from the China Health and Retirement Longitudinal Study (CHARLS) and constructed a multivariate linear regression using SAS 9.4 to examine the independent association of alcohol use (never, former, moderate, and at-risk drinkers) and depression with grip strength controlling for socio-economic factors and domestic partner status. Results: The study population consisted of 12,488 Chinese adults (mean age 59). The prevalence of ever drinking during lifetime and current at-risk drinking (>14 standard drinks [one standard drink contains 14 grams of pure alcohol] per week) in this population was 25.7% and 15.2% respectively. 28.4% of the study population had depression. Compared with never drinkers, moderate and at-risk alcohol use were independently associated with better grip strength (P<0.0001). Depression was independently negatively associated with grip strength (P<0.0001). Conclusions: We found that current alcohol use might be protective of grip strength while depression might be detrimental to grip strength among middle-aged adults. However, the underlying mechanism is unclear. Given the negative impact of alcohol and depression on adults’ overall health, clinicians should assess alcohol use and depression in middle-aged and older patients using validated tools and provide resources. Clinicians should counsel patients that if depression is not managed, patients may suffer from depression associated health consequences such as declined grip strength.

INFLUENCE OF DEPRESSION AND PERSONALITY ON SOCIAL FUNCTIONING IN OLDER ADULTS

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Among older adults there is significant comorbidity between depression and personality pathology and both are associated with poorer social functioning. Personality pathology is associated with greater prevalence, poorer recovery, and a higher likelihood of recurrence of depression in older adults. This study is a secondary analysis examining the relationships between personality traits associated with personality pathology (i.e. high neuroticism and low agreeableness), depression, and social functioning across older adults surveyed in primary care and psychiatric inpatient settings (N = 227). Individual variable as well as interaction models were examined. Higher neuroticism (FChange [1,217] = 40.119, p < .001), lower agreeableness (FChange [1,217] = 20.614, p < .001), and clinical status (i.e. primary care vs. psychiatric inpatient) (FChange [1,217] = 19.817, p < .001) were associated with poorer social functioning. Clinical status moderated the relationships between neuroticism and social functioning (B = -.0147, p = .0341) and between agreeableness and social functioning (B = .0268, p = .0015). Interaction effects were not observed between neuroticism and depression or agreeableness and depression as they relate to social functioning. However, depression severity was observed to mediate the relationship between neuroticism and social functioning [Indirect effect = .0212, 95% CI = [.0141, .0289]]. These findings highlight the importance of accounting for depression and clinical status in the assessment and treatment of older adults with personality pathology. Findings warrant future research focused upon mechanisms through which personality pathology and depression influence functional status in older adults.

MOBILE INTERVENTION OUTCOMES COMPARED PRE AND POST-SHELTER-IN-PLACE FOR MIDDLE AGED AND OLDER ADULTS

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The Meru Health Program (MHP), a mobile app-based intervention targeting depressive symptoms, teaches mindfulness and cognitive behavioral skills through video lessons and practices. MHP includes integrated asynchronous therapist and peer support. Our aim was to examine whether using the MHP reduced loneliness and improved mental health quality of life (QoL) in middle-aged and older adults with depressive symptoms (Patient Health Questionnaire-9 [PHQ-9] ≥ 7). The timing of this study partially overlapped with the emergence of the SARS-CoV-2 (COVID-19) pandemic resulting in California’s shelter-in-place (SIP) orders. Fifty participants (42 enrolled prior to SIP) completed baseline assessments with a mean age of 57.06 (SD = 11.26; Range: 40-81 years) exhibiting mild to moderate depression symptoms (PHQ-9: M = 12.28, SD = 5.47). Participants enrolled pre-SIP exhibited significant improvements in QoL, F(1,38) = 12.61, p = .001, η2 = .25, and significant declines in loneliness, F(1,38) = 5.42, p = .03, η2 = .13. Improvements in QoL were found for post-SIP participants as well, F(1,44) = 6.02, p = .02, η2 = .12. In contrast, loneliness did not improve for the post-SIP cohort, perhaps alluding to the increased impact of social isolation during SIP. Our findings indicate MHP can improve QoL symptoms before and during SIP. It is possible that middle-aged and older individuals may require more individualized support during SIP to help alleviate loneliness when social connection is severely restricted. MHP remains a promising and scalable solution for those middle-aged and older adults struggling with mental health symptoms.

OLDER ADULTS’ EXPERIENCES IN AN ONLINE INTERVENTION FOR MANAGING SUBJECTIVE DEPRESSIVE SYMPTOMS

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