P045
ILLNESS STIGMA, BODY IMAGE DISTRESS, TWARTED BELONGINGNESS, AND DEPRESSIVE SYMPTOMS IN YOUTH WITH INFLAMMATORY BOWEL DISEASE
Caroline Roberts, Kaitlyn Gamwell, Clayton Edwards, Marissa Baudino, Jeanne Tung, Noel Jacobs, John Grunow, Stephen Gillaspy, Larry Mullins, John Chaney
Introduction: Inflammatory bowel disease (IBD) involves invasive symptoms and embarrasing treatment side effects (e.g., weight gain/loss). Elevated levels of depressive symptoms are also observed in youth with IBD, and have been linked to perceived illness stigma and feelings of social isolation. One potential variable related to stigma that has received only minimal attention in the pediatric IBD literature is body image dissatisfaction, which is associated with poor social identity development and increased depressive symptoms in healthy youth. Due to the stigmatizing nature of IBD, youth may feel self-conscious about their body image, which contributes to decreased feelings of social belongingness and ultimately depressive symptoms. The current study tested a serial mediation model in which increased youth perceived IBD stigma was hypothesized to have an indirect influence on youth depressive symptoms through the sequential effects of stigma on youth body image dissatisfaction and increased twarted social belongingness, resulting in a significant illness stigma – body image dissatisfaction – twarted belongingness – depressive symptom serial mediation path.
Methods: Youth with IBD (Crohn’s = 36, Ulcerative Colitis = 30, Indeterminate Cohlty of VI among youth) between the ages of 10–18 yrs. (M = 14.5; SD = 2.12) were recruited from a pediatric gastroenterology clinic. Time since diagnosis ranged from <1 to 5.74 yrs. (M = 1.58; SD = 1.56). Youth completed measures of IBD stigma (Stigma Scale-Child; SS-C), body image dissatisfaction (Body Image Questionnaire; BIQ), twarted belongingness (Interpersonal Needs Questionnaire: Thwarted Belongingness Subscale; INQ-TB), and depressive symptoms (Children’s Depression Inventory- 2nd Edition; CDI-2). Disease severity was assessed by physician global assessment. Current medications and Body Mass Index (BMI) data were also collected.
Results: Eighteen percent reported elevated CDI-2 depression scores. Only gender and BMI were correlated with modeled variables. Further, the BMI – CDI-2 association was greater for youth taking prednisone. Primary analyses examining 95% confidence intervals from 5,000 bootstrapped regression resampling draws revealed significant direct effects for SS-C → BIQ, BIQ → INQ-TB; and INQ-TB → CDI-2. Bootstrapped mediation analyses indicated a significant serial indirect path for SS-C → BIQ → INQ-TB → CDI-2 (effect = 0.92, 95% CI = 1.41 to 2.187), controlling for gender, BMI, and prednisone medication.
Conclusions: Youth who perceive greater IBD stigma are more likely to experience increased body image dissatisfaction due to their IBD, which may engender feelings of social estrangement, and ultimately elevated depressive symptoms. Both stigma and body image dissatisfaction should be assessed and addressed in a multidisciplinary fashion by medical providers and mental health professionals.

P046
MINDFULNESS-BASED VIRTUAL REALITY: A PROMISING MIND-BODY INTERVENTION FOR YOUTH WITH INFLAMMATORY BOWEL DISEASE
Ana Vanessa Wren, Nicole Neiman, Martine Madill, Katherine Taylor, Hal Rives, Maria Menendez, Ellen Wang, Thomas Caruso, Samuel Rodriguez, Linda Nguyen
Background: Living with Inflammatory Bowel Disease (IBD) has been associated with increased psychosocial stress among pediatric IBD populations. Elevated psychological stress can exacerbate disease activity and IBD symptoms like abdominal pain, which in turn can negatively impact children’s mental health. There is an increasing need for mind-body interventions that can improve psychosocial processes among youth with IBD. Mindfulness-based interventions (MBIs) have been shown to be efficacious in improving emotional distress, pain, and inflammation in a range of pediatric and adult chronic illness/pain populations. Few studies have explored MBIs in pediatric IBD. Using virtual reality (VR) as the medium for an MBI in pediatric IBD has great potential given the increasing prevalence of VR in children’s hospitals, the immersive nature of the technology, and the high acceptability of VR among youth.
Aims: 1) Assess the feasibility and acceptability of mindfulness-based virtual reality (MBVR) among youth with IBD; 2) Assess the preliminary efficacy of MBVR on anxiety and pain.
Methods: Youth at an outpatient IBD clinic were offered MBVR. Our team developed a 6-minute MBVR experience, ‘MediMindfulness-Transitions’ (Stanford University & Weightless Studios), that focused participants’ awareness on a natural environment (e.g., waterfall in meadow, northern lights) and their breath. Participants rated their level of anxiety and pain on VAS scales (0-100mm) immediately before and after the MBVR experience. Paired t-tests were used to assess changes in patient-reported outcomes (SPSS 26). Patients also completed a satisfaction survey and provided qualitative feedback.
Results: The sample included 52 participants with IBD (M=15 yrs; 69% Crohn’s disease; 58% Male; 62% White). MBVR was easily integrated into clinic flow (offered before or after MD visit) and there was 100% treatment compliance. There were high levels of enjoyment (M=4.4, range 1–5) and relaxation (M=4.3, range 1–5) post-intervention; 50% of the sample reported MBVR was an ideal length and were extremely interested in using MBVR at home. Qualitative data revealed areas of enjoyment and suggestions for future use (Table 1). Exploratory efficacy analyses revealed MBVR decreased anxiety (16.54 ± 20.56 vs. 7.10 ± 13.27, p < 0.001) and pain (9.5 ± 16.19 vs. 3.04 ± 6.22, p < 0.01). One patient experienced worsening of their anxiety symptoms.
Conclusion: MBVR was shown to be feasible and have high acceptability among youth with IBD. The results demonstrated preliminary support for MBVR reducing acute anxiety and pain. This study suggests MBVR could be a promising mind-body therapy for youth with IBD. Future studies should explore the efficacy of MBVR during IBD procedures and treatments (e.g., blood draws, MRIs, infusions) and whether longer-term use of MBVR improves psychosocial outcomes.

P047
PARENT PERSPECTIVES ON COMPREHENSIVE CARE FOR CHILDREN WITH INFLAMMATORY BOWEL DISEASES: BUILDING A CARE DELIVERY MODEL FROM THE FAMILY UP
Hilary Michel, Sandra Kim, Nalyn Siripong, Robert Noll
Background: Patients with Inflammatory Bowel Diseases (IBD) require life-long management by gastroenterology (GI) and primary care providers (PCP). Guidelines exist outlining recommended healthcare services, but it is unclear which provider is responsible for which tasks, and what parents prefer.
Aims: To understand perceptions of healthcare quality and delivery for children with IBD, describe barriers to receiving comprehensive healthcare, and elicit preferences for how care would ideally be delivered.
Methods: Cross-sectional survey of parents of children ages 2–17 with IBD at a large, free-standing children’s hospital, recruited via an institutional research registry. Surveys assessed parent medical history, family demographics, perceptions of health care quality and delivery, barriers to primary and GI care, and preferences for care receipt.
Results: 217 parents were recruited, 214 consented, and 161 completed the survey (75% response). Mean parent age 14 years (SD 3); 51% male; 80% Crohn’s, 16% ulcerative colitis, and 4% indeterminate colitis. Most parents were Caucasian (94%), had a bachelor’s degree or higher (61%), and lived in a suburban setting (57%). Most had private insurance (43%) or private primary and public secondary insurance (34%). Most parents (N=149, 94%) thought the GI doctor was responsible for their child’s IBD care, and 8 (6%) reported shared responsibility by the GI doctor and PCP. 113 (71%) said their child’s PCP was responsible for primary care, 8 (5%) said GI doctor, and 37 (23%) said both. 95% of parents were confident in their GI doctor’s primary care knowledge, and 81% with their PCP’s IBD knowledge. 89% were satisfied with their communication with the PCP, and 98% were satisfied with their communication with the GI doctor. 53% did not know how well their PCP and GI doctors were communicating with each other. Only 4% of parents reported unmet healthcare needs, but those who did cited inadequate family support and mental health services. The greatest barriers to PCP care were lack of continuity with providers (22%) and scheduling (24%). The greatest barriers to GI care were scheduling (38%) and traveling to appointments (29%). Parent preferences for specific health care service delivery are found in Figure 1.
Conclusions: Parents of children with IBD are satisfied with provider knowledge and communication skills with them, though most are unaware how well their PCP and GI doctor are communicating with each other. Healthcare needs are being met for most patients in our cohort, but parents cite different barriers to primary vs. specialty care, and mental health services in particular are lacking. Parents seem to support co-management between their child’s PCP and GI provider. Understanding parent perspectives is essential to the development of family-centered healthcare delivery models for children with IBD.