

scored from 0 - 27 with scores of 5 - 9 indicating mild and  $\geq 10$  moderate or severe depression.

**Results:** 50 adolescents and 46 parents participated. Of adolescent participants, mean age was  $15.72 \pm 1.69$  years, 32(64%) were male, 18(36%) Hispanic, 15(30%) African American, 12(24%) multiracial/other. Mean score on the adolescent ACEs self-report Section 1 was  $2.04 \pm 2.08$  and Section 2 was  $1.26 \pm 1.07$ . Based on the PHQ-9 score, 28(56%) adolescents had no depression, 14(28%) had mild, and 8(16%) moderate/severe depression. We found that female adolescents as compared to males had a higher mean PHQ-9 score [ $6.17 \pm 4.42$  vs  $3.47 \pm 3.99$ ,  $p < .05$ ] and ACEs self-report Section 1 [ $3.17 \pm 2.6$  vs  $1.41 \pm 1.41$ ,  $p < .05$ ], respectively. We found no meaningful difference in PHQ-9 or ACE scores by race/ethnicity. Using Spearman correlation tests, we found a moderate positive correlation of PHQ-9 score with adolescent ACEs self-report Section 1 [ $r_s = 0.44$ ,  $p < .01$ ] and Section 2 [ $r_s = 0.5$ ,  $p < .001$ ]. The mean parent report of adolescent ACEs for Section 1 was  $1.13 \pm 1.88$  and for Section 2 was  $0.61 \pm 1$ . Using Wilcoxon signed-rank test, we compared parent report of adolescent ACEs with adolescent self-reported ACEs. Parent report was lower than adolescent report for Section 1 [ $1.13 \pm 1.88$  vs  $2.04 \pm 2.08$ ,  $p < .01$ ] and Section 2 [ $0.61 \pm 1$  vs  $1.26 \pm 1.07$ ,  $p < .01$ ], respectively.

**Conclusions:** Consistent with our hypothesis, we found a positive correlation of adolescent ACE score and PHQ-9 score indicating a relationship between a higher number of ACEs and mild and moderate depression in adolescents being seen for an annual well visit. However, contrary to our hypothesis, we found that parents reported significantly fewer ACEs for their adolescents than the adolescents themselves. Further investigation is warranted into measurement of adolescent ACEs by parental report as it may underestimate health risks for this age group.

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#### GENERATIONAL TRAUMA: TEEN PARENT REACTIONS TO A BRIEF INTERVENTION IN THE PRIMARY CARE CLINIC

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**Purpose:** Exposure to adverse childhood experiences (ACEs) has been linked to poor health and developmental outcomes across the lifespan. Adversity experienced by a caregiver in childhood can lead to a generational transfer of trauma, through an impact on caregiver mental health, parenting behaviors, and parent-child relationships. Adolescent parents have disproportionately high rates of exposure to childhood trauma, putting their offspring at high risk of poor health and developmental outcomes, through the intergenerational transfer of trauma. Prior work has demonstrated that a conversation about ACEs built into pediatric primary care visits can be well received by both parents and providers. Building on these findings, the purpose of this study was to examine teen parent acceptance of a brief conversation about generational trauma conducted during patient visits in the primary care setting.

**Methods:** The study was conducted in the Healthy Generations program, a medical home for teen parents aged 13-22 and their families, located at Children's National Hospital. 21 families were recruited for this study during in-person clinic visits. The study team developed a "Generational Trauma Conversation Card" (GTCC), a double-sided graphic depicting generational trauma transfer and strategies to

mitigate the health effects of trauma exposure. Healthy Generations physician providers conducted the intervention, a 5 minute open-ended conversation regarding the GTCC utilizing a semi-structured script. Following the intervention, teens completed a 20 question survey composed of Likert scale and free response questions. Participants were compensated with a gift card and this study was approved by the Institutional Review Board at Children's National.

**Results:** 21 teen mothers participated in the intervention and survey. Mean age was 18 years old. 57% of patients had not heard about generational trauma prior to this visit. 90% were comfortable or very comfortable learning about generational trauma from their pediatrician and 85% preferred to learn about this topic from their pediatrician compared to a therapist or social worker. 71% somewhat or strongly liked how the graphic portrayed generational trauma. 95% indicated that the strategies to reduce the effects of trauma on health, depicted on the back of the GTCC, were somewhat or very clear. 81% indicated that they were likely or very likely to make changes in their life based on this information and 95% would share this information with others.

**Conclusions:** The GTCC was an effective tool to facilitate discussion regarding generational trauma during patient visits in the Healthy Generations clinic. Teen parents responded positively to the intervention and expressed a preference for learning this information from their pediatrician. The GTCC offers a unique opportunity to incorporate discussion of ACEs with all patients, moving away from a focus on patient's individual ACE score and avoiding common barriers to ACE discussion such as risk of re-traumatization of patients through detailed questionnaires, lack of validated screening tools, and concerns over mandated reporting. In addition, the GTCC is action-orientated focused on patient education and strategies to mitigate the impact of trauma and intergenerational transfer of trauma.

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#### ASSESSMENT OF A POVERTY SIMULATION IN MEDICAL EDUCATION

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**Purpose:** According to the US Census 2019 Income and Poverty report, 10.5% of the population lives below the poverty line, and approximately 10.5 million individuals below 18 years were in poverty in 2019. Children and adolescents in poverty are at risk for poor developmental and psychosocial outcomes, presenting a significant financial burden for families and the general public. Yet low-income populations continue to face barriers to healthcare, leaving them vulnerable to worse health outcomes. Unfortunately, medical students may adopt unfavorable attitudes toward low-income patients due to lack of empathy, poor understanding, and burnout, which negatively affects patient care. A poverty simulation module was included in the medical student curriculum at our institution to improve understanding and empathy toward low-income patients.

**Methods:** IRB approval was obtained prior to data collection. Participants included medical students in one US medical school from 2018 to 2021. In 2021, students participated virtually due to the COVID-19 pandemic, though the objectives and methods remained the same as in person. Participants were placed in a poverty simulation, roleplaying as one of 26 different families facing poverty across four, 15-minute