COMMUNITY CARE OF THE WIDOW

A SOCIAL SERVICE OF INTEREST TO THE FAMILY PHYSICIAN

BY

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In the autumn of 1958 a doctor's wife initiated in the London area the first practical investigation into the problem of the widow and her family. It is perhaps strange that while every conceivable group of handicapped people has long had its individual representation, several million women undergoing similar emotional, economic, and social difficulties have only just been recognized as a group in special need. In England and Wales alone there are two and a half million widows, and of every five married women in this country one is a widow. The figures are published in the Census returns, but no special study had been undertaken in this country until Marris (1958) published his book *Widows and Their Families*. He investigated the experience of 70 working-class widows with children living in Stepney. The book received little public acclaim, a further indication that the neglect of the problem was both subtle and unconscious—a painful subject which might justifiably create a resistance in the minds of many.

Bereavement and its sequelae are everyday events with which the family doctor has to deal. Usually he is the first on the scene. For him bereavement is a situation to which he has had little help to bring, until the ready production of drugs came to his aid. Now he may give relief for sleeplessness; he may deaden the more acute stages of grief; but the basic problem remains untouched.

The work of the Cruse Club is described as a pilot experiment for the counselling and practical help of widows and their families, and the following observations summarize the experience of the first year of its growth as a social service.

The Problem Stated

In the introduction to Peter Marris's book, Dr. John Bowlby summarizes the situation of the widow both in her personal and social experience. He says:

"In our present Western civilization to be widowed is to be twice-stricken; both grief and poverty are the widow's lot. A satisfactory study requires, therefore, an understanding both of the emotional and the economic implications of widowhood, and of their interaction with each other. It requires also an ability to look at suffering dispassionately and without flinching. It seems probable that one reason for the neglect of the problem is the rarity of workers with this combination of gifts.

"Grief is no respecter of persons. Whether the bereaved is young or old, rich or poor, to lose another with whom his feelings are closely linked is to suffer emotional disruption. Not only is the external pattern of his life abruptly changed, but he finds himself at the mercy of conflicting impulses of great intensity—to remember, to forget; to blame, to forgive; to seek companionship, to avoid company. No wonder this is an experience which can endanger physical and mental health, both in the short-term and the long. The problem is to understand the nature of the processes set in train by bereavement, and the conditions which assist those processes to reach a healthy outcome or

which hinder it; since without such understanding neither healing nor preventive measures will be well based."

While it can be said at the outset that many widows do cope and readjust, more intimate knowledge reveals that too often they have borne more strain and stress than a concerned community would willingly pass without coming to their rescue. Many have looked back wishing they had had the counsel and practical help of such a service as the Cruse Club in the early years of bereavement.

Needs of the Widow

Guidance and counselling require maturity, tolerance, and the understanding of the irrational and conflicting emotions of the bereaved wife. Physicians are invariably the recipients of these strong feelings, both positive and negative. As one widow put it, "I blamed the doctor for letting my man die—but he didn't hold it against me." The busy general practitioner has not the time to listen, sympathetic though he may be. He will be fortunate if he can give more than the kindly word and a sedative. He needs the help of those able to take over and give the time and practical aid required. In addition to the need for understanding and for group relationships the widow needs help with her new economic situation. Many have had little experience in the handling of money affairs. The social agencies operating in the larger towns are often quite unknown to them, and at such a time the bereaved woman is little inclined to talk to strangers about her personal affairs. Most are unfamiliar with the advisory help of the Citizens' Advice Bureau, many with children have never heard of the child-guidance clinic with its team of experts in child welfare. In outlying districts their difficulties are indeed magnified, for often the only group activities are the Church and the women's institute, neither of which at the moment undertakes this counselling role.

The Widow with Children

Commenting on National Insurance and the widow, Bowlby suggests that "the plight of widows with dependant children is especially tragic. Their task is to be at once mother, housekeeper, and earner; and, because of their domestic ties, inevitably poor earners. Amongst this afflicted group there is, moreover, a subgroup which gives rise to special concern. It comprises widows with very young children who, in present conditions, find themselves under relentless economic pressure to neglect their children."

For the slightly older woman the practical problems enlarge with the age of her children: the need to provide the right education commensurate with their abilities and ages; the problem of housing, of supplementing the pension by earning; training for employment or re-employment; the supervision and care of the children—all are practical matters which call for advice and guidance and a knowledge of the right source for the right answer. In this connexion the counselling service of the Cruse Club is preparing fact sheets which will give information on relevant problems in an easily understood form.

The "One Parent" Family and its Problems

The emotional relationship of the widow and her children is perhaps of greater importance to their future stability than the more practical aspects of their background. The widow may well have an unconscious and

forbidden wish that she had no children, and thus would be relieved of the heavy task of bringing them up and providing for their care single-handed. She may seek comfort from them and become too possessive. If she has a son she may seek from him the emotional satisfactions she formerly had from her husband. This may lead to a mother fixation and either no marriage or a broken marriage for the son. Many widows' children would undoubtedly benefit by boarding-school co-education with teachers of both sexes. While we know that many have brought up their children alone with great success, those with large families often have too great a struggle and social tragedies frequently result. There is a very real need for benevolent families to take a close interest in the widow's children, so that the platform of their security may be widened and the children may feel a greater sense of support as they go out into the world. Assimilation into clubs is not enough without the close personal interest of the club worker. As widows have often said, "No one is interested in our children—and yet they may be taken advantage of because there is no protecting father in the background."

Financial Difficulties

The Controversial Earnings Rule.—All these needs of the widow are accentuated by financial hardship. The widows of Service men or of the victims of industrial accident or disease have no restrictions on earnings. Other widows can earn only a small amount before the earnings rule cuts the pension. This discrimination is hard to understand. Marris (1958) summarizes the situation well when he says, "Poverty accentuates all the morbid tendencies of grief—the isolation, bitterness, apathy; the sense of being rejected, a drag on the happiness of others—while to secure a comfortable living standard would, instead, at least encourage her to master them. Released from the fear of financial dependence, she would be less diffident in her family relationships. A widow with young children needs an income equivalent to a man's wage. While the children are under 5, it seems better that this income should not depend upon her ability to earn, since it may harm small children to be separated from their mother, even if their grandmother or an aunt would be willing to look after them. Once the children are at school, she may find companionship and interest in a job which relieves her loneliness."

Employment of Widows.—Prospective employers do not usually welcome the idea of engaging a widow whose only experience has been in the home. If she has worked before marriage she will be expected to take a refresher course. The change in role from being her own mistress in the home often makes it difficult for a widow to join the life of a large working community. She requires special reassurance that she will not be submerged in factory life. Should she wish to do full-time work she will undoubtedly have to forfeit some or all of her widow's pension under the earnings rule. If she can find employment for half the day only (which is far from easy) she may still exceed the small sum she is allowed to earn above her pension. While she may have every incentive to succeed and get on, she quickly realizes that only top-grade work and salary can free her from the rule which dogs her. She then forfeits her pension entirely and must depend wholly on her own health and strength. Training courses in other than factory and domestic work should be planned. The

capacity to train is as good in women as in men. The average intelligence quotient of women is the same as that of men.

A New Understanding of the Older Widow

The family doctor knows that older patients consult him more often than do the young. Widows in their loneliness become more concerned with their bodily processes and have a greater incidence of psychosomatic complaints. The healing value of work is too well known to need emphasis, and we welcome the increasing interest in the full or part-time employment of the elderly, many of whom are physically and mentally well able to continue working long after the normal time of retirement. Many older widows are still employable. Given rest periods, their output can be quite satisfactory. Work, and a sense of being wanted and of use to the community, can be the best antidote to depression. Many schemes nowadays are designed to cater for these older age-groups. An American business man has carried out an interesting experiment in this field by starting an "old people's store." This is not a shop catering exclusively for old people; it sells exactly the same goods as are to be found in any other shop of the same kind. Its uniqueness lies in the age of the employees, none of whom—doorman, book-keeper, saleswoman, or secretary—is under 60, and most of them are much older. When the founder of the store made this the condition of employment he was warned that he was heading for bankruptcy. In fact, the new store flourished and even withstood a period of general depression successfully because all the employees were happy to be working again and gave of their very best. This had such an excellent effect on the turnover that more "old people's stores" are now being planned.

In this country the workrooms for the elderly, including many widows and widowers, are proving very successful. In these schemes the organizers obtain assembly work requiring varied degrees of skill from factories, and this is allocated according to the age and ability of the member. The work is part-time, and the same remuneration is given to all. The fellowship of the workroom is both therapeutic and prophylactic. Medical men have found a marked diminution in the psychosomatic complaints of the participants.

Development of Counselling Service for Widows

In the early stages the needs of the widows as voiced by them set the pattern for the growth and planning of the service. Contact was quickly made with the medical officers of health and through them with the general practitioners in the area, who often refer cases to the Cruse Club. Local voluntary and statutory bodies are constantly brought in. These include the Citizens' Advice Bureau, Women's Voluntary Service (mainly for clothing), child guidance and psychiatric clinics, Toc H (practical jobs done for widows in the home), the clergy (for religious difficulties), the Ministry of Labour, education officers (for boarding-school placing, etc.), almoners, health visitors, probation officers, landlords offering special rates for holidays for widows and their children, employment agencies, benevolent societies, etc.

An advisory panel operates to give help with special cases.

One of the most important developments has been the circularizing of a monthly chronicle which is sent to widows, social workers, and interested bodies all over

the country. The purpose of this journal is educative, informative, and for the encouragement of the widow. It acts as a forum for the exchange of opinions on most aspects of the widow's plight. Nine numbers have already been issued as a preliminary to the opening up of the service in other parts of the country.

In the routine of counselling the widow is encouraged to help herself, and is guided to explore the pros and cons of a situation rather than to take advice and direction. She is encouraged in freedom of decision without persuasion. There is no suggestion of management but an aid to growing independence. A great deal of help is given by one widow to another in group discussion, but the individual talk with the counsellor (who needs careful selection and regular case conferences) is vital. Through the advisory panel checks may be made on the sociological, psychological, and economic aspects of problems which come up.

Other developments have included a marketing scheme with wholesale prices, a clothing exchange, help over housing and jobs, advice on money matters, the writing of business letters, etc.

Further Education for Young Widows.—One group with special problems is the young and more intelligent widow with children, capable of benefiting from higher education up to university level. Additional help is essential in the care of the children in the home during her absence. She really needs residential help, but has not the money to pay for it.

Pattern of Marriage and its Influence on Widowhood

As mentioned above, women's basic intelligence is no whit less than men's. Yet in many marriages it is assumed that business affairs are too complicated for the woman to understand. It may be that a considerate husband wishes to protect his wife from the anxieties of money matters, or maybe it is part of a technique to call out the protective urge in the man. Some women have a fixed idea in their minds concerning what is manly and what is feminine. When they become widows they are suddenly called upon to assume the responsibilities of the husband and sometimes the father. The percentage of married women who do not know their husband's earnings, his insurances, and his commitments is very high. On the other hand, some wives are given the pay packet and hand back to the husband his allowance. This is almost a matriarchal tendency that is more frequent in the North.

In the South, perhaps because there are fewer heavy industries of the male type, the office- or shop-worker is encouraged by his wife's "little woman act" (a phrase used by a woman) to assume the whole duty of the treasurer of the marriage assets. This may lead to irresponsibility on the woman's part because of the lack of knowledge of the husband's income and his pretence regarding its size. Wise couples have a shared knowledge of their assets and liabilities and have regular budgets of a sensible and flexible kind, neither over-emphasizing the financial side nor ignoring it. Life or endowment insurance and the making of a will are matters about which some husbands have a superstitious fear. Many widows who have tentatively raised the matter have been met with a suspicious reaction. In view of the fact that the expectation of life of men is less than that of women, most wives have widowhood ahead of them. There are three times more widows than widowers.

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The Welfare State is not designed to relieve a husband of the responsibility of providing for the future needs of himself and his wife and family. This latter principle is enunciated in a Government publication on National Insurance. A widow, especially one with children, drawing all her allowances and working within the earnings rule, has no more than the lowest wage of an unskilled worker. If she is unable to work, the National Assistance Board cannot help her beyond this standard. For these and other reasons the reality situation in marriage demands consideration of the future. Such consideration could well include the possibility of the wife's being encouraged in securing a training or skill when the children have reached a reasonable age. Mature men will face these realities and make provision accordingly. One last practical suggestion for the better-off groups comes from the Married Women's Property Act.

"Under the Married Women's Property Act, 1882, Section II, a policy of insurance can be taken out by a spouse on his or her life and expressed to be for the benefit of the surviving spouse or the children or both. This creates a trust in favour of the persons named, and while such policy is not exempt from duty, it pays duty as an estate by itself. This will normally mean that it will pay a much lower estate duty. The general rule is that all the property passing on a deceased's death is added together and the rate of estate duty chargeable is fixed by the total value of all the property. This does not apply to policies under the Married Women's Property Act. This is why the rate of duty may be very much lower. The premiums payable can be spread over as short a period as five years, and the policy can be made fully paid up after three annual premiums" (Pollard, 1959).

If women are to be encouraged to train for work of any kind husbands should share more often the activities and responsibilities of the home. As the wife shares more in the life of the community the over-sheltered tendency which we see in many marriages can be mitigated.

Effect of the Loss of the Father on Children.—Many studies have been made of maternal deprivation in the case of infants, but little has been investigated as yet of the problems of the fatherless child. Boarding-school staffs and social workers are well aware of the deep emotional disturbance in this kind of deprivation and its effect on schooling and psycho-biological development. More information is needed on this topic, which is an important aspect of the counselling service for widows.

Summary

A pioneer experiment in counselling and practical help for widows is described.

The findings resulting from the group discussions in the Cruse Club for widows are given.

The effects of bereavement, especially in its emotional aspects, are mentioned. Special case-work is required to help the widow to adapt to her new circumstances and to encourage her to resist the desire to cut herself off from the community.

The economic, vocational, and psychological aspects are examined.

The problems of widows with children are considered.

The pattern of marriage, with reference to provision for the needs of widows, is outlined.

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CARE OF THE ELDERLY PREVENTIVE MEDICAL CLINICS

[FROM A SPECIAL CORRESPONDENT]

A three-day conference on "Preventive and Clinical Medicine for Older People," jointly arranged by the welfare group of the Society of Medical Officers of Health and the British Geriatrics Society, was held in Bristol from March 31 to April 2. On the first morning, under the chairmanship of the president of the Society of Medical Officers of Health, Dr. J. STEVENSON LOGAN, the conference discussed preventive medical clinics for the elderly.

Teddington Clinic

Dr. JOHN MADDISON (M.O.H., Twickenham) told the story of the establishment of the Teddington clinic for preventive medicine for older people and of its first year and a half's operation. His work with Drs. R. C. F. Smith and G. Olbrich* had convinced him of the great need for clinics for the elderly to prevent or postpone the onset of many disabilities which were not detected early because the sufferers did not go to their doctors. From 1955 to 1958 he had struggled to persuade the Middlesex County Council and the Ministry of Health to consent to an experimental clinic, and in 1958 a one-year trial, to be followed by a report, had been approved. He had also spent much time and trouble in reassuring the local G.P.s that the clinic was not going to do their work for them nor entice away any patients, and that no patient would be referred for treatment without prior full report to his own doctor. He hoped that this had forestalled mischief-makers who played off one doctor against another, and he paid tribute to the co-operation of the practitioners concerned.

The clinic, which was still in the experimental stage, was open to any elderly person who wished to attend. It was staffed by himself and a woman doctor, his superintendent health visitor, and one or two other nurses. It did not cater for casual attendances, consultations, second opinions, or dealing with conditions under treatment by G.P.s. They wanted to see those who believed themselves to be healthy and who wanted advice on how to remain so. Most of what was ascertained there as part of a comprehensive check-up was associated with the ageing process; the whole examination took two hours and involved the use of apparatus not normally available to G.P.s, who in fact often sent patients for health supervision there. There was, he insisted, no duplication of services.

Dr. Maddison said that in the first 132 people who attended 156 types of disability had been found, totalling 1,367 or an average of about 10 per person, though not evenly spaced. Obesity, hypothyroidism, and particularly atherosclerosis were commonly found; for the latter they had encouraged the taking of maize oil containing linoleic acid creamed up with "complan" and a flavouring as a pre-breakfast drink. Other troubles which the clinic helped to put right were defective vision, ill-fitting dentures, defective hearing, and unwanted hair in women. Anaemia (in about one-third of all the patients), chest and abdominal complaints, and disabilities of the lower limbs, particularly

crippling of the feet in women, were common. Physiotherapy for the rheumatically affected would be valuable, but they had not got a physiotherapist as had Dr. J. A. Gillet in his Dagenham clinic.

Rutherglen Consultative Health Centre

The second paper, presented by Dr. W. FERGUSON ANDERSON, regional consultant in diseases of old age, Scottish Western Region, speaking for himself and his co-author, Dr. NAIRN R. COWAN, M.O.H., Rutherglen, described the experience gained at the Rutherglen Consultative Health Centre for Elderly People established in Rutherglen by the initiative of Dr. Cowan as long ago as 1952. Its aims, they said, were: (1) the provision of clinical facilities for medical assessment at the premises of the local authority; (2) the integration of hospital, local-authority, general-practitioner, and voluntary services for old people; (3) the extension of the health visitor's work to the aged; (4) the setting up of a chiropody and physiotherapy service; and (5) the study of the physical, mental, and social aspects of ageing.

The clinic premises also housed chest and gynaecological out-patient clinics of the hospital board, and chiropody and physiotherapy services of the local authority. There was also liaison with old people's voluntary services. The M.O.H. first saw old people referred by their doctors and carried out a thorough medical (including x-ray) and social assessment; later in the week the consultant physician also examined them, with the M.O.H. in attendance, and a joint conference was held on each individual, the results being communicated to his G.P.; health visitors were also fully involved. Dr. Anderson outlined the findings of the clinic's work, mentioning that 4% of the people seen were admitted to hospital for short-stay assessment (of the first 1,200 seen at the clinic 44 were admitted). Nearly all the patients reported back from time to time, and frequent visiting was required of 4% of those seen.

They were trying to build up a picture of the "normal" old person. From the records of 546 people aged 60 to 89 selected as healthy by strict criteria they found that the range of blood-pressure in healthy old people was wide, and systolic blood-pressure readings in the highest age range (80-89 years) reached a figure of 220 mm. for males and 230 mm. for females. Irrespective of age, diastolic blood-pressure of up to 104 mm. for males and 108 mm. for females were found. From an investigation into the blood-pressure of 304 women it was shown that the increase in the systolic and diastolic blood-pressure means was related to the degree of associated adiposity and was not significantly influenced by the presence of varicose veins. It was also found that, when the extent of adiposity was greater than 24% over ideal weight, a significant increase in systolic and diastolic blood-pressure was to be expected; that the heart enlarged with age; and that healthy obese old men were practically non-existent. A study of the cervical spine had revealed that C7 was often spared from osteoarthritic changes and appeared to act as a fulcrum between cervical lordosis and thoracic kyphosis. They were still analysing their social data.

They summed up by saying that the work was interesting and had proved a valuable experience for the clinic's staff; the morale of old people in the area had markedly improved; they had provided the G.P. with a useful service; and such a centre as this was an essential feature of an integrated scheme for the elderly.

Chiropody Service

Mr. H. ROSENSTEIN, chief chiropodist of a London County Council health division, gave a valuable paper on the setting up of a chiropody service for the elderly, now a very live subject since the Minister of Health in March, 1959, gave way to the pressure for development of a service by the local health authorities under Section 28 (i) of the National Health Service Act. The speaker thought it unfortunate

*Brit. J. prev. soc. Med., 1955, 9, 113.