most population-based studies have found lower rates of mortality in caregivers than non-caregivers. We examined the potential role of selection bias due to 1) study design and 2) selective participation in Caregiver-SOF, an ancillary study to the Study of Osteoporotic Fractures (SOF). Caregiver-SOF includes 1069 SOF participants (375 caregivers, each matched to 1–2 non-caregivers) identified in two phases: screening all SOF participants for caregiver status at SOF Visit 6 (1997–1999, n=4036 women, 23% caregivers) and rescreening all caregivers and a subset of non-caregivers matched on sociodemographic factors 1–2 years later. Mean age at initial screening was 79 years. Older women and women with poorer physical or cognitive functioning were less likely to participate. Caregivers had better functioning than non-caregivers at each screening. We calculated adjusted hazards ratios (aHR) to assess associations between caregiving and 10-year mortality in all 4036 initially screened women, women invited to participate (all caregivers and selected matched non-caregivers, n=1449), and the Caregiver-SOF sample (74% of those invited). Adjusting for functioning and matching variables, the association between caregiving and mortality in invited women (48% died; aHR=0.79; 95% CI: 0.65–0.97) was similar to that in initially screened women (37% died; aHR=0.84; 95% CI: 0.73–0.96), indicating minimal bias due to study design, and to that in Caregiver-SOF (48% died; aHR=0.80; 95% CI: 0.63–1.03), indicating minimal participation bias. These results lend validity to findings that caregivers have lower risk of mortality.

ASSOCIATION BETWEEN PERCEIVED SOCIAL SUPPORT FROM DIFFERENT SOURCES AND SELF-MASTERY AMONG U.S. CHINESE OLDER ADULTS

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Background: Researchers have examined the relationship between perceived social support (SS) and personal self-mastery (SM), but there is limited knowledge about this association among immigrant populations who may have less available external social support. This study examines the association between SS and SM among U.S. Chinese older adults. Methods: Data were derived from 3,157 Chinese older adults age 60 and over from the PINE study. SS was measured with 12 items from NSHAP regarding positive/negative SS from spouse, family, and friends. Overall SS is the sum of positive and negative support. SM was assessed by the 7-item Pearlin Mastery Test. Linear regression was conducted adjusting for confounders. Results: The mean SM of study participants was 34.6 ± 7.7(range: 7–49). Higher overall SS from spouse (b=0.94, SE=0.1), family (b=0.93, SE=0.1), and friends (b=0.94, SE=0.1) were associated with higher SM. Further, higher positive SS from spouse (b=1.1, SE=0.13), family (b=0.74, SE=0.1), and friends (b=0.87, SE=0.1) were also associated with higher SM. On the other hand, higher negative SS from spouse (b=-0.97, SE=0.18), family (b=-1.89, SE=0.24), and friends (b=-1.43, SE=0.42) were associated with lower SM. Conclusions: Our study shows both positive SS and negative SS are related to SM among U.S. Chinese older adults. Further longitudinal studies are needed to identify modifiable factors to improve SS and SM among immigrant populations.

DEPRESSIVE SYMPTOMS AND CHRONIC DISEASE: IS THERE AN ASSOCIATION FOR OLDER AFRICAN AMERICANS?

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The purpose of this study was to identify the association between physical health problems and depressive symptoms among older African Americans (age > 65) using the 2014 Health and Retirement Study (N = 1,206). Membership in a racial/ethnic minority group may restrict access to mental health services. Many existing studies have reported the higher prevalence of depressive symptoms among older minority populations. Racial/ethnic minority groups, particularly African Americans experience a disproportionate burden of chronic conditions, as well as disparities accessing health care and preventive services due to a variety of socioeconomic, behavioral, and other factors. For statistical analysis, depressive symptoms were measured with eight-item CES-D Scale (M = 1.546, SD = 1.952), and chronic health conditions were measured by asking whether respondents had ever diagnosed with the following seven diseases: high blood pressure, diabetes, cancer, lung disease, heart disease, stroke, and arthritis (M = 2.736, SD = 1.285). Sociodemographic covariates included self-reported health, age, gender, income (logged), marital status, and educational attainment. An OLS regression showed that older African Americans having one additional chronic health problem was associated with .133 higher depressive symptoms after controlling for the covariates (p = .002). The regression model could be an appropriate prediction on depressive symptoms, Adjusted R-square = .161, F (7, 1,198) = 34.127, p < .001. Depression and chronic illness together are drivers that increase healthcare costs and have developed into a critical problem for an already vulnerable older African American population, requiring a critical attention from both practice and policy.

DOES COPING MATTER? COPING AND CHRONIC PHYSIOLOGICAL DISTRESS AMONG AGING U.S. BLACK AND WHITE MEN

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Chronic physiological distress accelerates biological aging and is linked to chronic disease and premature mortality. Physiological distress biomarkers, such as cortisol, represent a key proximal outcome of stress and coping processes through which social inequities are posited to generate health disparities. This study explored how variations in coping may contribute to documented racial disparities in chronic physiological distress between midlife and older Black and White male participants in the National Survey of Midlife Development in the United States (MIDUS) II and the National Study of Daily Experiences (NSDE) II. Black and White men generally reported using similar coping strategies, though Black men relied more on positive reinterpretation, denial, drug use, and physical inactivity than White men. Of the 12 coping strategies examined, ten were unrelated to men's chronic physiological distress levels. Religious and spiritual coping appeared protective, but only for White men. Black men who reported drug use (i.e., illegal drugs,

prescription drug misuse) had less chronic physiological distress than those who abstained; drug use was unrelated to White men's distress. Findings suggest that how older adult men cope may not be an important determinant of whether they exhibit chronic physiological distress. Our evidence also does not support conventional categorization of coping strategies as "good" or "bad." Reducing racial health disparities among men may instead necessitate mitigating sources of stress implicated in chronic physiological distress, such as racism. More research investigating our unanticipated findings holds promise for developing targeted interventions to reduce racial disparities in chronic physiological distress among men.

ELDER ORPHANS AND THE RISK FOR LONELINESS AND MAJOR DEPRESSION

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Theories of Successful Aging and current gerontological research suggest that social connectedness remains crucial in later life. "Elder orphans" – those who live alone and lack close relationships – may be especially vulnerable to social isolation and mental health sequelae. This study examined associations among indicators of elder orphan status, loneliness, and depression. Data were derived from the baseline of an ongoing multi-wave study of late-life depression among adults ages 60+. All participants were interviewed by a geriatric psychiatrist; 123 (73.7%) were diagnosed with Major Depressive Disorder (MDD) and 44 (26.3%) were non-depressed. We examined effects of four indicators of elder orphan status (living alone, plus unavailability of nearby children, siblings, or friends) on loneliness frequency, and then with loneliness as an independent variable in the model, on MDD diagnosis. Gender, comorbidities, and financial difficulty were included in hierarchical and logistic regression models as covariates. In the hierarchical regression model, two indicators of elder orphan status— living alone ($p < .001$) and lack of nearby friends ($p = .009$)—were significant predictors of loneliness frequency. In the logistic regression model, worse health ($Exp(B) = 1.7$, $p < .001$) and loneliness ($Exp(B) = 4.2$, $p < .001$), were significant predictors of MDD diagnosis. Objective elder orphan indicators were associated with loneliness after controlling for health and financial concerns, and, in turn, frequency of loneliness, along with health conditions, was a significant predictor of MDD. Findings suggest elder orphans may be especially vulnerable to loneliness, and confirms earlier research linking loneliness and depression.

IMPROVING ACCESS TO EVIDENCE-BASED DEPRESSION CARE FOR OLDER RURAL ADULTS

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Primary care remains the de facto mental health delivery system where more than two thirds of antidepressants are prescribed. Yet, only 20% of patients improve after 12 months. Rural residents are more likely to be older, low-income, and to receive depression treatment in primary care due to the paucity of mental health providers in these areas. This contributes to health disparities for rural older adults. Collaborative Care management (CoCM) is an evidence-based approach to primary care depression treatment that supplements and supports the primary care provider with a behavioral health care manager and psychiatric consultant who employ principles of chronic disease management. This study reports findings from a CoCM implementation in eight rural FQHCs treating 5,392 (83% White) low-income patients. Depression outcomes, measured with the PHQ-9, were "response" (PHQ-9 score reduced 50%) and "remission" (PHQ-9 score <5). Almost half of treated patients (48%) experienced response and 24% experienced remission. Older adults (age 66+) were more likely to experience remission than younger patients (OR = 1.47) and to report minimal/mild symptomatology at last measurement (OR = 1.52). American Indian and Alaska Native patients (AI/AN; 8% of patients) revealed similar patterns with regression models showing age as a significant predictor of final PHQ-9 score and change between first and last PHQ-9. Our findings suggest that rural older adults may experience particular benefit from depression management integrated into primary care. The subanalysis of rural AI/AN individuals is notable given the dearth of published depression treatment data for this underserved population.

SUBJECTIVE AGE BIAS AS A PSYCHOLOGICAL PROTECTIVE FACTOR IN THE AGING PROCESS

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Subjective age bias (the difference between chronological age and felt age) has been explained as a protective factor that allows aging individuals to psychologically distance themselves from "older adults" as a group, thereby also distancing themselves from negative age-related identity threats like stereotyping and discrimination that can decrease current life satisfaction. To test this model, the current study aims to examine the moderating role of experiences of discrimination in the relationship between chronological age and subjective age bias. This study also examined self-esteem as an explanatory factor by which adopting a more exaggerated subjective age bias is associated with greater life satisfaction. The aims were addressed using a nationwide sample of older adults (N=3,294, Mean age = 64) from the third wave of the National Midlife in the United States study (MIDUS III). Moderation analyses confirmed that advancing chronological age is associated with a greater subjective age bias, and that this pattern is exaggerated for participants who experience higher levels of discrimination. Mediation analysis supported the hypothesis that greater subjective age bias in this sample was associated with higher life satisfaction, and that this relationship was partially explained by higher levels of self-esteem. These results suggest that increasing subjective age bias with age may operate to protect psychological well-being in the face of discrimination, a benefit partially explained by greater self-esteem. Future research should investigate the modifiability of subjective age in order to increase life satisfaction and other factors related to psychological well-being as people age.