

to religion; most does not. This paper compares research on religious socialization and morality, focusing on similarities and differences in findings, the potential of each tradition to inform and advance the other, and how that can be accomplished. Part of a symposium sponsored by the Religion, Spirituality and Aging Interest Group.

CHURCH AND FAMILY INFORMAL SOCIAL SUPPORT NETWORKS OF AFRICAN AMERICANS

Robert Taylor, and Linda Chatters, *University of Michigan, Ann Arbor, Michigan, United States*

Social support networks are an integral component of an individual's life. This presentation investigates the complementary roles of family and church members as sources of informal social support among African Americans. The analysis utilizes the African American sub-sample of the National Survey of American Life. A pattern variable was constructed that describes four types of church and family networks: 1) received support from both family and church members, 2) received support from family members only, 3) received support from church members only, and 4) never received support from family nor church members. Overall the findings indicated 1) the majority of African Americans received support from both groups, 2) a small group of respondents were socially isolated in that they did not receive assistance from either family or church members, 3) for some African Americans who were estranged from their family members, church members were an alternative source of social support. Part of a symposium sponsored by the Religion, Spirituality and Aging Interest Group.

SESSION 5930 (SYMPOSIUM)

LONGITUDINAL EFFECTS OF BECOMING A FAMILY CAREGIVER: THE CAREGIVING TRANSITIONS STUDY

Chair: David Roth

Discussant: Steven Zarit

Taking on caregiving responsibilities for older adult family members with disabilities is often considered to be a highly stressful experience that may adversely affect the health of caregivers. However, the vast majority of studies in this area compare existing samples of caregivers with questionably matched non-caregiving controls. In this symposium, we will present findings for a population-based sample of persons who became family caregivers while participating in a longitudinal epidemiological study. Changes in health and well-being are compared between these caregivers and non-caregiving control participants who were matched on multiple demographic and pre-caregiving health history variables. All persons enrolled as caregivers were providing sustained and substantial caregiving assistance. Presentations will include 1) a descriptive overview of the screening, eligibility, and enrollment methods used to construct these unique, population-based samples; 2) comparisons of within-person changes on measures of self-reported health and well-being for dementia and non-dementia caregivers; 3) changes in the caregivers' social networks, social engagement, and leisure time activities; 4) comparisons of longitudinal changes on circulating inflammatory biomarkers (e.g., IL-6, CRP, TNF alpha receptor

1) and cellular aging (telomere length); and 5) examinations of individual differences in caregiver outcomes using a stress process model. Becoming a family caregiver can be stressful, but the opportunity to help a loved one and the related feelings of purpose and deepening family connections may also promote resilience and enhance health. These questions are far from resolved, and rigorous, prospective, population-based studies like the Caregiving Transitions Study promise to provide compelling new insights.

ENROLLING INCIDENT CAREGIVERS AND MATCHED CONTROLS FROM A NATIONWIDE EPIDEMIOLOGICAL STUDY

David Roth,¹ William Haley,² Orla Sheehan,³ J David Rhodes,⁴ and Virginia Howard,⁴ 1. *Johns Hopkins University, Baltimore, Maryland, United States*, 2. *University of South Florida, Tampa, Florida, United States*, 3. *Johns Hopkins University School of Medicine, Baltimore, Maryland, United States*, 4. *University of Alabama at Birmingham, Birmingham, Alabama, United States*

Participants in the national Reasons for Geographic and Racial Differences in Stroke (REGARDS) study were asked about family caregiving responsibilities at enrollment (2003-2007). Among the 88% of participants who were not caregivers at enrollment, 1,229 reported becoming caregivers before a follow-up interview 12 years later. The Caregiving Transitions Study screened these participants and enrolled 251 as incident caregivers. All reported 5 or more hours of care per week, provided assistance with at least one ADL or IADL, and were caregivers for at least 3 months before a 2nd blood sample was obtained in the REGARDS study. A total of 251 noncaregiving control participants who reported no caregiving responsibilities over this 12-year period were also enrolled. Each control was matched to a caregiver on age (+ 5 years), sex, race, other demographics, and baseline (pre-caregiving) health variables. Descriptive analyses confirm the unique comparability of the samples compared to previous caregiving studies.

SELF-REPORTED HEALTH AND WELL-BEING ACROSS HETEROGENEOUS GROUPS OF CAREGIVERS

Orla Sheehan, and Jin Huang, *Johns Hopkins University School of Medicine, Baltimore, Maryland, United States*

Using the Caregiving Transitions Study (CTS) we compared the effects of caregiving on self-reported health and well-being in caregivers reporting providing dementia care, different levels of strain and amount of care provided. Caregivers (n=251) were 65% female, 36% African American and had a mean age of 71.8 years. A quarter of CGs reported being under a lot of strain and 47% provided care for persons with dementia. Dementia CGs (n=117) provided more hours of care per week (49.7 versus 37.7, p=0.001), more commonly reported high strain (36.8% versus 15.7%, p<0.03) and were more than twice as likely as non-dementia caregivers to report that caregiving interfered with taking care of their own health (33.9% versus 15.4%, p=0.003). Additional results will be reported on how these factors of dementia caregiving, level of strain, and hours of care affect well-being including perceived stress, treatment burden, depressive symptoms and health-related quality of life.