

Those with a high PHQ-2 score were less likely than those with a low PHQ-2 score to say they do major food shopping less than once a week (31% vs 47%). Those with a high PHQ-2 score were more likely to say that they always ate alone in the last week compared to those with a low PHQ-2 score (17% vs 7%). These findings demonstrate that older adults who lived alone, had a higher PHQ-2 score, and had a poorer diet were more likely to cook and do grocery shopping less often. Strategies and policies to support older adults to address depressive symptoms and to increase cooking and improve diet may have many health and social benefits and will be explored through this session.

I AM NOT INVISIBLE: THE IMPACT OF AGE DISCRIMINATION IN THE WORKPLACE

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Ageism and age stereotypes are widespread. They shape the lived experiences of older workers. This presentation focuses on the results of responses to an online survey exploring the impact of ageist treatment in the workplace. The results of online surveys from 113 teachers over the age of 50 indicated that ageist treatment is widespread. An analysis of open ended questions addressing the stressful impact of being victimized by ageism indicated that feeling invisible, isolated, and helpless are the three most common responses to ageist treatment in the workplace. Being victimized by ageism presents a threat to older workers sense of self and feelings of competence. The cultivation hypothesis suggests that in technologically advanced societies such as the United States, people often rely on the media as a primary source of cultural information. Media images tend to depict older adults in ways that maintain and create ageist stereotypes. Our research suggests that the framing of media content significantly influences the self-worth of older workers. In this presentation, we discuss examples of ageism in the workplace, the family, and the media, and discuss ways of combating biased and discriminatory treatment. Based on our ongoing research, we make suggestions for ways of responding to and coping with ageist treatment.

MEASURING CHILDLessNESS AMONG MIDDLE-AGED AND OLDER AMERICANS

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Existing literature on childlessness among middle-aged and older Americans is sparse, and measuring childlessness is not straightforward for those with complex family histories. To address this knowledge gap, we examined data on 19,929 respondents age ≥ 50 from the 2016 Health and Retirement Study. All analyses accounted for complex sample design to generate nationally representative estimates. The proportion of respondents without children differed significantly depending on how "childless" was defined: 1) 14.9% (95% confidence interval [CI]: 13.9-15.9%) having no biological

children, versus 2) 10.4% (95% CI: 9.5-11.3%) having no children/step-children that were living and in-contact. When measured based on absence of biological children, the prevalence of childlessness was higher in younger cohorts (17.7%, 13.2%, and 9.0% for age 50-64, 65-74, and ≥ 75 years, respectively, $p < 0.001$) and among more educated individuals (17.4%, 12.3%, and 9.6% for more than high school, high school, and less than high school education, respectively, $p < 0.001$). The prevalence of childlessness was also higher among men (16.7%) than women (13.2%) ($p < 0.001$) and among non-Hispanic whites (16.0%) than Hispanics (9.8%) ($p < 0.001$). Similar patterns, but lower prevalence, were observed when measuring childlessness based on absence of children/step-children that were living and in-contact. Although non-Hispanic whites (16.0%) were more likely than non-Hispanic blacks (13.0%) to have no biological children ($p = 0.007$), a similar proportion of them had no children/step-children that were living and in-contact (10.8% versus 10.6%, $p = 0.06$). Given fertility decline and growing family complexity, these findings help inform the structure of social support and long-term care needs of middle-aged and older Americans.

SESSION 2817 (PAPER)

INFORMAL AND FORMAL CAREGIVING ISSUES

CAREGIVER MENTAL HEALTH OUTCOMES: ARE THERE DIFFERENCES ACROSS GENERATIONS?

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Informal caregivers are a critical component of support for the rapidly aging population. Previous studies have addressed the effects of caregiving on mental health. However, they have not focused on differences among generational cohorts of caregivers of older adults, i.e., Millennial (born 1981-1996), Generation X (born 1965-1980), Baby Boomer (born 1946-1964), and Silent Generation (born 1928-1945). As the Millennial caregiver population grows in parallel with older adults and their increased needs, we must better understand Millennial responses to caregiving. Millennial caregivers provide a similar intensity of care as Baby Boomers in terms of hours per week but are more likely to be fully employed (40+ hours per week or more). We used caregiver data from the nationally representative Centers for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS) survey from 2015-2017 to conduct negative binomial regression ($n = 50,745$). Data analysis indicates that Millennial caregivers have an incidence rate ratio of 1.22 times more self-reported days of "stress, depression, and/or problems with emotions" compared to Generation X caregivers ($p < 0.01$); 1.64 times compared to Baby Boomers ($p < 0.001$); and 2.38 times compared to Silent Generation caregivers ($p < 0.001$). Generational differences show that Millennial caregivers may have different needs than older

generations of caregivers. Rather than assuming that the policies and interventions designed for older generations of caregivers will fit younger generations, implications of this work can help inform: 1) the design of programs to support caregivers' mental health, and 2) policy considerations that address the unique needs of a younger caregiver population.

DIVERSE FAMILY CAREGIVERS, DIVERSE EXPERIENCES IN CARING

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The Home Alone Revisited Study examined the experience of family caregivers including demands of caring for someone with physical, mental or behavioral health care needs, revealing a large proportion of caregivers managing medical/nursing tasks. The aim of this paper was to explicate racial/ethnic differences in the prevalence of tasks and the perceptions of caregivers regarding their responsibilities. The study was a nationally representative, population-based online survey that oversampled underrepresented groups. The sample included 2,089 diverse family caregivers (Hispanic, n=307; Black/African American, n = 231; Asian/Pacific Islander, n=196; White, n=1,284; multi-racial, n= 71), 57% women, ranging from 18 to 91 years of age. Overall, fifty-two percent of caregivers reported performing at least one medical/nursing task for their care recipient, with a greater percentage ($p<0.01$) engaged in these tasks in two groups: Asian/Pacific Islander (62%) and multiracial (62%). Across the five racial/ethnic groups, we found significant differences in having a choice, feeling pressure, and the influence of culture and religion on the decision to take on medical/nursing tasks. There were also significant differences in the prevalence of performing 17 specific tasks, reports of difficulty with the tasks, the extent to which respondents felt prepared, and the strain that they experienced in providing care. The findings reveal both commonalities and significant heterogeneity in the caregiving experience, suggesting the importance of advancing the dialogue among health and social service providers about providing culturally and linguistically appropriate care and developing responsive tools and resources to support family caregivers as they engage in complex care.

GRANDPARENTING AND HEALTH IN LATER LIFE: INTENSITY AND AGE, GENDER, AND URBANICITY VARIATIONS

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Grandparents play increasingly indispensable roles in providing family care. Although prior cross-sectional studies have shown a positive link between grandparenting and health, we know little about the optimal engagement level of grandparenting, its longitudinal implications, and variations on health outcomes. Guided by the role theory and social model of health promotion, we used propensity score analysis and multilevel analysis with three biennial waves

of China Health and Retirement Longitudinal Study (2011-2015) to examine the longitudinal impacts of grandparenting intensity (no, low-, moderate-, and high-intensity) on health (mobility limitations, depressive symptoms, cognition, and self-rated health) among 4,925 older adults aged 45 and older, and how these impacts vary by age (45-59/60+), gender (male/female), and urbanicity (urban/rural). Controlling for the baseline sociodemographics (e.g., education and income), health limitations (e.g., ADLs and IADLs), and health behaviors (e.g., drinking and smoking), our results showed that, compared to no grandparenting, grandparenting provided at a moderate level was associated with fewer mobility limitations, lower depressive symptoms, and better cognition. Furthermore, grandparenting had a positive impact on physical, mental and cognitive health for 60+ older adults but not for the young-old. Both older males and females showed better physical health if they provided care at a low level, but older females showed better self-rated health. Older adults in the rural area showed better physical health; for the urban area older adults, better cognition. Findings suggest that policies aimed at supporting grandparents should consider the optimal threshold and variations by age, gender, and urbanicity.

RURAL-URBAN DIFFERENCES IN SOCIAL CONNECTEDNESS AMONG ADULT FOSTER HOME RESIDENTS IN OREGON

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Social isolation has been linked to negative health outcomes, especially among older adults. Although ability to maintain social contact and existing ties to one's community is a primary benefit of receiving long-term supports and services in a community-based setting, few studies explored how geography might shape these residents' access to family members and friends. The current study explores this question in the context of adult foster homes (AFH), a type of family-style residential care licensed for five or fewer unrelated adults. Using cross-sectional data collected annually from 1,500 AFHs between 2015 and 2020, the study examines whether older adults residing in rural and urban AFHs in Oregon differ in terms of levels of distinct types of contact with their existing social networks. AFHs were designated as rural/urban at the zip code level using the definitions provided by the state coordinating organization for rural health. Results from negative binomial regression models show that rural residents were significantly less likely to receive help from their family members and friends in getting to medical appointments or outside activities (e.g., meals, walks, shopping) or receive social visits or phone calls compared to their urban counterparts. Rural and urban residents had similar levels of help with personal care and taking medications. These results remained unchanged after accounting for a set of home (e.g., Medicaid contract) and resident characteristics (e.g., acuity). These findings suggest important public health implications for improving rural residents' social connectedness and interventions aiming at improving social participation in long-term care residents.