database. In the frequency of NPS, there was no difference between the results in NPI of MCI with DM and MCI of our data (n = 225) except for sleep disturbance and appetite/eating disturbance (chi-squared test, P < 0.05). The sleep disturbance was more frequent in MCI with DM than in MCI of our database. On the other hand, the appetite/eating disturbance was less frequent in in MCI with DM than in MCI of our database. Moreover, the appetite/eating disturbance was not observed in MCI with DM.

Conclusion: NPS of MCI with DM is almost the same as MCI of our database except for sleep disturbance and appetite/eating disturbance. This result might be influenced by the disorder of lifestyle habits that is often observed in patients with DM or cognitive impairment of DM.

The limitation of our study is the small number of cases, further investigation is needed.

P153: The CIMA-Q and CompAS cohort studies on factors associated with Alzheimer's disease (AD): Exploring sociodemographic, health and neuropsychological profile of Subjective Cognitive Decline (SCD) participants from two culturally differentiated samples.

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*Some of the data used in the preparation of this proposal were obtained from the sample of the Consortium for the early identification of Alzheimer's disease - Québec (CIMA-Q; cima-q.ca). The CIMA-Q researchers contributed to the establishment of protocols, the implementation of the cohort, the ; obtaining of clinical, cognitive and neuroimaging data as well as the sequence of biological samples. A list of the researchers involved in the conception of CIMA-Q can be found on the website cima-q.ca

Objective: To explore commonalities and differences in the sociodemographic, health, and neuropsychological characteristics of participants with SCD recruited in two culturally differentiated cohort studies, namely CIMA-Q (Canada; Bellevile et al., 2019) and CompAS (Spain; Juncos et al., 2012).

Methods: Older adults with subjective cognitive complaints of the CompAS (N=251; 68.92% women; Control: 30.3%; SCD: 25.9%; MCI: 28.7%) and the CIMA-Q (N=179; 71.5% women; Control:16.1%; SCD: 36.8%; MCI:28.6%) were recruited, respectively, from primary care centers and memory clinics, excluding patients with dementia and other neurological or psychiatric disturbances. Cognitive complaints were assessed considering coincident items of the QAM and MFE questionnaires. Cut-off points for the 5%ile were calculated independently in both samples and according to this, participants were classified as SCD or controls (CompAS: N= 141; CIMA-Q: N=161) considering complaints relevance at baseline (Pereiro et al., 2021). Participants underwent neuropsychological assessment. Participants diagnosed as Mild Cognitive Impairment (MCI) were excluded from the analysis. Between cohort-studies and inter-group (control, SCD) differences were tested in the sociodemographic, health and neuropsychological measures considered. The Holm-Bonferroni correction was applied to reduce the probability of type I error ($p<.003$).

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Results: Identical cut-off points for 5%ile were obtained in both samples though SCD prevalence was slightly higher in CIMA-Q. For both samples, equivalence between Control and SCD participants in sociodemographic, health, functionality, and neuropsychological measures was observed. Only complaints and depressive symptomatology was significantly higher in SCD participants than in controls in both CompAS and CIMA-Q studies.

Participants of the CIMA-Q, Controls and SCD, showed significantly higher age, cognitive reserve proxies, comorbidity, and better attentional performance than the CompAS participants (see Table 1). CompAS participants, Controls and SCD, showed more neuropsychiatric symptomatology than CIMA-Q participants (see Table 1).

Conclusions: Control and SCD participants showed equivalence on sociodemographic, health, functional, and neuropsychological measures in both studies. However, significant between-sample differences in the two groups, particularly in SCD participants, were observed in sociodemographic, health, cognitive reserve, behavioral and attentional measures. Identification of these factors are critical to analyze the transcultural validity of cognitive complaints in predicting progression to AD.

Table 1. Between group (control, SCD) and Between study (CIMA-Q, CompAS) differences in sociodemographic, health, and cognitive measures

	CIMA-Q Between-group differences	CompAS Between-group differences	Between-studies differences	
			Control	SCD
Sociodemographics				
Age	NS	NS	CIMA-Q>CompAS; $F_{(1,124)}=22.78$; $p<.001$	CIMA-Q>CompAS; $F_{(1,172)}=36.97$; $p<.001$
Gender	NS	NS	NS	NS
Schooling (years)	NS	NS	NS	CIMA-Q>CompAS; $F_{(1,172)}=20.74$; $p<.001$
Prof. qualification	NS	NS	CIMA-Q>CompAS; $\chi^2_4=18.18$; $p=001$	CIMA-Q>CompAS; $\chi^2_4=33.95$; $p<001$
Cognitive reserve (quartiles)	NS	NS	CIMA-Q>CompAS; $\chi^2_3=13.57$; $p=004$	CIMA-Q>CompAS; $\chi^2_3==42.56$; $p<001$
Memory familiar antecedents	NS	NS	NS	CIMA-Q>CompAS; $\chi^2_1==15.03$; $p<001$
Neuropsychology				
Subjective complaints*	SCD>Control; $F_{(1,119)}=147.17$, $p<.001$)	SCD>Control; $F_{(1,177)}=192.87$, $p<.001$	NS	NS
Charlson Index*	SCD>Control; $F_{(1,115)}=5.29$, $p=.023$	NS	CIMA-Q>CompAS; $F_{(1,123)}=394.96$; $p<.001$	CIMA-Q>CompAS; $F_{(1,168)}=335.98$; $p<.001$
General cognition	NS (MoCA)	NS (CAMCOG-R)	--	--
GDS-15*	SCD>Control; $F_{(1,119)}=8.60$, $p=.004$	SCD>Control; $F_{(1,176)}=11.97$, $p<.001$	NS	NS
TMT-A (secs.)*	NS	NS	NS	NS
TMT-B (secs.)*	NS	NS	CompAS>CIMA-Q; $F_{(1,118)}=12.56$; $p<.001$	CompAS>CIMA-Q; $F_{(1,163)}=21.74$; $p<.001$
Verbal fluency	NS	NS	NS	NS
Semantic fluency	NS	NS	NS	NS
Boston test	NS	NS	NS	NS
NPI-Q	NS	NS	CompAS>CIMA-Q; $F_{(1,119)}=16.68$; $p<.001$	CompAS> CIMA-Q; $F_{(1,162)}=24.46$; $p<.001$
Immediate recall (RAVL test)	NS	NS	NS	NS
Short delay (RAVL test)	NS	NS	NS	NS
Long delay(RAVL test)	NS	NS	NS	NS
Intrusions (RAVL test)	NS	NS	NS	NS
IAVD*	NS	NS	NS	NS

Note: *On these measures, higher scores denote worse cognition or health condition. TMT: Trail Making Test (A and B forms); NPI-Q: Neuropsychiatric Inventory-Questionnaire; RAVL: Rey Auditory Verbal Learning; IAVD: Instrumental Activity of Daily Living.

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P167: Informal activities may explain improved depressive symptoms and resilience in nursing home residents: A cross-sectional study in Dutch and Flemish nursing homes

Objective: Pleasant, meaningful, recreational or other activities are often used in depression treatment in nursing home (NH) residents. Residents may also undertake such activities alongside or without a treatment (informal activities). It is not clear if such informal activities can partially explain treatment effects. Our aim was to explore associations of depressive symptoms and resilience with informal activities in residents.

Methods: We calculated product scores of frequency and pleasantness for activities from 18 activity clusters in NH residents (AIM, Activities to Improve Mood inventory, Knippenberg et al., in prep). The Geriatric Depression Scale, 8 items (GDS-8, Jongenelis et al., 2007) and the Brief Resilience Scale (BRSnl, Dutch translation, Leontjevas et al., 2014) were administered when interviewing residents. Professional caregivers filled out the Nijmegen Observer Rated Depression scale (NORD, Leontjevas et al., 2011). Spearman's rho's of 0.20 to 0.39 and of 0.40 to 0.60 were regarded as weak and moderate, respectively.

Results: 277 Dutch speaking NH residents (male, N=104, 38%), from Flanders Belgium (male, N=137, 49.5%) and the Netherlands participated in the study. We found positive weak associations between the self-reported and observer-rated depression scales (GDS-8 and NORD), and between the AIM total score and resilience (BRSnl). Negative weak associations were found for both depression scales and resilience, and for the depression scales and AIM. Individual AIM clusters showed positive weak to moderate associations between resilience and activities stimulating cognition (e.g. reading, puzzling), activities related to nature (e.g. walking in a park, activities with animals), or doing something meaningful for others (e.g. helping with daily routines or volunteering). Regarding depression, next to the three mentioned clusters, negative weak to moderate associations were also found for craft activities, social activities, and showing a positive mindset (e.g. humour, giving compliments).

Conclusion: The results underscore the value of activities that residents may undertake on their own alongside or without a treatment. More research is needed to understand whether informal activities alongside or without a treatment may explain intervention effects (e.g. placebo effects) on depression or resilience, and how these activities may be used to improve treatment protocols.