OMEGA, Vol. 49(3) 217-236, 2004

PROMOTING SELF-CARE AND DAILY LIVING SKILLS AMONG OLDER WIDOWS AND WIDOWERS: EVIDENCE FROM THE *PATHFINDERS* DEMONSTRATION PROJECT*

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ABSTRACT

While most bereavement intervention programs for the recently widowed focus primarily on loss and grief issues, few, if any, specifically address ways to engage in necessary self-care activities, to assume new responsibilities that once belonged to their deceased spouse, and to remain socially connected to the larger community. The *Pathfinders* demonstration project was designed to provide important health and wellness information in a supportive environment where the participants could develop self-care and daily living skills and learn how to access additional community resources to meet their specific needs. This article describes changes in self-care and daily living abilities reported by the *Pathfinders* participants and ways in which they used what they learned in the classes to achieve health and independence and to meet the daily challenges of widowed life. Eight-four widows and widowers (age 50+) participated in one of five 11-week class sequences. Statistically significant, although incremental improvements over time were reported in active coping, health care participation, household management, home safety, and nutritional self-care skills. Almost all the participants reported applying

*The *Pathfinders* Demonstration Project was funded by a grant from the Ben B. and Iris M. Margolis Foundation.

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at least some of the class content in their daily lives and nearly 70% sought additional information from sources outside the classes. After completing the program, many participants believed they were better prepared to take care of themselves and to address the daily challenges of widowed life. The results of the *Pathfinders* demonstration project suggest a promising new line of research focused on bereavement interventions other than those that traditionally address grief and loss issues alone.

Much of the attention directed at the health consequences of spousal bereavement has focused on mortality and morbidity rates as well as the negative effect the stress of the loss has on the health and well-being of the surviving spouse (e.g., Bonanno & Kaltman, 1999; Gallagher-Thompson, Futterman, Farberow, Thompson, & Peterson, 1993; Hall & Irwin, 2001; M. Stroebe & Stroebe, 1993; W. Stroebe & Stroebe, 1987; Williams, 2002). Recently, however, there has been a growing body of research that suggests that at least some of the influence that spousal loss has on the health of widows and widowers could be attributed to the intervening role of health behaviors and the ability to address their own self-care needs.

The loss of a spouse can be disruptive to existing health care practices, as well as interfere with the adoption of new healthy behaviors. Persons overwhelmed or preoccupied with their grief often neglect their own nutrition, fail to exercise regularly, discontinue physical and social activities that they previously did as a married couple, and become more accident prone because they pay less attention to their personal safety (Johnson, 2002; Powers & Wampold, 1994; Quandt, McDonald, Arcury, Bell, & Vitolins, 2000; Rosenbloom & Whittington, 1993; Schone & Weinick, 1998; Shahar, Schultz, Shahar, & Wing, 2001). Furthermore, bereavement can adversely impact the performance of tasks of daily living that are essential for health and independent functioning. For example, meal planning and preparation, household maintenance, managing finances, as well as other tasks often go unattended by the surviving spouse if these tasks were primarily the responsibility of his or her deceased partner. Those who fail to acquire new skills to accomplish these tasks are at increased risk for long-term mental and physical health problems (Carr et al., 2000; Lund, Caserta, & Dimond, 1993; Olson & Hanover, 1985; Powers & Wampold, 1994; Rosenbloom & Whittington, 1993; Stroebe & Schut, 1999; Wells & Kendig, 1997) and can deplete the bereaved of energy to cope with the negative emotional effects of the loss itself (Lund, Caserta, Dimond, & Shaffer, 1989). Surviving spouses who are deficient in such competencies often report greater coping difficulty because of lower feelings of self-efficacy, autonomy, and perceived control (Lund et al., 1989).

Furthermore, the role changes that accompany widowhood can be particularly stressful, especially those related to disruptions in life patterns and daily routine, and changes in social relationships and connectedness (Anderson & Dimond,

1995; Moss, Moss, & Hansson, 2001). Therefore, bereaved spouses often find themselves needing to adapt to new roles and identities while remaining socially connected to their informal networks and the larger community (Richardson & Balaswamy, 2001; Stroebe & Schut, 1999). The importance of remaining socially connected has been recognized as an important feature of successful or optimal aging because both informal socially supportive relationships as well as access to formal community services potentially can reinforce or facilitate health-related behaviors and outcomes (Rowe & Kahn, 1997, 1998). Older bereaved spouses often want to learn ways to access services and programs more effectively and how to maximize opportunities to meet and socialize with others (Lund et al., 1989; Utz, Carr, Nesse, & Wortman, 2002). Inexpensive entertainment, leisure, and physical activity options, safe places to go to socialize with others (Anderson & Dimond, 1995), and even volunteering opportunities (Lund, 1999) represent ways the bereaved remain socially connected and function more effectively and comfortably as a single person. These activities provide them potential linkages to the service network and other community resources and could represent opportunities for time away from grief itself (Caserta, Lund, & Rice, 1999).

Recent theoretical developments, most notably the Dual Process Model of Coping with Bereavement (Stroebe & Schut, 1999), have suggested that the most effective adaptation involves the oscillation between two types of coping processes: loss orientation, which addresses the global and emotional stressors associated with the loss itself; and restoration, which consists of coping strategies directed toward ongoing secondary stressors consequential to one's new status as a widow or widower. These secondary stressors are related to the need for the bereaved to assume new responsibilities and learn new skills and to adapt to new role expectations. While most bereavement intervention programs (like support groups, brief counseling, or one-on-one programs) have focused primarily on loss orientation issues (for reviews see Kato & Mann, 1999; Lieberman, 1993; Litterer Allumbaugh, & Hoyt, 1999; Schut, Stroebe, Van Den Bout, & Terheggen, 2001), few if any have addressed the secondary stressors related to engaging in necessary self-care activities, learning new tasks in order to assume responsibilities that once belonged to the deceased spouse, and the need to remain socially connected as a single person in a coupled society.

We responded to this need by developing the *Pathfinders* demonstration project, a self-care and health education program for older widows and widowers. Its primary purpose was to provide the participants important health and wellness information in a supportive environment where they could develop self-care and daily living skills and learn how to access other relevant community resources for information and support. Understanding and coping with grief also was included in the program. This article describes changes in self-care and daily living abilities reported by the *Pathfinders* participants and describes ways in which they perceived themselves using what they learned in the classes to achieve health and independence and to meet the daily challenges of widowed life.

METHODS

Although a more detailed description of the *Pathfinders* project is published elsewhere (Caserta et al., 1999; 2001), the programmatic and methodological issues especially relevant to this report are presented below. The program consisted of 11 weekly 2-hour classes that were facilitated by professionals with expertise in self-care or health education. The program content included taking charge of one's overall health (immunizations, health screenings, communicating with one's health care provider), stress management, managing finances, understanding grief, medication management, exercise and physical activity, accessing community services, healthy nutrition for one, maintaining a clean and safe home, social functioning as a single person (socialization opportunities) and personal growth issues (trying new things that lead to a healthier life). These topics were carefully selected because previous bereavement research has documented their importance (Caserta et al., 1999; Hughes, 1995; Lieberman, 1996; Lund et al., 1989; Powers & Wampold, 1994) and they are relevant to healthy aging and quality of life (Brice, Gorey, Hall, & Angelino, 1996; Rowe & Kahn, 1998). With two exceptions, one topic was covered each week. Part of the first class was dedicated to setting health-related goals followed by how to take better charge of one's health. Household maintenance and home safety also were covered in one session. Therefore, 13 topics were covered over the 11-week sequence.

During the first hour of class, each presenter provided a lecture and led the widow(er)s in group discussions, in-class demonstrations, and exercises pertaining to the topic. A 20- to 30-minute question and answer period followed. The remaining 30 to 40 minutes were reserved for socialization where healthy snacks and beverages were made available to facilitate informal social interactions. Workbooks containing outlines of the lectures, handouts with additional information, and other learning aids for use outside the classroom setting were provided. A "Free Literature" table also was available each week so that the participants had access to brochures and pamphlets pertaining to the week's topic as well as sources of additional information and support in the community. Participants were guided and encouraged to set specific goals each week that applied the course content. A licensed clinical social worker who was certified as a grief counselor was available at the weekly meetings to provide support and address any emotional problems that might emerge.

The sequence of classes was scheduled during warm weather seasons to avoid attendance problems due to inclement weather and winter holidays. Sessions were held at a centrally located site in the community that was conveniently accessible by automobile and public transportation.

Evaluation data on the program were collected through self-administered questionnaires over 4 time points: prior to the start of the classes (baseline), after the completion of the 11-week sequence (post-test), and at 2- and 4-month follow-up. We also kept attendance records for every participant at each class session.

Sample and Recruitment

Although *Pathfinders* was designed primarily for older adults who were recently widowed it was open to any interested widow or widower provided they were age 50 or older. Participants were recruited through several strategies. Some were referred by community agencies that served or had contact with older widows and widowers (e.g., AARP Widowed Persons Service (now the Grief and Loss Program), senior centers, churches, libraries, mortuaries, hospice services and other health care providers). Each of these sources distributed brochures and posted flyers describing the program. Participants also were recruited through newspaper advertisements and television spots. Finally, we used newspaper obituaries to identify potential participants who were widowed between six months to 1 year and sent them letters and brochures describing *Pathfinders* and inviting them to participate. Once interested participants contacted the project office, a trained research assistant visited them at their home to answer any questions they had concerning the program, obtained informed consent, and delivered the baseline self-administered questionnaire that was returned in a self-addressed stamped envelope after it was completed.

Eighty-four older widows and widowers joined the program and completed the self-administered questionnaires. Seventy-two (85.7%) of the participants were women with an average age equal to 69.0 years ($SD = 8.6$) for the full sample. The median annual household income category was $10,000–$19,999. Most of the participants were high school graduates (92.9%), lived alone (75%), were not currently employed (81.9%), and had been married for an average of 42.3 years ($SD = 12.5$) when their spouse died. The median length of time the participants were widowed was 12 months when they joined the study. Although the program was intended primarily for those who lost their spouse more recently, 17% ($n = 14$) of the participants were widowed more than two years. However, almost 79% were widowed 18 months or less prior to joining *Pathfinders*, which suggests that the program did have the greatest appeal to those who were more recently widowed.

Measures

In addition to demographic and background information, the self-administered questionnaires consisted of a competencies scale measuring perceived self-care abilities, items dealing with the application of class content in their daily lives, content areas in which the participants sought additional information from other sources beyond the *Pathfinders* classes themselves, and the degree to which they worked on and met their personal health and self-care goals. The competencies scale was included in all four assessments while the latter measures were included in the post-test and 2- and 4-month follow-up questionnaires. These measures are described in greater detail below.

The final data point (4-month follow-up) also included two open-ended questions asking the participants to describe any benefits they believed they received as a result of their participation in the program as well as any positive changes they observed within themselves since they joined the project. This latter question was followed by a single 5-point Likert format item that asked, "To what extent do you believe your participation in this project is related to these changes (1 = not at all; 5 = a lot)? The responses to the open-ended questions were content-analyzed for emergent themes.

Perceived Competencies

Perceived competencies were measured using a 23-item scale in which the participants were asked to rate their ability in a variety of self-care and daily living skills. The items were scored using a 3-point Likert format (1 = not at all, 2 = somewhat, 3 = a lot). This instrument is a modification of a scale we used in our earlier research (Caserta & Lund, 1993; Lund et al., 1989), but some items were revised to more accurately reflect the program content. A principle components factor analysis (varimax solution) generated five factors. Each factor represents an internally consistent subscale reflecting a particular self-care area. The five self-care areas represented are: 1) *active coping*, which corresponds to those skills used to manage time effectively, identify and use sources of help, and manage stress; 2) *health care participation* or skills important to assuming an active role in one's health and health care; 3) *household management*; 4) *home safety*; and 5) *nutritional self-care*. The factor loadings and alpha coefficients for each subscale are presented in Table 1.

Daily Application of Content and Information Seeking

The questionnaire included two checklists itemizing the 13 content areas covered by the *Pathfinders* classes. For one checklist, the participants were asked to check each content area they were applying in their daily lives. The participants were similarly requested to indicate the content areas about which they have sought additional information outside the classes. This was followed by an open-ended question asking the participants to describe how they obtained the information they sought.

Personal Goals

The participants were asked three questions pertaining to the pursuit and attainment of their personal goals regarding their own health, self-care ability, independence, and well-being. These were: "To what extent do you believe you met your own personal goals for this program?" (On a scale of 1 [not at all] to 5 [met all of my goals], "Do you continue to work on them?" (1 = not really, 2 = somewhat, 3 = yes, fairly regularly), and an open-ended question

Table 1. Perceived Self-Care Skills: Five Factor Solution (Varimax Rotation)

Factor/Items	Factor loadings
Active Coping (alpha = .88)	
Organize time	.75
Organize/utilize sources of help	.69
Identify community resources	.69
Understand and meet leisure needs	.68
Engage in regular exercise	.64
Adapt to changing conditions	.64
Cope with failures or setbacks	.61
Plan things in advance	.59
Meet and get to know new people	.52
Health Care Participation (alpha = .78)	
Understand when to schedule important medical exams	.81
Know when/where to get immunizations	.68
Understand appropriate use of OTC medications	.61
Use prescription medications wisely	.59
File forms (insurance, Medicare, etc.)	.45
Communicate effectively with health care provider	.44
Household Management (alpha = .64)	
Balance checkbook and similar mathematical tasks	.83
Manage finances and budget wisely	.61
Keep household organized and clean	.60
Perform and endure required daily physical activities	.48
Home Safety (alpha = .75)	
Handle minor household repairs	.81
Recognize and remedy potential household safety hazards	.76
Nutritional Self-Care (alpha = .66)	
Read and understand food labels	.87
Plan and prepare nutritious meals	.78

asking the participants what some of their main goals were for participating in the program.

RESULTS

Five 11-week sequences were held during the course of the *Pathfinders* project. An average of approximately 17 participants enrolled in each sequence (Range: 12 to 20). The overall attendance at the classes was quite good. The mean attendance (out of 11 possible classes) was 7.8 ($SD = 3.2$). The median number of classes attended by the participants over the course of the study was 9 or an 82% attendance rate.

Reported Changes in Self-Care and Daily Living Skills

Analyses of variance (ANOVA) with repeated measures were conducted to determine any changes that were reported by the participants in the five self-care areas measured by the competencies scale over the 4 data points. The results are presented in Table 2. The baseline scores for active coping ($M = 20.7$; $SD = 3.8$), health care participation ($M = 16.0$; $SD = 2.2$), household management skills ($M = 10.1$; $SD = 1.8$), home safety skills ($M = 4.4$; $SD = 1.2$), and nutritional self-care ($M = 5.2$; $SD = 1.0$) were each above the theoretical midpoint for the respective subscale.

Although the skill levels on average were not exceedingly low when the participants joined the study, statistically significant improvements over time were reported in each self-care area. The overall changes over time observed for both active coping ($p < .05$) and home safety skills ($p < .01$) were primarily linear (contrasts were significant at $p < .01$ and .001, respectively) where the levels steadily increased over the four data points. Alternatively, the changes over time observed for health care participation and nutritional self-care were largely curvilinear where only the quadratic effects were statistically significant ($p < .01$ for health care participation, and $p < .05$ for nutritional self-care). In both instances, there were incremental increases from baseline up to and including the 2-month follow-up and then a decline to near baseline levels at the 4-month follow-up. Finally, the polynomial contrasts indicated that changes over time for household management skills had both a linear ($p < .01$) and a curvilinear ($p < .001$) component. The subscale scores gradually improved from baseline through the 2-month follow-up and declined slightly to the post-test level at the final data point.

We also investigated if these observed changes were influenced or moderated by other background factors (age, gender, educational level, annual household income, years married at the time of the spouse's death, and length of widowhood). After inspecting Pearson product-moment correlations between the self-care subscales for each time point and these factors, only gender (represented by a

Table 2. Changes Over Time Within Five Dimensions of Self-Care

	Baseline		Post-test		Two months follow-up		Four months follow-up		Time	Polynomial contrasts (*F*)		
Outcome	*M*	(*SD*)	*M*	(*SD*)	*M*	(*SD*)	*M*	(*SD*)	*F*-ratio	Linear	Quadratic	Cubic
Active coping[a]	20.7	(3.8)	21.4	(3.3)	21.6	(3.0)	21.7	(3.5)	2.71*	7.99**	2.01	0.14
Health care participation[b]	16.0	(2.2)	16.2	(1.9)	16.6	(1.7)	16.0	(2.0)	2.98*	0.64	7.46**	2.58
Household management[c]	10.1	(1.8)	10.5	(1.4)	10.8	(1.4)	10.5	(1.5)	5.89***	6.84**	13.21***	0.95
Home safety[d]	4.4	(1.2)	4.7	(1.0)	4.7	(0.9)	4.8	(1.0)	4.30**	10.92***	2.34	1.85
Nutrition[d]	5.2	(1.0)	5.3	(0.8)	5.4	(0.8)	5.3	(0.9)	3.43*	2.73	4.70*	1.89

[a]Possible range = 9 (low) – 27 ((high). [b]Possible range = 6 (low) – 18 (high). [c]Possible range = 4 (low) – 12 (high). [d]Possible range = 2 (low) – 6 (high).

*$p < .05$. **$p < .01$. ***$p < .001$.

dummy coded variable were 1 = female) generated consistent significant correlations with home safety at each data point. The average correlation over the four data points was –.31, ranging from –.26 to –.40 (all at least $p < .05$). In each instance, women reported lower levels of home safety skills compared to men.

Consequently, we replicated the repeated measures ANOVA for home safety using gender as a between group factor. These analyses revealed gender as a significant main effect, independent of time ($F = 13.38$, $p < .001$). Time dropped from statistical significance as a within-subjects factor. Although not statistically significant, however, there was a trend in the data suggesting improvement in home safety skills among the widows from baseline ($M = 4.2$, $SD = 1.2$) to the 4-month follow-up ($M = 4.7$, $SD = 1.0$). Although the widowers' scores were higher than the widows throughout the four measurements, they showed little change, remaining near 5.5 (range: $M = 5.4$; $SD = 0.8$ at 2-month follow-up to $M = 5.6$; $SD = 0.8$ at baseline).

Application of Content and Information Seeking Behavior

The data in Table 3 represent the extent to which the *Pathfinders* participants reported applying the program content in their daily lives following the completion of the classes. Virtually all the participants (97%) reported that they applied at least some of the content from the classes in their daily lives, averaging approximately seven content areas for any one individual over the course of the project. More than half of the participants reported applying 10 of the 13 content areas in their daily lives. The three content areas most commonly applied were those pertaining to becoming or staying physically active (71%), taking charge of one's health, and meeting others and making friends (both 60%).

There were three content areas that more than 50% of the participants used on a daily basis at post-test but were substantially less applicable at the latter two data points: accessing services; dealing with stress; and understanding grief. Each of these topics may have been deemed more relevant by the participants as they entered the program but decreased in importance as they were widowed longer.

Nearly 70% of the participants sought additional information outside the classes and did so for an average of three topics per person (see Table 4). No specific content areas clearly dominated, most likely due to variability among the participants in pre-existing knowledge, skill levels, and need. However, approximately one-third of the participants wanted to know more about physical activity (36%), being a more active participant in their own health (34%), and ways to grow personally by trying new things (31%).

The strategies the participants used to acquire new information varied and several participants mentioned more than one strategy over the course of the project. Typical sources of additional information included what was provided by professionals, services, and programs (e.g., area agencies on aging, health care providers and organizations, AARP), and books, magazines, and videos—either

Table 3. Extent to Which Content from *Pathfinders* Classes was Applied in the Participants' Daily Lives Once Classes Ended

	Data points			
Content areas	Post-test	Two months follow-up	Four months follow-up	Average
Setting goals for yourself	68%	49%	51%	56%
Taking charge of your health	65%	55%	60%	60%
Nutrition	63%	48%	52%	54%
Maintaining clean safe home	59%	52%	49%	53%
Minor home repair/maintenance	41%	35%	33%	36%
Managing finances	56%	59%	48%	54%
Staying active/exercise	71%	71%	72%	71%
Managing medications	43%	43%	48%	45%
Accessing services	53%	35%	36%	41%
Understanding grief	60%	46%	46%	51%
Dealing with stress	65%	49%	49%	54%
Meeting others/making friends	71%	54%	55%	60%
Trying new things	71%	51%	43%	55%
Percent applying some information	100%	91%	99%	97%
Mean No. of content areas	7.8	6.5	6.4	6.9

borrowed from the public library or a similar community resource or privately purchased. Other information-seeking strategies included taking classes in order to learn more about a specific topic, and contacting friends, family, or other members of one's informal network.

Pursuit and Attainment of Personal Goals

The goals that the *Pathfinders* participants set for themselves were quite diverse; however, most involved issues related to coping more effectively with grief, loss, and the daily challenges of widowed life, being more socially connected and involved with others, and becoming more independent and self-sufficient. Participants mentioned goals derived from specific parts of the educational content presented in the program, including assuming greater control

Table 4. Proportion of *Pathfinders* Participants' Who Sought Additional Information Outside the Classes (by Content Area)

	Data points			
Content areas	Post-test	Two months follow-up	Four months follow-up	Average
Setting goals for yourself	13%	14%	24%	17%
Taking charge of your health	25%	37%	40%	34%
Nutrition	20%	26%	31%	26%
Maintaining clean safe home	10%	17%	19%	15%
Minor home repair/maintenance	9%	20%	18%	16%
Managing finances	18%	26%	25%	23%
Staying active/exercise	38%	40%	29%	36%
Managing medications	7%	23%	24%	18%
Accessing services	20%	19%	13%	17%
Understanding grief	28%	25%	28%	27%
Dealing with stress	27%	22%	19%	23%
Meeting others/making friends	21%	30%	27%	26%
Trying new things	27%	32%	33%	31%
Percent seeking some information	63%	71%	72%	69%
Mean No. of content areas	2.6	3.3	3.3	3.1

over one's health, better management of household finances, improvements in physical activity and nutrition habits, accessing services more effectively, and becoming more skilled in household maintenance. A few reported goals were directed toward personal growth like "trying something new" and "getting to know myself better."

As seen in Table 5, the participants reported at least moderate success in their efforts to meet their personal goals and continued to work on them with reasonable consistency during the four-month period following the completion of the classes. More than 90% of the participants reported a 3 or higher on the 5-point Likert item that asked to what extent their goals were met and more than 40% of them (and 50% at the four-month follow-up) had scores equal to 4 or 5. Similarly, most participants continued to work on their goals with nearly 60% reporting doing so on a regular basis over the post-test and follow-up data points.

Table 5. Meeting Personal Goals

Questions about goals	Data points		
	Post-test	Two months follow-up	Four months follow-up
To what extent you met your personal goals [*M* (*SD*)] (1 = not at all; 5 = all goals)	3.4 (0.9)	3.5 (0.8)	3.6 (0.7)
Somewhat % (3 or better	91%	94%	98%
Almost all % (4 or 5)	46%	43%	50%
Do you continue to work on them?			
Somewhat	33%	31%	41%
Fairly regularly	59%	61%	56%

Self-Perceptions of Positive Change

Content analyses of the open-ended comments regarding the *Pathfinders* participants' perceptions of the benefits they obtained from their involvement with the project as well as positive changes they observed within themselves generated three major themes. The two most prominent were the interrelated concepts of increased self-efficacy and the perception that they attained greater skill and knowledge that made them better prepared to take care of themselves and take on new responsibilities.

Perceptions of self-efficacy emerged through expressions of a newfound confidence in several instances as suggested by the following representative comments:

> I got more secure.

> It (the program) gave me the self-confidence to cope with all the problems of being alone.

> It helped me get started and gave me a lot of confidence in myself.

> It gave me hope for the future and in myself and ways to set goals and encouragement to follow through with them.

> I am more confident living by myself.

> I feel more sure of myself.

> I am more confident and eager to make new friends and enjoy fun and relaxation and make positive contributions to others and society.

Even if overall feelings of confidence were not explicitly expressed, several participants pointed to specific self-care areas in which they believed they were better prepared.

> Found helpful ideas in managing life and household and understanding self.
>
> Yes! Understanding grief and stress. Medications. Learning what is available. Learning pitfalls and contracting of things I don't know anything about. Networking for repair people.
>
> To plan my time for doing things.
>
> Renewed interest in exercise. A few good ideas are very helpful.
>
> I am definitely more assertive!

Others, while not mentioning a specific area felt better prepared, in a general sense, to meet the challenges of daily widowed life.

> I learned something from every class.
>
> I learned some things that I didn't know before.

The third major theme pertained to how participants used what they learned to reconnect to others and the larger community. They viewed their connections to others as sources of social interaction and informational social support.

> New friends and community resource info that I might need in the future.
>
> I consciously pushed myself to meet new people and make new friends.
>
> I have tried community classes and participated in activities in the Senior Citizen Center.

When the participants were asked at the four-month follow-up to what extent their participation in the project was responsible for the changes they observed in themselves on a scale of 1 (not at all) to 5 (a lot), most (92%) reported a score of 3 or higher ($M = 3.8$; $SD = 1.0$) and 60% responded with a 4 or 5. This could be interpreted to suggest that the *Pathfinders* program was at least somewhat responsible—and for many, largely responsible—for these positive changes.

DISCUSSION

For the most part, the older widows and widowers entered the *Pathfinders* program fairly skilled in each of the self-care and daily living skill areas that were assessed but were able to still improve by participating in the project. Improvements over time were reported in active coping, household management, and home safety abilities in particular. While the men who participated remained quite skilled in keeping a home safe and secure, trends in the data indicated that the women reported less ability but showed some improvement, although time as

a within-subjects factor dropped from statistical significance once gender was entered into the model. The failure to attain statistical significance was probably due to a loss of statistical power to predict change over time once gender was added as a group effect in the repeated measures ANOVA. Except for this one instance, however, the participants' perceived competencies were largely independent of gender, age, educational level, annual household income, and how long they were married when their spouse died. These perceived abilities also appeared to be independent of how long the participants were widowed, although most of them were widowed 18 months or less and it is not clear if a correlation would emerge if more of the participants were widowed longer and had more prior opportunities to learn what was presented in the classes from other sources.

Increases in health care participation and nutritional self-care subscale scores were somewhat short-lived. Although there were improvements over time over the first three data points, scores for the four-month follow-up returned to near baseline levels. It is not entirely clear why this occurred. Some of it can be attributed to measurement error especially for the nutritional subscale, which consisted of only two items (Nunnally & Bernstein, 1994). Also, the participants may have slightly overestimated their skill levels at the post-test and three-month follow-up time points or conversely, slightly underestimated their ability at the final data point. Another possible explanation could be that as they became more knowledgeable in these areas, some of the participants may have reassessed their skill levels to one that they perceived to be more realistic.

Although statistically significant, the changes over time observed in the competency subscales were sometimes incremental (while usually in the positive direction). Two things could explain this. First of all, improvements in these self-care areas are often gradual for many individuals when these changes are guided by information-seeking and goal-setting strategies that involve small doable steps toward a targeted outcome. The two-hour weekly sessions were primarily designed to give the participants the information, guidance, and resources in order to take the initial steps needed to make improvements in those areas in which they believed they needed to change and to continue to make progress over time. Furthermore, individuals with similar subscale scores could be initially skilled in different specific tasks or abilities within the larger self-care or daily-living category and then differentially improve in some skills but remain stable in other abilities. For example, two individuals may have a similar baseline score for household management where one is more skilled in budget or financial issues but not as proficient at keeping the house itself organized or clean, while the opposite is true for the other person. Assuming that after participating in the program they both improve in those abilities in which they were initially less skilled while remaining adept in the others, they both would show an incremental change in the subscale score but the source of the improvement would be different.

The above illustration underscores an important characteristic of the participants in the *Pathfinders* program, which is similar to what is often observed in other broadly focused health education programs. The participants were quite heterogeneous in their initial levels of knowledge, skills, and need when they entered the program. This was evident in the diverse goals they set as well as the additional information the participants sought outside the classes. A benefit of this variability, however, is that it created an atmosphere where they learned from each other, both inside and outside the class setting, in addition to the material they received from the presenters. While it was unreasonable to expect that all the program content was equally applicable to each participant, there was information that was relevant to each participant's unique situation. The participants reported that they were using the information in their daily lives in a relatively broad fashion, although the content specifically related to managing stress and understanding grief itself, and accessing services was more applicable early on and less important as they were bereaved longer and/or they obtained the help they needed from a community service or program.

A common perception that emerged for many participants was an increased sense of self-efficacy where they felt more confident in their ability to take care of themselves and to address the daily challenges of widowed life. They also appeared to use the community (both the formal service network as well as informal relationships) as a source of social interaction and informational support. Some, for the first time since their spouse's death, were beginning to make a greater effort to pursue socialization, educational, and leisure opportunities within the community. The participants were contacting agencies, organizations, community experts, and (in a few instances) taking classes to learn more about remaining independent and healthy or becoming more so.

Because *Pathfinders* was funded as a community-based demonstration project and not as a controlled experimental study, there are some obvious limitations that temper our interpretation of the findings. First of all, as in virtually all community programs, selection factors introduced a potential source of bias (Rossi, Freeman, & Lipsey, 1999). Only those interested, motivated, and willing to seek ways to improve their overall situation joined the project and it is very likely that some who would benefit the most from a program like *Pathfinders* may be less inclined to participate. Others may simply believe that they would not benefit from participating in such a program because they perceive themselves as managing effectively on their own. This is a challenge common to both health promotion (Rakowski, 1998; Williams et al., 1998) and bereavement programming (Levy, Derby, & Martinowski, 1993; Lund & Caserta, 1998). While better outreach efforts could improve the accessibility of those who are more difficult to locate, motivation is a key ingredient to participation in any program aimed at voluntary behavioral change, knowledge or skill improvement, and it is for those individuals that programs are primarily designed.

It also is obvious that a single, two-hour session is often not sufficient in and of itself to provide in-depth coverage of any self-care or daily living topic. As mentioned earlier, however, this was not the program's intent. Its purpose was rather to provide enough information along with goal-setting strategies and referrals to community resources to help the participants take the first steps toward improved health and independence, given their own unique experiences, preexisting knowledge, skills, and need. The accomplishment of this overall aim was somewhat supported by evidence of their continued information-seeking behavior and goal-setting strategies.

Perhaps the most significant caveat regarding the interpretation of these findings is that because this demonstration project did not allow for a non-intervention comparison group, we cannot definitively conclude that all reported improvements in self-care and daily living skills were due solely to participation in the *Pathfinders* program. The following factors, however, suggest that program participation may be at least partially related to the findings. The participants reported some success in meeting their personal goals and continued to work on them throughout the course of the project, even after the classes ended. The four-month period of time following the classes was short enough to minimize the effect of potentially confounding external influences on improvements in self-care and daily living skills, while controlling for baseline skill levels. Although it is possible that some of what they learned and other improvements that occurred may have developed independent of whether they participated in *Pathfinders*, the participants attributed at least some of the positive changes they observed in themselves directly to their participation and many thought that *Pathfinders* was largely responsible for these changes.

Despite these limitations, however, the results of the *Pathfinders* demonstration project suggest a promising new line of research focused on bereavement interventions other than those that traditionally address grief and loss issues alone and the loss-oriented coping processes used to manage these sources of distress (Stroebe & Schut, 1999). Carefully planned investigations into those intervention strategies that also incorporate and foster the restoration-focused coping processes that have been receiving increasing attention in bereavement theory (as in Stroebe & Schut's [1999] Dual Process Model) and their effectiveness warrant serious consideration. Controlled experimental designs using larger, diverse samples should be implemented to test the effectiveness of interventions that combine the restoration-focused elements of programs like *Pathfinders* in combination with grief support compared to those that represent the current standard of care in bereavement programs, like the traditional bereavement self-help group. Such efforts could precipitate more promising developments in bereavement programming where older widows and widowers are provided resources to develop skills needed to confront the everyday challenges to their health, functioning, independence, and quality of life.

REFERENCES

Anderson, K. L., & Dimond, M. F. (1995). The experience of bereavement in older adults. *Journal of Advanced Nursing*, *22*, 308-315.

Bonanno, G. A., & Kaltman, S. (1999). Toward an integrative perspective on bereavement. *Psychological Bulletin*, *125*, 760-776.

Brice, G. C., Gorey, K. M., Hall, R. M., & Angelino, S. (1996). The STAYWELL program: Maximizing elders' capacity for independent living through health promotion and disease prevention activities. *Research on Aging*, *18*, 202-218.

Carr, D., House, J. S., Kessler, R. C., Nesse, R. M., Sonnega, J., & Wortman, C. (2000). Marital quality and psychological adjustment to widowhood among older adults: A longitudinal analysis. *Journal of Gerontology Social Sciences*, *55B*, S197-S207.

Caserta, M. S., & Lund, D. A. (1993). Intrapersonal resources and the effectiveness of self-help groups for bereaved older adults. *The Gerontologist*, *33*, 619-629.

Caserta, M. S., Lund, D. A., & Rice, S. J. (1999). *Pathfinders*: A self-care and health education program for older widows and widowers. *The Gerontologist*, *39*, 615-620.

Caserta, M. S., Lund, D. A., & Rice, S. J. (2001). Participants' attendance at a health promotion program for older widows and widowers. *American Journal of Health Education*, *32*, 229-236.

Gallagher-Thompson, D., Futterman, A., Farberow, N., Thompson, L. W., & Peterson, J. (1993). The impact on spousal bereavement on older widows and widowers. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research and intervention* (pp. 227-239). New York: Cambridge University Press.

Hall, M., & Irwin, M. (2001). Physiological indices of functioning in bereavement. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 473-492). Washington, DC: American Psychological Association.

Hughes, M. (1995). *Bereavement and support: Healing in a group environment.* Washington DC: Taylor & Francis.

Johnson, C. S. (2002) Nutritional considerations for bereavement and coping with grief. *Journal of Nutrition, Health and Aging*, *6*, 171-176.

Kato, P. M., & Mann, T. (1999). A synthesis of psychological interventions for the bereaved. *Clinical Psychology Review*, *19*, 275-296.

Levy, L. H., Derby, J. F., & Martinkowski, K. S. (1993). Effects of membership in bereavement support groups on adaptation to conjugal bereavement. *American Journal of Community Psychology*, *21*, 361-381.

Lieberman, M. A. (1993). Bereavement self-help groups: A review of conceptual and methodological issues. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 411-426). New York: Cambridge University Press.

Lieberman, M. A. (1996). *Doors close, doors open: Widows grieving and growing.* New York: G. P. Putnam's Sons.

Litterer Allumbaugh, D., & Hoyt, W. T. (1999). Effectiveness of grief psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *46*, 370-380.

Lund, D. A. (1999). Giving and receiving help during later life spousal bereavement. In J. D. Davidson & K. J. Doka (Eds.), *Living with grief: At work, at school, at worship* (pp. 203-212). Levittown, PA: Brunner/Mazel.

Lund, D. A., & Caserta, M. S. (1998). Future directions in adult bereavement research. *Omega*, *36*, 287-303.

Lund, D. A., Caserta, M. S., & Dimond, M. F. (1993). The course of spousal bereavement in later life. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research and intervention* (pp. 240-254). New York: Cambridge University Press.

Lund, D. A., Caserta, M. S., Dimond, M. F., & Shaffer, S. K. (1989). Competencies, tasks of daily living, and adjustments to spousal bereavement in later life. In D. A. Lund (Ed.), *Older bereaved spouses: Research with practical applications* (pp. 135-156). Washington, DC: Taylor-Francis/Hemisphere Press.

Moss, M. S., Moss, S. Z., & Hansson, R. O. (2001). Bereavement and old age. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 241-260). Washington, DC: American Psychological Association.

Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). New York: McGraw-Hill.

Olson, T., & Hanover, J. (1985). Preparing women to be widows. *Health Values*, *9*, 8-11.

Powers, L. E., & Wampold, B. E. (1994). Cognitive-behavioral factors in adjustment to adult bereavement. *Death Studies*, *18*, 1-24.

Quandt, S. A., McDonald, J. Arcury, T. A., Bell, R. A., & Vitolins, M. Z. (2000). Nutritional self-management of elderly widows in rural communities. *The Gerontologist*, *40*, 86-96.

Rakowski, W. (1998). Evaluating psychosocial interventions for promoting self-care behaviors among older adults. In M. G. Ory & G. H. DeFriese (Eds.), *Self-care in later life: Research, program, and policy issues* (pp. 85-117). New York: Springer.

Richardson, V. E., & Balaswamy, S. (2001). Coping with bereavement among elderly widowers. *Omega*, *43*, 129-144.

Rosenbloom, C. A., & Whittington, F. J. (1993). The effects of bereavement on eating behaviors and nutrient intakes in elderly widowed persons. *Journal of Gerontology: Social Sciences*, *48*, S223-S229.

Rossi, P. H., Freeman, H. E., & Lipsey, M. (1999). *Evaluation: A systematic approach* (6th ed.). Thousand Oaks, CA: Sage.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, *37*, 433-440.

Rowe, J. W., & Kahn, R. L. (1998). *Successful aging: The MacArthur Foundation study*. New York: Pantheon Books.

Schone, B. S., & Weinick, R. M. (1998). Health-related behaviors and the benefits of marriage for elderly persons. *The Gerontologist*, *38*, 618-627.

Schut, H., Stroebe, M. S., Van Den Bout, J., & Terheggen, M. (2001). The efficacy of bereavement interventions: Determining who benefits. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 705-737). Washington, DC: American Psychological Association.

Shahar, D. R., Schultz, R., Shahar, A., & Wing, R. (2001). The effect of widowhood on weight change, dietary intake, and eating behavior in the elderly population. *Journal of Aging and Health*, *13*, 186-199.

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, *23*, 197-224.

Stroebe, M. S., & Stroebe, W. (1993). The mortality of bereavement: A review. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 175-195). New York: Cambridge University Press.

Stroebe, W., & Stroebe, M. S. (1987). *Bereavement and health: The psychological and physical consequences of partner loss*. New York: Cambridge University Press.

Utz, R. L., Carr, D., Nesse, R., & Wortman, C. B. (2002). The effect of widowhood on older adults' social participation: An evaluation of activity, disengagement, and continuity theories. *The Gerontologist*, *42*, 522-533.

Wells, Y. D., & Kendig, H. L. (1997). Health and well-being of spouse caregivers and the widowed. *The Gerontologist*, *37*, 666-674.

Williams, J. R. (2003). Effects of grief on survivor's health. In K. J. Doka (Ed.), *Living with grief: Loss in later life* (pp. 191-206). Washington, DC: Hospice Foundation of America.

Williams, S. J., Drew, J., Wright, B., Seidman, R., McGann, M., & Boulan, T. (1998). Health promotion workshops for seniors: Predictors of attendance and behavioral outcomes. *Journal of Health Education*, *29*, 166-173.

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