

IIV in loneliness and age was associated with significantly fewer physical health symptoms ($p < .05$) but was not reliably associated with sleep duration. Finally, age and IIV in loneliness did not interact to predict either physical health symptoms or sleep duration. Older participants diminished IIV in loneliness – and lack of differential vulnerability to IIV in loneliness – is consistent with theoretical models of older adults' socioemotional regulation (i.e., socioemotional selectivity theory). Contrary to expectations, a higher variability in loneliness was related to lower average physical health symptoms. Discussion will focus on the meaning and importance of IIV in loneliness for older adults' health.

DOES POOR SLEEP QUALITY PREDICT FUNCTIONAL LIMITATIONS?

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Previous work from our group (Friedman, 2016) linked sleep complaints to declines in mobility and risk of incident limitations over a 9-10 year follow-up among middle-aged and older adults. While these results suggest that poor sleep might undermine functional capacity, the self-report nature of the data leaves the robustness of this association unclear. The current study addressed this uncertainty by examining links between sleep and mobility limitations using subjective and objective assessments of both. Data were from the Midlife in the United States (MIDUS) study: the biomarker sub-sample ($N = 664$) from the original cohort (collected 2004-2006) and the Refresher cohort (collected 2011-2013). Sleep was assessed using the Pittsburgh Sleep Quality Index (PSQI; subjective) and 7 consecutive days of actigraphy (objective). Functional capacity was assessed by self-report of limitations and measured gait speed, grip strength, and chair stands. In linear regression models adjusting for demographic and health factors, lower PSQI scores (better sleep quality) predicted fewer reported limitations, stronger grip, quicker gait, and faster chair stands (all $p < .01$). Of the objective sleep metrics, time to fall asleep and time spent awake during the night predicted more self-report limitations, weaker grip (latency only), and slower gait speed and chair stands. These results extend our prior work by showing a) subjective sleep is linked to measured as well as self-reported physical function, and b) objective assessments of sleep predict reduced physical function, albeit to a lesser extent. They also brighten the spotlight on sleep as a key health determinant in older adults.

EMOTIONAL TONE OF DREAMS AND DAILY AFFECT

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One theoretical function of dreams is emotion processing. However, few studies have examined how daily emotions in waking life (i.e., daytime affect) affect the emotional tone of dreams (i.e., dream affect) that night, and vice versa. This study examined daily bidirectional associations between dream affect and daytime positive and negative affect. Participants were 61 nurses who completed 2-weeks of ecological momentary assessments. If participants remembered the previous night's dreams ($n_{\text{participants}}=50$; $n_{\text{days}}=268$), they reported the dream's emotional tone upon waking ('0'=very negative to '100'=very positive). Participants also

responded to a short-version of the Positive and Negative Affect Scale three times/day. Multilevel modeling was used to evaluate two temporal directions (dream affect → daytime affect or daytime affect → dream affect) at the within- and between-person levels. After adjusting for sociodemographic covariates, at the within-person level, daily positive affect was higher and daily negative affect was lower than usual on days following more positive dream affect ($B=0.19$, $p < .05$; $B=-0.26$, $p < .05$, respectively). When we added the other temporal direction, today's positive or negative affect was not associated with dream affect that night. At the between-person level, nurses who reported more positive dream affect also reported more positive daytime affect ($B=0.52$, $p < .01$), but not less negative daytime affect ($B=-0.34$, $p > .10$). Findings suggest that dream affect is predictive of daily affect, but not the other way around. Future studies could further examine if emotions closer to sleep are more strongly associated with dream affect to motivate more precisely-timed affect interventions.

FACTORS ASSOCIATED WITH PERCEIVED STRESS AMONG DEMENTIA CAREGIVERS WITH POOR SLEEP

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Poor sleep among family caregivers of individuals with dementia is associated with higher levels of caregiver stress. Modifiable factors that increase risk of stress among caregivers with poor sleep are targets for intervention. This analysis aimed to identify factors associated with greater caregiver stress among caregivers with poor sleep. Baseline data from an ongoing trial of a dyadic sleep intervention program for individuals with dementia and their caregivers with poor sleep quality (defined by Pittsburgh Sleep Quality Index total score > 5 ; $N=21$ dyads; mean age 70.8 ± 11.1 for caregivers, 80.5 ± 8.3 for care-recipients) were analyzed. Caregiving factors included Zarit Burden Index (ZBI) and SF-12 Short Form Health Survey (SF-12v2). Care-recipient factors included Mini-Mental State Examination (MMSE) and Revised Memory and Behavior Problems Checklist (RMBPC). Stress was measured with the Perceived Stress Scale (PSS). Analyses included Pearson correlations and t-tests. Caring for multiple care-recipients ($n=5$: 24.8 ± 2.7) was associated with higher (worse) PSS scores than caring for one care-recipient only ($n=16$: 19.6 ± 3.7 , $p=0.011$). Caregivers with higher PSS also had a significantly higher ZBI score ($r=0.53$, $p=0.015$), higher distress related to care-recipient behaviors on the RMBPC ($r=0.57$, $p=0.009$) and worse mental health on the SF-12v2 ($r = -0.47$, $p=0.037$). PSS was not associated with care-recipient MMSE. These findings suggest that caregivers with poor sleep who care for multiple care-recipients may be at higher risk of stress. This work also identified potential targets (e.g., caregiver burden, mental health, distress related to care-recipient behavior) for reducing stress in this population.