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Title page

Navigating the choppy waters to Nirvana. A critical reflective account of caring for ageing parents in the fourth age

Dr Alison McInnes
Northumbria University,
Department of Social Work, Education and Community Wellbeing,
Faculty of Health and Life Sciences,
Room H010,
Coach Lane Campus East,
Benton,
Newcastle upon Tyne,
NE7 7XA,
UK.

alison.mcinnnes@northumbria.ac.uk

ORCID

Alison McInnes <https://orcid.org/0000-0003-0543-0651>

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Abstract

This article revisits a paper and from an autoethnographic/critical reflective biographical approach re-examines seven cultural notions/myths, which may encourage ageism. It is framed within my experiential knowledge of caring for my ageing parents, with the tensions and challenges that this brings. The commentary emphasises that by analysing the impact of our personal life experiences, we can start to understand both the intended and unintended consequences of policy and practice affecting those in the fourth age. As a social work educator, I wanted to reflect upon how my tacit experiential knowledge, if made explicit, could impact upon my own and others' learning. The recent death of my father has allowed for a period of reflection on my own caring and indeed my professional social work experience, knowledge, skills and practice. The ageing process is unequal as class and socio-economic factors, i.e. geography, age, gender, religion and ethnicity, all play parts in determining how someone ages, and indeed upon the care an individual older person receives. A fuller understanding of negotiating the role of one stakeholder, that of a family carer in the ageing process, is elicited in this paper.

Keywords:

Ageing, autoethnography, biographical approach, critical reflection, expert by experience, fourth age, gerontology, personal experience, social work.

Navigating the choppy waters to Nirvana. A critical reflective account of caring for ageing parents in the fourth age

Introduction

The paper proffers a critical reflective biographical account from a registered social worker/academic in the United Kingdom (UK) re-examining seven cultural notions, or myths, which may encourage ageism (Dixon and Gregory 1987; Sidell 1995; McInnes 2004). This commentary is based on the last five years during which I have (in collaboration with others) informally cared for my ageing parents. Tensions and challenges that arose, and lessons learned, during this period will be considered in terms of the personalities of my parents and their physical and mental health. These will be examined in the context of the myths of chronology, inflexible personality, misery, rejection and isolation, dependence and unproductivity, physical ill health and mental deterioration (McInnes 2004).

The term the 'oldest old' (people at the upper segment of the age pyramid, i.e. those aged 85 years and older) is stereotypically associated with a loss of autonomy and degeneration. In reality a large proportion of older people will never lose their autonomy or suffer physical or mental ill health; it is unexceptional in many countries in the twenty-first century to reach this age and beyond. The 'fourth age', with its recognition of successful ageing (Rowe and Kahn 1997), is preferred, whilst acknowledging that the risk of 'unsuccessful' ageing, drawing on the notion of 'frailty', is also an important concept (Encyclopaedia Social Sciences 2020).

Demographics and context

The UK has an ageing population (Office of National Statistics 2018) with approximately 12 million people aged 65 and above, of which 1.6 million are aged over 85 years. Between 2017 and 2040, the number of people aged over 85 (the group most likely to need health and care services) is projected to almost double from 1.4 to 2.7 million (Age UK 2019a). Ageing societies pose challenges for health and social care systems (WHO 2018) with those aged 85 plus having higher levels of dementia, multi-morbidity and dependency (Kingston, Comas-Herrera and Jagger 2018).

Health challenges

Sixty nine per cent of those aged 85 plus develop multi-morbidities (Kingston et al. 2018), defined by Cassell et al. (2018) as the coexistence of two or more long-term medical conditions or diseases. Often related to this is the long-term condition of 'frailty', in which multiple body systems gradually lose their in-built reserves (Skills for Health 2019). Ninety three per cent of older people living with frailty have mobility difficulties (NHS 2019) and are at greater risk of accidents, falls, disability, care home and emergency hospital admission, and death (Gale, Cooper and Sayer 2015; NHS Digital 2017; Kinsella 2018). Ageist and pejorative terms such as 'social admission', 'bed blockers' and 'frequent fliers', habitually used in hospitals to describe older patients (Borland 2011), downplay the serious medical issues that older people may have (Borland 2011; Curran and Chattopadhyay 2015). Physical and mental health problems can interact (Naylor et al. 2016). One in six people over the age of 80 has dementia (Alzheimer's Research UK 2019; Alzheimer's Society 2019), a range of

progressive conditions that affect the brain (Dementia UK 2019) and which can impact health and social care services (Davidson, Goodwin and Rossall 2013).

Social care demands

Care for those in the fourth age is often provided by family, friends, neighbours, or a combination, without payment (unpaid or informal care), and may include emotional support, personal care and help with practical tasks (Kelly and Kenny 2018). One in six adults, (approximately 8.8 million people), are informal caregivers (Carersweek.org 2019). Recent estimates of the number of unpaid carers in England suggest an increase from 5.9 million in 2001 to 7.6 million in 2018 (Petrie and Kirkup 2018). Demos (2018) estimate the figure to be around 8 million which will increase (Pickard 2013), though carers' invisibility challenges the collection of reliable figures (Buckner and Yeandle 2015). Tronto (2017: 30) identifies that informal family care is an expectation arising from neoliberal societies believing, 'if people are now less well cared for, it must, by definition, be a failure of their own personal or familial responsibility'. Policy analysts in the UK note inherent tensions between expectations to do more to support older relatives and pressures to stay longer in employment (Starr and Szebehely 2017).

Providing unpaid care can have adverse effects on carers' relationships, finances, health and well-being, and ability to participate in employment (Kelly and Kenny 2018). Carers juggle their caring and paid employment roles, often foregoing career development opportunities and taking annual or sick leave to provide care (Carer's UK

and Age UK 2016). In addition, a deprioritising of the carer's health, diet and exercise routine is common (Pinquart and Sörensen 2007; Bauer and Souza-Poza 2015).

For many older people and their families, getting access to, co-ordinating and maintaining decent quality, stable and reliable home care, is a real struggle (Pursch and Isden 2018). The lack of continuity of well-trained carers can be distressing, with new care workers being sent on a regular basis (Age UK 2018). Older people and their families sometimes find the process for accessing help poorly signposted and hard to navigate. There have been reports of overworked carers not staying the full length of their planned visit and 'box ticking' by multiple different carers each week, with consistency of carers often not given priority by service providers (Stockwell-Smith, Kellett and Moyle 2010; Age UK 2018; Pursch and Isden 2018). The result can be insufficient time to construct relationships and poor communication.

This is often compounded by older people declining offers to see their GP, or refusing support services at home, a phenomenon described as 'resistance to care' (Konno, Kang and Makimoto 2012). The language of 'resistance' is quite common and includes 'rejection of care', 'lacking insight' 'aggressive behaviour', 'combative behaviour', 'agitated behaviour' and 'non-compliance' (Konno, Kang and Makimoto 2012). A critical, gerontological response to this language argues that the response by an older person may be because services are unresponsive or irrelevant. For older people, the changes and transitions and the emotional impact involved in using care services (e.g. being observed naked in the shower, or having food cut up) may require significant adjustment.

As with any age group, home means much more than a place to reside and instead should be a place of safe refuge and security. In England an estimated three-quarters of a million older people live in the private rental sector, with consequent insecurity of tenure (Age UK 2019b). Older people want to feel secure both financially and in their own homes (Pursch and Isden 2018). Unfortunately, the UK Government's paper on the funding of social care is still forthcoming (Jarrett 2019) so any concerns for the financial security of the ageing population remains unresolved.

Methods

Following in the footsteps of Mark Twain ('write what you know') an analysis of my own personal journey of caring for my ageing parents is explored to make my tacit experiential knowledge explicit and so enrich, validate, and authenticate a fuller understanding of the ageing process. This commentary reflects on the underpinning dominant pejorative negative discourses, language, labels, and stereotyping about older people. The pervasive language espoused in dominant public discourses in the UK regarding the alleged burden of older people is often alarmist and diminishes the value and integrity of being an older person (Calhoun et al. 2012). For example, Willetts (2019) explores the intergenerational attitudinal gap in his provocatively-titled 'The Pinch: How the Baby Boomers Stole Their Children's Future—and How They Can Give It Back'. Analysing cultural notions, or myths, about ageing will underpin a challenge to the use of ageist language, discourse and communication styles when working with people in the fourth age. A more informed, positive understanding to benefit, emancipate and empower those in the fourth age will be presented.

This article draws on what White (2001) and Al-Makhamreh and Lewando-Hundt (2008) call reflexivity. According to White, 'reflexivity becomes a process of looking inward and outward, to the social and cultural artefacts and forms of thought which saturate our practices' (White 2001: 102). Reflexivity suggests that by analysing the impact of our personal life experiences, we can start to understand the intended and unintended consequences of policy and practice, in this case affecting those in the fourth age.

Context

Although the context of this paper is UK-based, many of the themes identified have relevance internationally. Ageing is a global phenomenon, though its trajectory and the response to it is not. I have become 'an expert by experience'. This term has been adopted in UK social care (Commission for Social Care Inspection 2009) and social work education (Department of Health 2002; Preston-Shoot 2007), in order to value the lived expertise of contributors. These include people living with or caring for a person who uses services (Scourfield 2010).

McLaughlin (2009) critiques this term by asking what criteria is used to define an 'expert' and their 'experience' and questions the unequal power position between a social worker (by virtue of their training) and an individual receiving services (McLaughlin 2009). Further criticisms include a lack of diversity of contributors and an over-emphasis on negative experiences (Anghel and Ramon 2009). It has been contested, however, that 'experience should be prominent in the conceptual base of

gerontology' (Bytheway 1996: 613). My 'expertise by experience' claims no universality, as I am not an expert on everybody's experience of caring for ageing parents. Ageing is unequal as class and socio-economic factors, i.e. geography, culture, age, gender, religion and ethnicity, all play parts in how someone ages and indeed upon the care an individual older person receives (Higgs and Gilleard 2019).

This commentary also draws attention to my academic social worker role by examining possible relationships between my professional practices and my personal experiences emanating from my family of origin (Smith 2012). Social workers should not only be concerned with utilising formal knowledge, but also encouraged to critically and reflectively examine personal knowledge (Kwan and Reupert 2019). The Self plays a critical role in how to 'frame an ambiguously troublesome situation [and] impose a narrative structure through which the incoherent features of that situation are named and storied' (Sellick, Delaney and Brownlee 2002: 494). However, in analysing the caring relationships with my parents, I also need to consider that my personal needs may have 'leaked out' in unforeseen ways (Kwan and Reupert 2019), via the phenomenon known as 'transference' (Butler 2016; Smith 2012).

By using critical reflection the power relations, interactions and the decisions made between me, my brother and my parents are explored (Hakaka and Holmes 2017). Reflections were manifested through writing in a journal (Hickson 2011). Boyd and Fales (as cited in Lam, Wong and Leung 2007) distinguish stages of reflective learning, which includes inner discomfort. At the beginning of my journey in caring for my parents, I experienced inner discomfort at the nature of the personal experiences

I brought to my social work educator role. This included contemplating what others might think of these experiences and how I would integrate these positively with benefits to my own learning and practice (Smith 2012).

Tensions and contradictions exist between critical reflection and the cultures of objectivity and self-disclosure. The personal and the emotional in learning has been explored by Fook and Askeland (2007), using their model of Critical Reflection. Critical Reflection can involve personal disclosure and acknowledging emotion, which may compete with the social work educator experience of being rational and objective (Fook and Askeland 2007). I needed to be mindful and utilise critical social work to examine inequality and oppression and be aware that notwithstanding its intentions to provide help to older people, social work practice itself might be oppressive and socially controlling (Healy 2012; Smith 2012).

The product of my critical reflective analysis of the impact of my personal life experiences is applied to the original seven cultural notions, or myths (Dixon and Gregory 1987; Sidell 1995) which may encourage ageism in the UK. It was argued that these myths exist with some basis in truth and fact (McInnes 2004). However, they have become exaggerated and generalised, leading to stereotyping which can in turn promote oppressive practice. These stereotypes, or established lay or cultural beliefs, are maintained because there are elements of truth in them, but generally they over-simplify and stigmatise (McInnes 2004).

The older population is not a homogeneous group, but clearly some older people encounter certain difficulties in relation to their advancing years. Certain situations or problems are seen more frequently in the older population and ageism is a form of prejudice used by those who generalise the differences they observe to the entire older population (Chiu et al. 2001; Levy, 2001). This approach includes viewing all older people as marginalized, vulnerable, frail, and likely to be sick (Bytheway, 1994). The reality, however, is quite different (McInnes 2004). Language and dominant discourses associated with the fourth age in policies and the media, are often underpinned by ageism and fail to convey accurate accounts and understandings of successful ageing (Duffy 2017).

There is a need, therefore, to understand 'meaning' when working with and researching older people, which requires distancing oneself from ageist preoccupations with the '*decline of the body*' (Minkler 1996). Indeed Hepworth (2000: 1) argues that '*ageing ... is not a straightforward linear trajectory towards inevitable physical; personal and social decline but a dynamic process of highly variable change: ageing is simultaneously a collective human condition and an individualized subjective experience.*' According to Bytheway (1995, 2005), ageist prejudice is based upon presumptions about different generations or chronological age. The following list of myths was utilised as an important safeguard, or check against prejudice, negativity, discrimination, inequality, oppression, and misunderstanding of my parents' lives.

The myth of chronology

The myth of chronology defines older people as a homogeneous group by virtue of their age, in spite of the diversity and autonomy in their lives. Several key points have emerged which all informal carers and professionals making decisions about those in the fourth age should understand. By arbitrarily designating chronological age to older people is not beneficial, as life is not over, most remain independent irrespective of age, feel that their health is good and enjoy a good quality of life (Neuberger 2009). Furthermore, no matter what chronological age a person is, it is still worth treating health problems (Mitchell cited in Davidson, Goodwin and Rossall 2013).

My father was, and my mother still is, a unique individual. Both were fiercely independent, and my father did everything in his power to live longer than his parents, who both died at the age of 67. He kept his weight down by watching his diet ('I eat to live, not live to eat'), not smoking and rarely drinking alcohol. He exercised on a regular basis until a hip replacement in his early 80's curtailed these activities. He was the more sociable of my parents and his social networks and friendships endured until his mid-80's. However, once his mobility decreased and not fully embracing digital technology, he started to neglect his social networks. On the other hand, my mother has always been a 'loner' and seems quite happy with little human interaction.

In their mid-80s both my parents became exclusively reliant on their children as they lacked other significant relationships or social networks. Seeing having friends as important for all individuals we encouraged our parents to maintain friendships. However, in their fourth age they lacked the energy, or the inclination, to be proactive

in this respect. From a selfish point of view as an informal family carer increased social interaction by my parents would have given me some respite, knowing that they had/have other people to talk to and share their unique experiences of ageing.

The myth of inflexible personality

This suggests that older peoples' personalities change with age, in that they become more inflexible, intolerant, and conservative. However, individuals often want to retain choice and control of their decision making. Moreover, they desire clear guidance and support from professionals and especially from family, who are often the first port of call for both accessing support and discussing decisions (Redding et al. 2014; Blomgren et al. 2011).

My father up until his death tried to remain flexible. In his early 80s he adopted two dogs to help a friend out, ignoring the long-term consequences of his actions. My response was to become intolerant and inflexible, labelling my father as selfish, as I would have to look after the dogs if his health deteriorated. With hindsight I should have been more encouraging, since the dogs gave my father unconditional love and the company he was missing from friends. In the last year of my father's life we had to move my parents from their large detached home, in which they had resided for 50 years, into a small rented bungalow. They coped well with the stress of this huge life transition. I was the one bereft for the loss of my childhood home.

Since my father was terrified of dying, he ignored this prospect and did not take up opportunities to put his affairs in order; neither of my parents had wills, funeral plans, or made any financial arrangements. When my father was in hospital before he died, a nurse described this as having a 'Blitz mentality' i.e. just get on with life and hope the issues go away. This was most challenging to my brother and I, and in the end, we probably limited their choice and control over decision making, by 'swooping in' and taking control. After numerous accidents in his car, as a result of which I expressed the concern that he may injure a child, my father declared 'I don't care if I knock over a child, I need my independence!' This uncharacteristic declaration was more than likely a result of his vascular dementia. However, with the luxury of time and the benefit of hindsight, I should have discussed with him his perceived loss of independence in more detail before I effectively banned him from driving.

The myth of misery

This asserts that because people are older, they are unhappy. Those in the fourth age may feel vulnerable and there is a perception that any criticism of a service will result in its withdrawal. Consequently, they may appear as being unhappy by default (Konno, Kang and Makimoto 2012). My father tried to enjoy his life until the end and I suspect the thought of not being as mobile, or as physically able after being hospitalised, precipitated his demise and eventual death. While my father was in hospital for the last time, my mother remained optimistic and positive with my father about his health up until the end. She also seemed to become more independent and caught buses and taxis by herself, for the first time in several years. She did not dwell on the negatives and got on with living.

It was myself and my brother who were miserable and often felt like we were living in 'purgatory', especially during the last month of our father's life. It was a constant battle to keep him in hospital where he was safe; I spent considerable time advocating on his behalf with the nurses who wanted to discharge him, as they needed his bed. Our lack of control was challenging, in that we could not know what the future would hold, and we assumed and anticipated the worst. We were the ones experiencing misery. Putting this into context, life beyond our parents still carried on, with all the stresses and pressures of day to day family living, professional life, our own health issues, and our own social and emotional needs. During this period having friends sit and listen was highly valued, and this is something that my parents were not fortunate enough to experience.

Informal carers for ageing parents are often at breaking point. The demands placed on them are immense and navigating the system and making life changing decisions is often extremely challenging. As a society we need to establish what is reasonable for families to do and the help they will get to support them as carers. There is currently little appreciation of how much informal care many families are already providing for their ageing relatives. Asking families to do more will not fix the inherent problems in our health and social care systems. More support needs to be given to those who are carrying enormous amounts of responsibility for ageing relatives (Grünwald, Damman and Henkens 2020) so that stress reduces, positive caring can occur and relationships can remain intact (Tolkacheva et al. 2011).

The myth of rejection and isolation

This contends that British society is uncaring towards and rejects its older people. Linked to this is an expectation by older people that the NHS should be cost-free, with a refusal to accept that health and social care services should have financial costs attached to them. This may therefore lead to unwillingness on the part of the older person to accept those services (Konno, Kang and Makimoto 2012). Feelings of social isolation can occur even in the presence of a large number of other people, and if we are to address those feelings we need to recognise the importance of social support via relationships with health and care professionals, despite the challenge in terms of the available time that professionals have (Redding et al. 2014).

For many people, social interaction needs to continue, or indeed, increase when we enter the fourth age. However, others may value solitude and choose to only interact with and have a small number of contacts (Redding et al. 2014). The fourth age is also a time of bereavement and loss, which may reduce older people's support networks; therefore older people may need to be encouraged and supported to participate and engage (Mitchell cited in Davidson, Goodwin and Rossall 2013). Social relationships are as important as a healthy diet and exercise for mental and physical health and successful ageing (Bowling cited in Davidson, Goodwin and Rossall 2013; Pearce et al. 2019).

My parents have not been isolated during the last four years and have had good relationships with their family and eventually their formal carers. My mother's choice

not to have a wide social circle may have helped her since my father's death, in that she seems happy in her own company. She is not isolated in the sense that she has formal carers visiting her three times a day and she enjoys a chat with them all. She shares the experience of many older people in that her carers are numerous, but she has a core team of about eight females so there is some continuity of care. We are all individuals with different personalities: unlike my mother who enjoys solitude, I have consciously made friends throughout my life and nurture and sustain these relationships and as I do not have children I will need my social networks as I age.

The myth of dependence and unproductivity

This myth perpetuates the belief that because older people are not usually engaged in paid employment they are not productive members of our society and they are therefore dependent upon others. It could be counter-argued that older people, by using the formal services provided by professional carers, instead of relying upon family and friends, are exerting their own independence and choice. Older people may not choose to give up their independence and still want to be involved in decisions about their lives (Davidson, Goodwin and Rossall 2013). Essentially it is physical or mental ill health, and not necessarily age, which leads to a loss of independence and needing care from others.

There is a constant tension between independence and safety, and it is often 'problem focused' rather than looking at those in the fourth age as individuals (Redding et al. 2014). They are often able to do activities that are important to them, to help maintain a sense of pride, achievement and identity, such as doing the washing-up, and may

be disappointed when these everyday tasks are taken over by carers (Redding et al. 2014). There is a need not only to be cared for but cared about when major decisions are made. For example, trusting someone with Lasting Power of Attorney over decisions relating to one's care and finances, (Lloyd cited in Davidson, Goodwin and Rossall 2013). Rather than being unproductive, Redding et al. (2014) found that most participants in their research referenced the future, putting plans in place for supporting family in their absence, e.g. with funeral arrangements.

We all have our own unique experiences and I am aware that my parents were quite privileged as seniors, in that they had good jobs and subsequent pensions and could afford formal private care. I did involve a social worker initially to ask for help and support with my parents, but my mother had been employed in a management role in social services and was uncomfortable with social workers entering her life. Because of this she became 'resistant to care' and stopped this service involvement without my knowledge. When their house became neglected and my parents could no longer deal with letters and finances etc, my brother and I felt forced to invoke a Lasting Power of Attorney and employ formal carers on their behalf.

Without the help of social services and not knowing where to access good reliable services this involved endless telephoning and there were several setbacks before a reliable service was found. With hindsight, I was not attuned to the adaption that my parents would have to make when formal carers came into their home. I was too engrossed with my own worries regarding their safety and probably 'infantilised' them to protect them. They were in fact just told what was happening, with little collaboration

involved. Their safety became the main issue at the expense of their choice, which retrospectively could be viewed as oppressive. In circumstances like these there is always the potential for intra-family conflict with decision making. I am aware of how fortunate I was in that I did not have to make any decisions alone and relieved that my brother and I have never argued about any aspect of caring for our parents. My experiences support findings by Romoren (2003) in that the informal care given to older parents by sons is often underestimated.

The myth of physical ill health

This perpetuates the view that old age automatically involves deterioration in physical health and that illness is part of the ageing process. It is recognised that even frail people in their fourth age need 'to get up and moving' (Davidson, Goodwin and Rossall 2013: 5) as mobility or functionality once lost is hard to recover. Whilst older people recognise the constraints that their health conditions sometimes place on their lives, they often focus on living and are not preoccupied with their health (Redding et al. 2014). Many older people described as 'frail' dislike the term and want to be supported to be as independent as long as possible. Subsequently, services investing in 'frailty' strategies risk being rejected by the very people they are seeking to support (Redding et al. 2014). Furthermore, there is often a 'risk averse' attitude among both health and social care professionals and individual's families, which often results in older people being discouraged from participating in activities of daily living (Redding et al. 2014).

Unfortunately, the last four years saw a decline in the health of both of my parents, which involved reduced mobility and increased medication. Antecedent to my father's

death both parents experienced a 'revolving door' into hospital, where they were 'patched up' and returned home. These hospital admissions often coincided with me just about to go on a work trip overseas, and after such an episode, a respite residential care admission was sought for both of my parents. Being honest this was as much about respite for me, as it was for my parents. I had been admitted to hospital during this time with my own health issues and my father asked, 'what will we do if anything happens to you?' It is so apparent that the physical health of informal carers and those being cared for are entwined in far reaching ways.

The myth of mental deterioration

This suggests that older people deteriorate mentally and become 'senile' (Dixon and Gregory 1987) and that the presence of mental health problems presents challenges to communication. Mental health problems are often undiagnosed by health-care professionals, and the stigma surrounding these illnesses often makes people reluctant to seek help (Royal College of Nursing 2018). However, it is important to note that not all people in the fourth age suffer mental health problems. In addition to physical and mental health, personality may be a factor affecting longevity (Davidson, Goodwin and Rossall 2013).

During the last four years unfortunately both my parents have suffered some memory loss and my father was diagnosed with vascular dementia. This has caused me some challenges and issues in my role as an informal carer. I have experienced feelings of guilt because there were times when I found it difficult to like being with my father, mainly precipitated by what I regarded as his self-centred and attention-seeking

behaviour. However, we have also shared funny times and on both sides a sense of humour and positive attitude were vital. Overall, whilst acknowledging that person centred care is desirable, I often became directive when my parents' safety was potentially compromised.

The Mental Capacity Act (MCA) (2005) sets out a regime which governs the making of decisions for people who lack mental capacity, based on what is in their best interests (Section 4 MCA). The key aims are empowerment, protection and support, balanced against physical risk, welfare and happiness and the patient's wishes and values. It has been questioned however whether the best interests test is 'fit for purpose' for vulnerable older people? (Szelepet 2018). Indeed, balancing protection and safety with my father's wishes and happiness created a huge challenge; a compromise had to be found between the intellectual and the emotional aspects of his care. As an informal carer it is difficult, if not impossible, to reconcile these stresses and the attendant feelings. I experienced feelings of relief when my father died, feelings which were ultimately tied up with guilt and the bereavement process (Aronson 1990).

Conclusion

The 'deficit conception of ageing' which perpetuates the myths above, needs to be abandoned. Instead we need to address how policy and practice can help to maintain and regain autonomy and independence in the fourth age (Davidson, Goodwin and Rossall 2013). These familiar stereotypes/categories often implore us to consider differences between ourselves and those in the fourth age. However, we need to

acknowledge that these differences are smaller than these stereotypes suggest. What needs to be recognised is not the age of a person, but their individual characteristics. Individuality in the fourth age can so easily become submerged by the pressures facing our health and social care system (Redding et al. 2014).

To redress the perpetuation of negative stereotyping and the myths surrounding those in the fourth age, there needs to be a significant shift towards positive caring practices involving the co-production of health and social services for older people (Hafford-Letchfield and Formosa 2016). Older people need to be involved in policy making and the design and delivery of services, as they are the 'experts of their experiences'. Like my parents, everyone is an individual with their own story to tell. Any future collaboration should consider the impact of the experiences of the personal, cultural, geographical, social and health issues upon the ageing process. Outcomes when this is implemented, are more efficient, sustainable and cost-effective (SCIE 2016).

There is a necessity to identify, critique and challenge ill-informed and oppressive language, labels and discourses used to describe people in the fourth age and to explain ageing issues. Informal carers need to reflect on and collaborate with ageing parents to challenge the myths of ageing and avoid 'knee jerk' reactions. Successful ageing for all depends on this. I have learned considerably from my informal caring experiences, and I am fortunate to have wide social networks with many good friends, I have a will and my funeral arrangements in place. Hopefully as I age successfully, life will be easier both for me and for those I leave behind.

Statement of ethical approval

As this is a personal reflective commentary and as my mother has capacity and has always encouraged education, ethical approval was sought and granted by her, to use her my experiences for the benefit of learning. Therefore, Northumbria University did not require a submission for ethical approval.

Statement of conflict of interest

No potential conflict of interest was reported by the author.

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