Apathy is a psychological syndrome characterized by lack of motivation, interest, flattening of affect and social withdrawal; which has been associated with cognitive and functional decline in community dwelling older adults. Many of these associations have been investigated using subscales of depression tools, with varying sensitivity and specificity. The objective of this study was to develop an apathy measurement model, which distinguishes depression and apathy, using the Geriatric Depression Scale Long Form (GDS). We conducted an exploratory factor analysis (EFA) in a memory clinic cohort (N=81) who completed the GDS. Based on the EFA results, we ran a confirmatory factor analysis (CFA) in a community dwelling cohort of older adults (≥65 years old) enrolled in the Central Control of Mobility in Aging study (CCMA) and computed factor scores in both cohorts. CFA of the GDS in the CCMA cohort (N=538) yielded 3 factors: Depression (14 items; Cronbach's α=0.77), Apathy (10 items; Cronbach's α=0.63), and Cognitive concern (4 items; Cronbach's α=0.546). In linear regression models, adjusted for age and gender, the memory clinic cohort had significantly higher Apathy factor scores (β = .18, $t(618) = 4.49$, $p < .001$) factor scores compared to the CCMA cohort.Our findings suggest that the CFA derived apathy score is a reliable and valid tool to distinguish apathy from depression in older adults. This novel measurement model can be employed in both clinic and research populations to investigate the role of apathy in cognitive decline.

DEPRESSION SCREENING AND RATES OF MOOD DISORDER DIAGNOSIS AND SUICIDE IN YOUNGER AND OLDER ADULTS

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Rates of suicide are elevated among older adults in the U.S. and around the world, with the highest rates in older men (CDC, 2019; WHO, 2014). More than half of older adults who die by suicide were in contact with a primary care physician within the month prior to death, and almost one-third within the prior week (Luoma et al., 2002; Stene-Larsen & Reneflot, 2019), demonstrating the importance of better identification and treatment of mental health issues among older adults across healthcare systems. Depression, a well-established risk factor for suicide, goes under-diagnosed and under-treated, especially among older adults (Bryant, 2010). The University of Rochester Medical Center has led integration of patient-reported outcomes assessment via large-scale implementation of PROMIS measures across multiple departments. We compared results of PROMIS depression screening from 1/1/2015 to 8/31/2019 with mood disorder diagnoses within the year prior and year following screening. Twenty-six percent (39491/154669) of adults under age 65 and 23% (11694/51702) of those age 65 and older screened positive for mild, moderate, or severe depression. Whereas 29.0% of younger adults who screened positive received mood disorder diagnoses, 22.1% of older adults received a diagnosis ($\chi2(1)=214.69$, $p<.001$). Suicide outcomes using National Death Index data will also be reported. Results confirm depression is underdiagnosed (and, by extension, likely undertreated) at all ages, but show a distinct disparity for older adults, which may put them at greater risk for negative outcomes such as suicide.

DEPRESSIVE SYMPTOM PROFILE TRANSITIONS FROM MIDLIFE TO LATE LIFE IN THE WISCONSIN LONGITUDINAL STUDY

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Late-life depression is a significant public health problem among the growing elderly population in the United States. Structural social capital has previously been associated with lowering depressive symptoms in later life, but these results have been inconsistent. However, few studies have investigated this association when investigating different subtypes of depression. The current study used data from the Wisconsin Longitudinal Study (WLS) of 3,197 respondents to examine how structural social capital influences baseline depression statuses and transitions in these depression statuses. Latent class and latent transition analysis (LCA/LTA) were used to identify latent statuses at two time points in the WLS – 1992 and 2011 – as well as transitions between those statuses. Four depression statuses were identified at both time points: Very Depressed, Depressed and Lonely, Agitated and Restless, and Not Depressed. Gender, self-rated health, total assets, structural social capital measures, and polygenic score for depression were all predictors of baseline depression statuses. Transitions between depression statuses were associated with two forms of structural social capital – social support and social involvement. These findings add to the increasing number of studies investigating subtypes of depression in older adults as well as to scholars examining the association between structural social capital and depressive symptoms. Results suggest possible social and behavioral factors policymakers can use to identify risk of depression in mid-life and areas of intervention to improve depressive symptoms for aging adults.

DIETARY BEHAVIOR AND DEPRESSIVE SYMPTOMS IN LATE-LIFE MARRIAGE

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Epidemiologic studies have linked dietary patterns to psychological health including depression, anxiety, and stress. However, no research has examined dyadic associations between dietary behavior and depressive symptoms in older married couples. In this study, one hundred and one couples 51 to 90 years of age who were married or in a marriage-like relationship and living together for at least 6 months were recruited. Participants completed questionnaires and self-reported their dietary behavior (i.e., the total number of meals, number of snacks, and number of fast-food meals eaten in a typical day and the number of meals they eat alone and eat sitting down). They also completed the 20-item Center for Epidemiologic Studies Depression Scale. Results of the Actor Partner Interdependence Models controlling for

income, education, chronic conditions, and marital satisfaction, showed that for wives only, more meals eaten in a day were associated with lower depressive symptoms (actor effect). Additionally, more snacks eaten by the wife and more meals eaten alone by the wife were associated with higher depressive symptoms for the husband (partner effects). Findings suggest that wives' dietary behavior is particularly important, not only for their own but also their husbands' mental health in late-life marriage.

EFFECTS OF PAIN AND DEPRESSION ON ADL DISABILITY OVER 6 YEARS OF FOLLOW-UP AMONG OLDER ADULT AMERICANS

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The objective of this study was to examine the effect of co-occurring pain and depression on ADL disability over 6-years of follow-up among older adult Americans. We studied 5,236 participants aged 65 years and older from the National Health and Aging Trends Study (2011-2017) The primary outcome was ADL disability defined as any limitation in ADLs (eating, bathing, transferring, dressing, moving inside, and out of bed). The independent predictors were self-reported pain and depression. Covariates included socio-demographics (age, gender, marital status, race/ethnicity and years of formal education), body mass index, and comorbidities. Participants were categorized into four groups according to pain and depression: no pain and no depression, pain only, depression only, and depression and pain. Generalized Estimation Equation model was used to estimate the odds of ADL disability as a function of pain and depression. All variables were analyzed as time-varying except for age, race/ethnicity, and education. The odds of ADL disability as a function of pain only and depression only was 1.62 (95% CI 1.38-1.91) and 2.13 (95% CI 1.54-2.95), respectively. The odds of ADL disability as a function of pain and depression were 3.92 (95% CI 3.13-4.92). Older age, being married, Hispanics, and comorbid conditions were also predictive factors of ADL disability over time. Female participants and those with higher levels of education were less likely to report ADL disability over time. The findings suggest that both pain and depression significantly increased the risk of ADL disability in this population over 6-years.

EFFECTS OF TREATMENT PREFERENCE ON ADHERENCE, ATTRITION, AND PROCESS MEASURES AMONG OLDER ADULT WORRIERS

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Patient preference may be related to treatment outcomes through decreased rates of attrition and higher rates of adherence and patient satisfaction. We present findings from a 2-stage randomized preference trial of cognitive-behavioral therapy (CBT) and yoga for the treatment of late-life worry. We examine rates of preference for CBT and yoga, as well as the stability of these preferences over time. We also examine the impact of preference on adherence, attrition, and process measures (satisfaction, treatment expectancies, and working alliance). Five hundred participants were randomized to either the randomized controlled trial (RCT; N=250) or the preference trial (participants chose the treatment; N=250). All participants received 10 weeks of an intervention. Among those in the preference trial, 48% chose CBT and 52% chose yoga ($p>.05$). Strength of preference was similar between the groups; 73.3% and 76.2% reported a strong preference for CBT and yoga, respectively ($p>.05$). Fourteen percent of those who preferred CBT at baseline preferred yoga upon completion of the intervention, while 12.2% of those who preferred yoga at baseline preferred CBT upon completion of the intervention ($p>.05$). There were no significant differences between participants in the RCT and preference trial on intervention adherence, attrition, satisfaction, or working alliance ($p's>.05$). Treatment expectancies were higher for the preferred intervention ($p's<.0001$). Results suggest that older adults prefer CBT and yoga at similar rates, and these preferences are stable. Receiving a preferred treatment had no effect on adherence, attrition, satisfaction, or working alliance.

GRANDPARENTING AND WELL-BEING OF HONG KONG OLDER ADULTS: THE MEDIATING ROLE OF INTERGENERATIONAL RELATIONSHIPS

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Grandparenting and intergenerational relationship play important roles in some older adults' later life, especially older people of Chinese culture. This study investigated the relationship between grandparenting activities, intergenerational relationship, and psychosocial well-being of Hong Kong Chinese older adults. A representative sample of 507 grandparents (aged 55+) were telephone surveyed in June to July 2019. Level of involvement in grandparenting activities was measured. Resilience and happiness were measured by Connor-Davidson Resilience Scale and Subjective Happiness Scale. Two single-item instruments were adapted to capture the relationships between older adults and adult children, and between grandparents and grandchildren, respectively. A series of linear regressions and mediation tests with bootstrap approach were performed to examine the relationships between grandparenting activities, intergenerational relationship, and resilience and happiness. After controlling for socio-demographics, the frequency of grandparenting activities correlated positively with resilience and happiness. The relationship was partially mediated by inter-generational relationships including the relationships with adult children and grandchildren. The findings have concluded that grandparenting involvement and satisfactory intergenerational relationship are protective factors of health and wellbeing. Future healthy aging policy-making or programming should expand the scope from focusing on individual older adults to strategies of achieving the family-friendly goal so that intergenerational relationships could be better nurtured, benefiting not just the family as a functional unit but also the older adults' healthy aging.