Challenges due to burden of disease can affect adherence to self-care behaviors and optimal health outcomes in those living with T2DM. This study utilized state- and national-level data from the 2015 BRFSS to compare QoL measured by the prevalence of physical and mental burden days among older adults (OAs) compared to younger adults living with T2DM. The results of our analysis showed that OAs living in the US were significantly less likely to experience at least one mental burden day when compared to their younger counterparts (OR = 0.61, 95% CI: 0.58, 0.64), while gender, education, race, BMI, and depression, CVD, or another chronic condition were significantly associated with the odds of experiencing at least one mental burden day. Whereas, in Kentucky OAs were less likely to experience at least one mental burden day when compared to their younger counterparts (OR = 0.48, 95% CI: 0.35, 0.66). Gender, education, BMI, and depression were significantly associated with the odds of experiencing at least one mental burden day or one physical burden day. The findings of this study suggests that the questions used by BRFSS to measure QoL may not be the most suitable for OAs who likely have different criteria for self-reported mental or physical burden days. When assessing QoL or burden of disease among the aging at a population level, considerable thought should be given into the questions asked and if they appropriately examine patient-level QoL in this population.

COGNITIVE FUNCTION IN COUPLES AND COLLABORATIVE INVOLVEMENT IN TYPE 1 DIABETES MANAGEMENT
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Managing type 1 diabetes involves coordinating complex daily behaviors that benefit from higher cognitive function. One’s spouse’s cognitive function may also be beneficial as spouses may collaborate in daily adherence behaviors and may be especially beneficial for older adults who may be experiencing poorer cognitive function. We examined: 1) whether one’s own and one’s spouse’s cognitive function predicted lower (better) HbA1c, 2) whether collaborating with a more cognitively capable spouse was especially beneficial, and 3) whether the benefit of partners’ cognitive ability occurred through better adherence. 199 couples were recruited where one member was diagnosed with type 1 diabetes for at least one year (52% females, average age 46.8 years, range 25.9-74.9, average duration of diabetes 27 years). Both patients and spouses completed the information subtest from the Wechsler Adult Intelligence Scale-Fourth Addition as a measure of general intelligence. Patients rated the collaborative involvement of their spouse in their diabetes and their adherence to their medical regimen. Multiple regressions revealed that spouse’s higher intelligence uniquely and solely predicted better HbA1c over patient’s intelligence. Collaborating with a spouse of lower intelligence was associated with higher HbA1c for older adults; collaborating with a spouse of higher intelligence was associated with somewhat lower HbA1c. Mediational analyses indicated that spouse’s intelligence was associated with higher HbA1c through better adherence behaviors. The results suggest that individuals with type 1 diabetes who have a spouse of lower cognitive function may benefit from support from others in their network to manage their diabetes.

SOCIOEMOTIONAL SELECTIVITY THEORY AND THE PERCEPTION OF CHRONIC PAIN
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The Fear Avoidance model of chronic pain (FAM) posits that pain perception is best understood in the context in which pain occurs. An aspect of context that has received little attention is the effect that future time perspective and its related goals may have on chronic pain perception. According to the Socioemotional Selectivity Theory (SST), young adults have instrumental goals to prepare for the future and older adults have goals to establish and maintain wellbeing. These differences have profound effect on cognition including attentional bias. It was hypothesised that future time perspective would influence pain perception through attention to pain. A total of 306 participants, 18 – 88 year olds with chronic joint pain completed the Numeric Analogue Scale for pain, three scales to measure the FAM constructs: Pain Vigilance Awareness Questionnaire, Pain Catastrophization Scale, and the Pain Anxiety Symptoms Scales, and, two scales to measure the SST constructs: Future Time Perspective Scale, (measures the goals and opportunities anticipated in the remaining life span) and the Positive Affect Negative Affect Scale (measures mood). Structural equation modelling finding supported the hypothesis and the model of fit indices indicated a good fit ($\chi^2 (53) = 127.412$, $p = .000$, TLI .958, CFI = .971, SRMSEA = .056, RMSEA = .068, CI 90% [.053, .083]). This is the first time that age, future time perspective and the positivity effect have been shown to contribute the pain experience through attention. It provides a possible framework for exploring age appropriate psychological treatments for chronic pain.

HOW MULTIPLE CHRONIC DISEASE BURDEN INFLUENCES COMMUNITY-BASED BEHAVIORAL HEALTH PROGRAM PARTICIPANTS
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Background: Studies have shown that participation in community-based self-management education programs can result in improved healthful behaviors (exercise, cognitive symptom management, coping, and communications with physicians), improved health status (self-reported health, fatigue, disability, social/role activities, and health distress), and decreased days in the hospital. Problem: One of the understudied factors thought to influence efficacy in community-based self-management programs is the presence and impacts of multiple chronic conditions on participants within community based behavioral health program populations. Multiple chronic diseases when scaled collectively can be considered as a participant’s individual disease burden to be included in other analyses. Methodology: This investigation explores possible ways disease burden associates with
such important constructs as participant personal characteristics and participant confidence in controlling impacts of their disease symptoms and participant preferences for use of various methods of coping with disease impacts. Results indicate a complex pattern of relationships between such factors as personal characteristics of program participants and their perceived mastery over the impacts of their disease symptoms, and their preferred mechanisms for coping. Implications: program designers and managers can better understand the differential influences of disease burden on participants analyzed with their personal characteristics and their preferential uses for coping mechanisms and their perceived ability to withstand the added burdens of multiple chronic diseases.

DOES ONSET OF CHRONIC CONDITIONS MODERATE THE IMPACT OF RELATIONAL EVENTS ON DEPRESSED MOOD?
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More than 62% of adults aged 65+ have more than one chronic condition; this number increases to more than 82% for those 85+. Older adults simultaneously experience changes in their relationships due to negative relational life events, including illness, injury, or death of a loved one. Stressors occurring in tandem can overload psychological resources and increase risk for poor mental health. Informed by the stress process model, we assessed the influence of relational life events on depressive symptoms over time and evaluated the moderating effects of chronic condition onset. Self-reports of four stressful life events, five chronic conditions, and depressive symptoms as measured by the CES-D came from 2,948 older adults participating in the ORANJ BOWL panel. Using longitudinal multilevel mixed effect modeling, we examined trajectories of depressive symptoms across three waves. While depressive symptoms increased over time, they were greater for people who experienced more relational life events and the onset of more chronic conditions. Participants who reported experiencing all four relational life events but no chronic conditions had an average CES-D score of 5.28 (p<.0001); average CES-D score increased to 12.72 (p<.0001) for those who reported four life events and the onset of four or more new chronic conditions during the study period. In summary, chronic condition onset moderated the relationship between life events and depressive symptoms. Findings highlight the need for practitioner awareness of increased mental health risks for people experiencing stressors in multiple domains of life.

SEX DIFFERENCES BETWEEN ATTITUDES TOWARD MEDICATIONS AND POOR ANTIHYPERTENSIVE MEDICATION ADHERENCE IN ELDERLY
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Despite its importance for blood pressure control, antihypertensive medication adherence remains a challenge in older adults. Explicit and implicit attitudinal ambivalence toward medications (holding both positive and negative explicit attitudes, and discrepant explicit and implicit attitudes, respectively) may underlie low adherence. We examined whether race, age, or sex affect the associations between attitudes, ambivalence, and adherence. A questionnaire and explicit association test captured medication attitudes from hypertensive adults aged ≥55 (N=199). Adherence was measured with the Krousel-Wood Medication Adherence Scale (K-Wood-MAS). Higher scores on the attitudes and adherence scales indicate more positive attitudes and worse adherence, respectively. Associations and effect modification by sex, race (white vs. nonwhite), and age (<65 vs. ≥65) were tested in separate ordinary least squares regressions. The sample was 51.0% female, 43.7% nonwhite, 35.5% aged ≥65, with mean K-Wood-MAS=64.64 (SD=0.88). Better adherence was associated with more positive net explicit attitudes (β=0.18, 95% CI -0.30, -0.06, p=0.003), and worse adherence with higher explicit ambivalence (β=0.05, 95% CI 0.01, 0.09, p=0.028). The associations with explicit attitudes and explicit ambivalence were significant for men (β=0.30, 95% CI -0.48, -0.11, p=0.002 and β=0.09, 95% CI 0.03, 0.15, p=0.005, respectively) but not for women (β=0.07, 95% CI -0.423, 0.09, p=0.378 and β=0.00, 95% CI -0.06, 0.05, p=0.982, respectively) (p-values for interaction=0.062 and 0.031, respectively). No race or age differences were identified. Adherence was not associated with implicit attitudes or implicit ambivalence. In conclusion, explicit attitudes and explicit attitudinal ambivalence may underlie low adherence to antihypertensive medications, particularly for older men.

ASSOCIATION OF MULTIMORBIDITY WITH INCIDENT SHINGLES AMONG OLDER AMERICANS
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Older adults with multimorbidity are susceptible to shingles due to deterioration of immune function related to coexisting chronic disorders and immunological change. Although the association between individual chronic diseases and incident shingles has been documented, little is known about the effect of having multiple conditions on the risk for developing a new case of the disease. Multimorbidity is a normal condition with advanced aging. This paper examines risk of shingles onset associated with multimorbidity defined as having one or more chronic diseases including hypertension, diabetes, cancer, heart disease, lung disease, arthritis, and stroke) among older American. Data for this study come from the 1992-2016 Health and Retirement Study. The study finds that risk for onset of shingles linearly increases with number of chronic disorders when age, gender, and race/ethnicity were adjusted (adjusted OR: 1.58, 95% CI: 1.37, 1.80 for those with 1 chronic condition vs adjusted OR: 3.43, 95% CI: 2.21, 5.53 for those with 6 conditions). The risks for multimorbidity were little changed after additional adjustments for socioeconomic status and health behaviors. The effect of multimorbidity on developing shingles

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