This presentation describes the “crush” experience as it occurs among older adults. A basic definition of a crush is a one-sided, proto-romantic relationship. The scholarly and commonsense understanding in American culture focuses on the crush as most commonly occurring during the developmental phases of adolescence and pre-adolescence. Symbolic interactionists view life course as a somewhat fluid process of adapting to changing situations in life. Experiences like the crush can potentially occur at almost any age at which romantic thoughts and feelings are possible. Our ethnographic research on older adults residing either in group facilities or in domiciliary locations indicates that crushes are fairly common. These crushes follow the same general narrative as crushes among younger people: a beginning, a middle and an end. There are two narrative styles among older adults: face-to-face and mediated. The crush in a group facility is encouraged by interaction during social hours, meals, entertainment, and religious/spiritual activities. Crushes are more observable among women who do not have to delve into their past for objects of their affection. Available amours from the mass media include young celebrities such as Michael Buble and Josh Groban. These crashes differ from those among younger women in the denouement, to the degree affection generally fades away from memory rather than comes to a distinct end. Factors such as increased access to electronic media and music, and increased sociality in the community and in residential environments will create situations in which the security, excitement and rewards of a crush are plausible.

Session 3075 (Paper)

MOOD, EMOTIONS, AND HEALTH

AGE-RELATED DIFFERENCES IN CLINICAL AND PSYCHOSOCIAL PREDICTORS OF UNMET NEEDS IN BLADDER CANCER SURVIVORS

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Understanding of unmet needs and their predictors among bladder cancer (BC) survivors is critical to optimize health care planning for patients. This study compares between younger (<65 Years) and older (≥65 Years) BC patients across seven domains of unmet needs (e.g., informational, psychological, supportive care, daily living, communication, logistic, and sexuality needs) and their demographic, clinical, and psychosocial predictors. BC survivors (N=159; 47% women) were recruited from the Bladder Cancer Advocacy Network and completed a questionnaire that included the needs assessment survey (BCNAS-32), hospital anxiety and depression scale (HADS), coping (BRIEF COPE), social provisions scale (SPS), and self-efficacy beliefs (GSE) scale. Although no significant group differences in all reported needs emerged, both groups reported more communication (IQR = 50 (62.5) and less sexuality needs
Older patients reported higher depression and anxiety (IQR = 32 (11.5); N = 68) than younger patients (IQR = 28 (11.0); p < .01; N = 88). Multivariable analyses stratified by age showed significant effects of gender among older patients with women experiencing more psychological, care, communication, and sexuality needs than men. Multivariable analyses also showed age-related differences (p < .05) in the predictors of needs controlling for covariates (e.g., gender). Among older patients both higher depression and anxiety and lower self-efficacy beliefs were associated with more psychological, care, and communication needs. Among younger patients, higher depression and anxiety were associated with more psychological, logistic, daily living, and communication needs. Results emphasize the importance of tailoring care planning for patients based on age.

LINKING RELIGIOUS IDENTITY, PARTICIPATION, AND FAITH TO DOMAINS OF MENTAL HEALTH IN LATE LIFE
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Religiosity in late life has been linked to psychological well-being outcomes. However, there has been insufficient attention to complex associations between different domains of religiosity and domains of psychological wellbeing. We explored associations between religious identity, religious participation, religious coping (trust in God), and mental health indicators of depressive symptoms, life satisfaction, and positive/negative affect among 797 independent, retirement community-dwelling older adults. At baseline, religious identity (expressed as self-concept) and religious participation (church attendance) each were associated with fewer depressive symptoms (b=-0.47, p<0.05; b=-0.19, p<0.05). Religious identity, however, was significantly associated with both life satisfaction and positive affects but not with negative affect. Religious coping was associated with greater life satisfaction and positive affect. Our longitudinal analysis documented a statistically significant decline in depressive symptoms, and increase in life satisfaction and positive affect, with corresponding increase in religious identity over time. However, changes in religious identity did not lead to significant changes in negative affect over time. Religious coping and church attendance fully explained the influence of religious identity on changes in life satisfaction. Although the influence of religious identity on depressive symptoms and positive affect was weakened, its significant influence was maintained even after the consideration of religious coping and church attendance. Beyond religious identity, we also observed a significant increase in positive affect with a corresponding increase in religious coping. Overall, our findings support expectations that religious identification and practices are associated with greater psychological well-being among community dwelling old-old adults.

THE ASSOCIATION BETWEEN MIDLIFE EDUCATION AND DEPRESSIVE SYMPTOMS IN LATE LIFE: THE AGES-REYKJAVIK STUDY
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Background: Disability and depression are associated with cumulative health adversities such as socioeconomic status (SES), nutrition, medical care, and education among older adults. However, there is little evidence on the longitudinal association between mid-life education level with a disability and depressive symptoms in older adults in Iceland. The aim of the study was to examine the association between mid-life education and prevalence of activity of daily living (ADL) dependency and high depressive symptoms in late-life.

Methods: A large community-based population residing in Reykjavik, Iceland (n=4991, 57.3% women, 76.9±5.8 yrs) participated in a longitudinal study with an average of 25 years of follow-up. Mid-life education was categorized into 4 groups (primary, secondary, college, and university). ADL dependency and high depressive symptoms were assessed on average 25 (±4) years later. The 5-item ADL dependency score ranged between 0 (no difficulty) and 18. Depressive symptoms were assessed by the 15-item Geriatric Depression Scale (GDS).

Results: After controlling for demographic and health-related risk factors, those with higher education at mid-life were significantly less likely to have high depressive symptomatology (6 or higher GDS scores, Odds Ratio (OR) = 0.65, 95% Confidence Interval (CI): 0.52 – 0.82, P < 0.0001). However, mid-life education was not associated with ADL dependency in later life.

Conclusion: Our study shows that mid-life education is associated with depressive symptoms 25 years later, while no association found with ADL dependency among Icelandic older adults.

TRANSITION TO WIDOWHOOD: TRAJECTORIES OF DEPRESSIVE SYMPTOMATOLOGY AMONG JAPANESE OLDER ADULTS
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Spousal loss is one of the most consequential negative life events for the surviving partners. While there is abundant research on mental health and well-being of widows, most of these studies rely on the post-bereavement data. In this study, we use the data from the National Survey of Japanese Elderly (NSJE), which is a publicly available longitudinal data set collected from Japanese adults aged 60 years and older. The current study uses the first seven waves of data from 1987 to