritual journey (Bianchi, 1984). The primary task of ageing is spiritual development. Spiritual development is helped by an appropriate societal context in which ageing as spiritual journey can flourish. This has implications for health and social care services.

KEYWORDS. Ageing, Scotland, older people, spiritual journey, spiritual need, caring task

SCOTLAND'S CHANGING SPIRITUAL LANDSCAPE

Increasing Interest in Spirituality and Health

An examination of the spiritual landscape in Scotland throws up some interesting observations. In line with much of Western Europe there is a significant decrease in adherence to traditional, formal institutional religion (Davie, 1994). The decreasing number of people regularly attending places of worship evidences this (Scottish Census, 2002). However, whilst traditional religion appears to be in decline, there is a corresponding *increase* in the number of people expressing the importance of spirituality for their lives and claiming to have spiritual experiences and beliefs (Hay, 1990). Spirituality appears to have migrated from the overtly religious towards a more individualistic and subjective quest that has no necessity of a formal structure, doctrinal beliefs or an anchoring community of like-minded believers (Heelas et al., 2005). People now want to *believe* in things spiritual, but no longer wish to *belong* to traditional religious institutions (Davie, 1994).

This broadening understanding of spirituality is reflected in health care settings by the increasing focus on spirituality within the literature surrounding medicine, nursing, social work, and occupational therapy,[1] a rising interest in complementary and alternative medicine (Austin, 1998), and a developing holistic view of health and illness within which the role of chaplaincy is rapidly gaining recognition.

Expanding Spirituality from the Particular to the Universal

In an environment that highly values the role of the "specialist," such a holistic view of health presents very particular challenges to individual professions and to the ways in which multi-disciplinary teams function in practice. As medicine and health care advance in knowledge of the micro mechanisms of the ill body, so the need for greater specialisation increases. In tension with this emphasis is the practical need expressed by people encountering illness to be treated as whole persons who require the universal (overarching meaning) and the particular (the individual self) to be held in critical tension throughout their experience of illness. Within such a context spirituality becomes of foremost importance.

In order to provide authentic holistic, active, total care, attention should be given to providing appropriate services that meet the *actual* needs of patients and their carers, that is, not simply the needs that health care professionals may perceive or/and assume, without reference to the wishes, desires and experiences of patients. The concept of patient focussed care is currently central to Scottish/UK Government health care policy, which stresses the importance of patient and carer views informing service developments. There is a good deal of evidence that suggests that patients desire to have their spiritual needs met within a healthcare context (Murray et al., 2004). Developing strategies to meet such expressed needs is therefore very much part of current governmental approach. Spirituality and spiritual care are not optional extras for "religious people."

Religion and Health–The Known Research

In the light of these cultural changes it is not coincidental that spirituality and religion are fast becoming recognised as a significant part of the healthcare research agenda, even amongst those more inclined towards the biomedical end of the research community spectrum (Fry, 2000). The extensive research work of people such as Harold Koenig

and David Larson in the United States is indicative of the possibility of developing an evidence base to explore the possibility of there being a positive association between religion, spirituality and health (Larson et al., 1997; Koenig, 2001).

A similar evidence base to that being produced within the United States has still to be developed within the United Kingdom and Europe. It is therefore not possible to draw direct comparisons across cultures. Nevertheless, the evidence that does exist is helpful in locating some potential benefits spirituality and religion could offer at a clinical as well as a pastoral level.

THE POLICY CONTEXT IN SCOTLAND

Patient Focus and Public Involvement

In Scotland, the current and previous Ministers of Health have promoted the philosophy of patient focused care. Patient Focus and Public Involvement[2] (PFPI) was launched in December 2001 following key commitments within Designed to Care[3] and Our National Health: A plan for action, a plan for change.[4] The Partnership Agreement[5] commits the Scottish Executive to addressing the following themes in all its work:

- Growing Scotland's economy;
- Delivering excellent public services;
- Supporting stronger, safer communities; and
- Developing a confident, democratic Scotland.

In line with these themes, National Health Service (NHS) Scotland is committed to equality, excellence, and the provision of high quality health services across Scotland. The leadership for this commitment comes from both the Minister for Health and Community Care and the Chief Executive of NHS Scotland.

Key to the provision of this culture of continuous improvement in clinical quality is the involvement of patients, services users, their families and the public in the design, development and delivery of the services they use. The health plan outlined in the document "Our National Health: a plan for action, a plan for change" therefore committed NHS Scotland to giving patients a stronger voice and involving people and communities in the design and delivery of health services.

PFPI developed the Health Plan commitments into a framework for change that covered the entire breadth and depth of NHS Scotland.

The White Paper, Partnership for Care[6] set out a vision of a patient-focused National Health Service based on a new partnership between patients and staff. Meeting the challenge of Partnership for Care means ensuring that whatever the individual circumstances of someone's life, they have access to the right health services to meet their needs. This includes their spiritual needs.

The NHS Reform (Scotland) Act 2004 now underpins these Partnership for Care commitments and places specific duties on NHS Boards to involve the public and promote equality of opportunity. The Act also provides for the establishment of a Scottish Health Council, with a distinctive identity within NHS Quality Improvement Scotland. These bodies will quality assure NHS Boards' delivery of their patient focus and public involvement commitments on behalf of the people of Scotland.

In relation to spiritual care there is clearly a need for some understanding of spirituality among all health service staff. The focus over the last three years (2000-2004) has been on understanding and supporting the development of spiritual care policies in every Health Board area in Scotland. Scottish Health Care Chaplaincy has been identified as the obvious location for a new kind of spiritual care which appeals to all faiths and none. There are challenges in moving from a largely Church of Scotland based chaplaincy service to one that represents and supports people from all faiths and none (Mowat and Swinton, 2005).

Spiritual Care Guidelines

At the same time and in response to the types of changes and developments highlighted earlier, a steering group was set up to explore what was required in terms of enabling chaplains to provide effective spiritual care. This group produced a set of guidelines for good practice. This process resulted in a Health Department Letter (HDL) to all Health Boards providing guidance on the development of local policies, which are being steered and developed by hospital chaplains and other staff; two conferences aimed at senior Trust management; and the setting up of a Chaplaincy Training and Development and Spiritual Care Co-ordinating Unit. Each Board is developing local spiritual care policies and these are being implemented by the chaplains, lead managers, and widely representative Spiritual Care committees.

Spirited Scotland

The Scottish Executive Health Department has funded an initiative known as *Spirited Scotland*, which offers a broad perspective on Spirituality and Health in Scotland (Mowat and Ryan, 2003). It acts as a networking point, hosts a website and issues a newsletter. In practical terms it has supported the development of confidence amongst health and social care staff to deal with spiritual issues by offering educational initiatives within the Trusts. A newly formed *Centre for Spirituality, Health and Disability*, at the University of Aberdeen,[7] is also pursuing a research and development agenda that promises to make a significant contribution to the area of spirituality and health care.

It is clear then that, within Scotland, there is an important movement to take healthcare in directions which meet the types of spiritual need prevalent within contemporary culture.

The largest proportion of patients in the NHS is over 65. This group of older people have particular challenges. They are likely to experience multiple pathology, age-related vicissitudes, and anxieties about their own ageing and mortality. The spiritual imperatives experienced by these people are likely to affect their well-being and experience of ageing.

AGEING AND THE SEARCH FOR MEANING

Ageing is part of the task of being human. It involves decline and loss. The spiritual journey is bound up with the search for meaning. To paraphrase T.S. Eliot, an English 20th Century poet, there are two fundamental questions in life. Firstly, what does life mean and secondly, what are we going to do about it? Both as individuals, and as a society, our various discourses concerning ageing are a more or less helpful means of handling such questions. I will argue below that the search for meaning in ageing is fundamentally a spiritual task, unique to each one of us, yet common to all. It is what binds us together and also what prompts us to isolate ourselves from each other. A discourse which acknowledges this can assist both the older person and the carer to create or locate meaning in the aging process (Seeber, 1990). A successful ageing according to this perspective, is therefore one that embraces and self consciously embarks upon a spiritual journey (Mowat, 2003). To take it further–the spiritual journey is bound up with ageing–and further still–ageing is a spiritual journey.

AGEING AND THE INDIVIDUAL–BALANCING DISCOURSES

In order to give substance to the idea of the various discourses that can be in operation simultaneously we will briefly consider the different situations of Pam and Angus.

Pam, aged 54, complained of stomach pain. Within one week of consulting the General Practitioner about her symptoms she was given a diagnosis of pancreatic cancer with liver secondaries. Her dilemma became how to continue living with that knowledge. What could be her *method* of daily life in a world that held no promise of tomorrow?

Her method became apparent. She held in her mind two ways of viewing her situation: two assumptions or discourses. Firstly, she made an assumption of immortality. She would recover despite the odds of recovery and she embraced vigorously plans for her future. Secondly, she made an assumption of mortality. She spoke clearly about her imminent death. She acknowledged the importance of living in the moment without reference to the future.

She operated these personal discourses concurrently. Sometimes they appeared within the same sentence. Her visitors became aware that she required them to keep up with these discourses and respond appropriately. Her visitors had the role of offering her confirmation of both these assumptions. These two assumptions were both of extreme importance to Pam in her struggle to come to terms with her situation.

Angus is 84. He is married to Sheila who is 69. They married two years ago, two years after Angus' first wife Mary died. Sheila is an old family friend. Angus is very happy indeed with Sheila and sees himself as fortunate to have met two women with whom he could live in great harmony in his lifetime.

Angus has a number of symptoms and visits the general practitioner regularly–he is highly motivated to remain healthy and well, given his relatively new marital status. He views himself as a naturally cheerful individual. Most of his contemporaries and long-term friends from college days are either dead or have cancer. A weekly phone call to his daughter includes a catalogue of funerals, terminal illnesses and disabling conditions belonging to others.

Angus, like Pam, also operates two discourses, but he only *engages* with one–the assumption of immortality. Angus acts as though his life span will continue indefinitely. He rarely discusses the possibility of his own demise despite his age and he plans ahead for holidays and events years hence.

Angus was unable to speak with his first wife about her impending death. He has not allowed himself to be confronted with a situation that has made him face, in stark terms, his own mortality, his own ageing. He looks well and young for his age. He still plays golf–his aches and pains are related to age rather than illness. Angus' two discourses are not balanced. This potentially leaves him very vulnerable if his lifestyle and life circumstances are radically changed through ill health.

MAINTENANCE OF BALANCE

As we progress through life, our life voices are a balance between immortality and imminence. We must have both these discourses to progress–but they move in and out of focus depending on our current circumstances. Ageing is a process of maintaining a balance in the discourses of immortality and imminence so that we can manage ourselves and our lives and maximise our meaning.

Our carers and helpers, our family and friends must learn to follow our balance which changes on a daily basis–this involves careful listening and observing, the real work of compassionate caring. Pam's story shows that listeners to the discourse must also learn to move with the emphasis between immortality and imminence that prevails at any one moment.

AGEING AND SOCIETY–TWO DISCOURSES

Scottish society also seems to work with two ageing discourses. At first glance they are very different. In what could be called the *problem based discourse*, ageing is assumed to be difficult and essentially a problem both for the individual and society. Conversely, ageing is portrayed as the advent of wisdom and an opportunity for both the individual and society.

Both these discourses have implications for the individual and the perception of successful ageing. Both these discourses seem to share the same underpinning assumptions although they look somewhat different superficially.

FIRST DISCOURSE: THE PROBLEM BASED THEORY OF AGEING

In our current Scottish society, ageing is most commonly seen as something to be feared and rejected. Ageing is something to be ignored.

Ageing is something that happens to other people. Ageing is a problem to "fix" through social, economic, or health policy. Ageing is a biological "mistake" or challenge that will eventually be rectified through scientific endeavour (Kirkwood, 2000).

The problem based discourse around ageing can be understood as a fear of death and the instinctual drive towards denial of death. In a secular environment the reality of death has the potential to render life meaningless. Meaning of life questions, in our current society, are bound up with maintenance of youth and continuity of "youthful" practice. When illness occurs, as it does increasingly with old age, the individual is required, mostly unwillingly, to reflect on his or her position and the meaning of his/her life in a wider context.

This problem based approach to ageing could be considered to be similar to the psychological position known as the paranoid-schizoid, which is described by Kleinian psychotherapy (Greenberg and Mitchell, 1983). In this position the relationship to the object, in this case ageing and death, is very stark and uncompromising and places the perceiver in a difficult and rigid position. Ageing is seen as a mistake to be rectified in due course. The underpinning assumption is that ageing is a "bad" thing. We find ourselves surprised by old age rather than planning for it. This perception of ageing is rooted in the wish to avoid the realities of ageing and death. By denying it, ageing loses its power to make us afraid. This is most often displayed by the denial of old age in oneself, but the recognition of it in others. Escaping or cheating old age also has a market value.

The research around ageing in this discourse tends to focus on collective solutions using a positivistic methodology. In this position successful ageing is defined by the clever avoidance or overcoming of the vicissitudes of old age. The successful ager is the one who escapes old age. Rewards are for people who "do not look their age" or who are "marvelous for their age." Medicine helps with this by improving techniques, for instance, hip replacements, heart bypass surgery, plastic surgery, sophisticated biomedical interventions. Social science helps by redefining the concept of elderly in terms of retirement age or in terms of pension rights and financial bonuses.

Since ageing and death are inevitable, the strongly held internal belief that ageing does not happen to self, only others, hosts the potential for anomie (Douglas, 1967), that is, dislocation from the mainstream structures of society and societal beliefs as the individual does relentlessly age.