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Objective: This study aims to identify multiple dimensions of religiosity among young adults at the beginning and end of the transition to adulthood, and describe how transition patterns of religiosity in early adulthood are associated with filial elder-care norms in midlife. **Background:** There is a broad consensus that religiosity is multidimensional in nature, but less is known regarding transitions in multiple dimensions of religiosity from early to middle adulthood and predicted filial eldercare norms as a function of those religiosity transitions. **Methods:** The sample consisted of 368 young adults participating in the Longitudinal Study of Generations in 2000 (mean age = 23 years) and 2016 waves. We conducted a latent class and latent transition analyses to address our aims. **Results:** We identified three religious latent classes among young adults in both 2000 and 2016 waves: strongly religious, weakly religious, and doctrinally religious. Staying strongly religious young adults between 2000 to 2016 waves reported higher filial elder-care norms in the 2016 Wave than those who were in staying weakly religious, staying doctrinally religious, and decreasing religiosity transition patterns between 2000 to 2016 waves. **Conclusion:** Our findings suggest that religiosity is still an important value for young adults shaping their intergenerational relationships with their aging parents. **Keywords:** religiosity, filial eldercare norms, young adults, transition to adulthood

STRESSFUL FAMILY CONTEXTS AND HEALTH IN DIVORCED AND MARRIED MOTHERS

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Using prospective data over 25 years from a sample of 416 women, the first objective of the current study was to investigate the biopsychosocial process over the second-half of the life course comparing mothers with different marital histories. The second objective was to investigate this biopsychosocial process for 296 married mothers focusing on their marital quality over middle years. The results suggested that, compared to being married, divorcing in early-midlife launched an adverse biopsychosocial process for women leading to physical pain, physical limitations, and depressive symptoms over their mid-later years, largely through early-midlife financial stress, regardless of later recoupling. However, subsequent financial stress did not influence divorced mothers' later-life health problems, suggesting their development of resilience. For consistently married mothers, both marital stress and financial stress uniquely influenced all three health problems throughout their mid-later years. For all mothers, these health problems progressed over mid-later years, as indicated through their stabilities and mutual influences, and these health problems also selected mothers into further escalating financial and marital stress over their mid-later years. Elucidating differential short- and long-term health influences of marital and financial stressors for divorced and married mothers provides a potentially useful information for targeted early preventive intervention efforts and policy formation. Such interventions can promote and develop resiliency factors, thereby aiding middle-aged mothers to prevent from adverse biopsychosocial processes.

WHY DO PEOPLE DIVORCE LATE IN LIFE? SWEDISH GRAY DIVORCE NARRATIVES

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Divorce rates for people 60+ has increased in many parts of the Western world in what has been described as a "grey divorce revolution". In Sweden these divorce rates have more than doubled since the millennium. But why do people choose to divorce late in life and what is the impact of life phase typical transitions? Qualitative interviews with 37 Swedish men and women (aged 62-81) divorced after the age of 60 were collected, covering themes regarding the divorce process: motives for and experiences of divorce, and life as grey divorcee. The results by thematic analysis show that motives for divorcing earlier in the life-course, such as abuse, unfaithfulness and addiction are prevalent also among older people. However, they tend to be framed differently in later life and be integrated into divorce narratives informed by age. We identified four life phase typical narratives for divorce: 1) Lack of a common project for the third age. 2) Partners personality change due to age related disease. 3) Increased freedom after empty-nest allowing emancipation from a dominant partner. 4) A final romantic adventure as a form of rejuvenation. All these life-phase typical narratives are related to the third age as a time of self-fulfillment, where the partner can either be part of or an obstacle to that project. The results will be used to discuss current older cohorts' views of family norms and later life from the perspective that current older cohorts participated in the divorce revolution in the 1970s as young adults.

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Family Caregiving Interventions

A SYSTEMATIC REVIEW OF EFFECTS OF PHYSICAL ACTIVITY OF FAMILY CAREGIVERS OF OLDER ADULTS WITH CHRONIC DISEASE

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More than 17 million family caregivers (FCGs) provide care for older adults with chronic illness in the US. Caregiving for older adults with chronic disease places a considerable burden on FCGs and they tend to neglect their personal health. Generally, physical activity (PA) programs benefit the physical and psychological health of FCGs. However, no review of PA randomized clinical trials (RCTs) focused on FCGs of older adults with chronic disease. In this systematic review, we analyzed the most recent trends (2010-2020) in RCTs identifying the effects of PA in this population. This review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. Electronic databases (PubMed, CINAHL, Embase, PsycInfo, Cochrane Library) were searched for publications dated from 2010 to 2020.

All studies included were appraised for quality using the Cochrane Collaboration Risk of Bias Tool. Of the resulting 16 studies, most studies (n=11) targeted FCGs of older adults with dementia or cancer. Most FCGs were non-Hispanic white. PA interventions with mixed modes (e.g., aerobic and resistance exercise), mixed delivery methods (e.g., in-person and telephone) and mixed settings (e.g., supervised gym- and unsupervised home sessions) were used most frequently. PA interventions significantly improved psychological health but had inconsistent effects on physical health. Tailored PA programs, designed based on FCGs' goals, preferences and limitations, may improve upon physical health outcomes. Future PA studies should include samples of racially and ethnically diverse FCGs of older adults representing a broader range of chronic diseases.

CHARACTERIZING SUPPORTIVE SERVICES USE BY CAREGIVING RELATIONSHIP STATUS

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Informal caregivers of aging older adults experience a high degree of burden and strain. These emotional experiences often stem from stressful tasks associated with caregiving. Caregiving supportive services that target the provision of support for stressful tasks are instrumental in alleviating caregiving burden and strain. Research is limited on what types of caregiving supportive services caregivers are accessing by relationship status and their source of information. We sought to characterize caregiving supportive services use by caregiving relationship status. We analyzed cross-sectional data from the 2015 National Study of Caregiving limited to caregivers of older adults ≥ 65 years. Caregiver relationship status (i.e., spouse, child, other relative/non-relative) was the independent variable. Bivariate analyses were performed to examine the association with caregiver relationship status and 1) any use of supportive services, 2) type of supportive service used among users, and 3) source of information about supportive services. Our sample consisted of 1,871 informal caregivers, 30.7% reported using supportive services. By caregiver relationship status, children had the greatest use of supportive services compared to spouses and other relatives/non-relatives (33.3% vs. 22.5% vs. 22.1%, $p=.02$, respectively). Among users of services, there were no differences in type of services used. Spouses primarily received their information about services from a medical provider or social worker (73.8%, $p=.004$). Our findings highlight the need to ensure that other caregiving groups such as spouses have access to important supportive services such as financial support. Medical providers and/or social workers should be better leveraged and equipped to provide this information.

DESIGN THINKING AS A METHOD FOR DEVELOPING CAREGIVER (AND OTHER) INTERVENTIONS

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“Design Thinking,” an innovative, human-centric approach to problem-solving, seeks to ensure that design efforts “solve the right problem.” This presentation describes the Design Thinking process and illustrates its use in the context of three design studio sessions with of family caregivers of patients at the Integrated Memory Care Clinic (IMCC), a comprehensive medical home for persons living with dementia. The Design Thinking process entails five steps – Empathize, Define, Ideate, Prototype, Test – that engage consumers/end-users to identify, as precisely as possible, the issues or concerns that are most important to them and to further identify the possible solutions that seem to most fully address these concerns. The process can be described as one of divergent and convergent thinking. In the first session, the Empathize phase, IMCC caregivers were asked to think as broadly as possible about needs not being met by IMCC. These topics were reviewed more convergently in the second session, the Define phase; here the participants agreed on a shorter, prioritized list of needs to be addressed. In the third session (that combined the Ideate and pre-Prototype stages), participants identified 14 topics (interventions) they felt should be included in this program. Finally, in the Test phase, they assessed the topics and agreed that the most important need IMCC could address would be to provide a comprehensive orientation program for new caregivers. IMCC clinicians concurred with the salience of the problem to be solved and saw addressing it as contributing substantially to the improvement of IMCC clinical care.

ETHICAL AND METHODOLOGICAL CONSIDERATIONS INTERVIEWING DEMENTIA CAREGIVERS

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Greater inclusion of people living with dementia (PLWD) and their caregivers in research is a global research priority and an expressed priority of dementia advocacy organizations. Absent inclusion of PLWD and caregivers, our understanding of dementia-related experiences and optimization of care and caregiving interventions is stymied. Qualitative interviewing techniques constitutes a primary method for obtaining PLWD and caregivers' perspectives. Yet, there is little guidance on use of qualitative interviewing techniques among PLWD and caregivers or discussion of potential challenges encountered, despite unique vulnerabilities faced throughout the research process, which may be further heightened among historically excluded groups. Meaningful progress toward inclusion of PLWD and their caregivers in dementia research necessitates broader examination of associated methodological and ethical considerations that arise in the conduct of interviews. Drawing from a large multi-site qualitative study of dementia caregivers with exposure to high levels of social disadvantage, we used a multiple-triangulation qualitative approach across