maintenance of confidentiality (CoC); financial support for uncovered services (SA); and provider education (QS). Some challenges we have encountered include: provision of specialty, not primary, care (CC); no-show rate of high-risk youth (PC); lack of internal mental health providers with transgender expertise (CoC); insurance coverage issues (CoC, AS); long wait time for new patient visits (AS); and mental health comorbidities (QS).
Conclusions: Providing services to transgender youth within an academic hospital setting is logistically possible, economically feasible, and can deliver a high quality of care. Organizing this service implementation using PCMH principles ensures that multiple domains of quality are being addressed. Laying the groundwork to serve this very rewarding patient population involves provider training and needs assessment of clinical capabilities.
Sources of Support: None.

106.

TRENDS IN DISORDERED EATING BY SEXUAL ORIENTATION IN WESTERN CANADA

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Purpose: Health disparities between sexual minority (SM) adolescents and heterosexual adolescents have been identified for risky behaviors such as substance use and risky sexual practice. Yet, few studies have looked at disordered eating (e.g., binge-eating and self-induced vomiting) which may cause serious health consequences. SM youth may be at higher risk for disordered eating, in part because of stress and trauma experiences. Additionally, prevalence of disordered eating within the same sexual orientation group may change over time, as seen in general adolescent samples. We thus examined (a) trends in disordered eating within each orientation group and (b) disparities between SM and heterosexual adolescents in western Canada.
Methods: Data were from the British Columbia Adolescent Health Survey of 1998, 2003, and 2008, a province-wide, school-based, cluster-stratified random survey of students in grades 7-12. We included students from school districts participating in at least 2 of 3 survey years (weighted N's $>$ 210,000), with 91% heterosexual (HET), 7% mostly heterosexual (MH), 3% lesbian, gay, and bisexual (LGB). Measures included binge eating (twice a month or more) and vomiting on purpose after eating (at least one time for boys; twice a month or more for girls).Trends in prevalence across survey years were tested by contingency tables with z tests. Age-adjusted odds ratios assessed differences in disordered eating between SM groups and HET groups in each year. All analyses were stratified by gender and adjusted for complex sampling.
Results: Binge-eating rates declined between 1998 and 2008 among HET boys (8.4% to 6.4%) and HET girls (14.5% to 12.9%) and between 2003 and 2008 among MH girls (23.7% to 19.3%). Among LGB boys, the rates declined from 30.2% in 1998 to 14.8% in 2003, then increased (but not significantly) to 24.2% in 2008. A significant decrease in vomiting was found among HET boys (from 3.8% in 1998 to 2.5% in 2008). Among LGB boys, the rates declined from 19.4% in 1998 to 4.5% in 2003, followed by an increase to 18.5% in 2008. LGB girls had increasing rates from 9.3% in 2003 to 16.2% in 2008. MH boys and MH girls had 1.5-2 times odds of binge eating and vomiting compared to their HET peers. Orientation differences between LGB and HET were narrower in 2003 than in 1998 (AOR of binge eating for boys 4.7 to 2.1; for girls 2.6 to 1.8; AOR of vomiting for boys 6.3 to 2.1; for girls 4.1 to 3.8), followed by a widening gap in 2008 (AOR of binge eating for boys 4.5; for girls 2.4; AOR of vomiting for boys 9.3; for girls 6.4).
Conclusions: A declining trend in disordered eating was observed for heterosexual youth and a V-shaped trend for LGB youth. Sexual minority youth were at higher risk across all years. Findings suggest the need to continue monitoring trends by orientation and explore factors that may influence the trends.
Sources of Support: Grants #CPP86374 & #MOP 119472, Canadian Institutes for Health Research; McCreary Centre Society's BC Adolescent Health Survey.

107.

UK AND IRISH SURVEILLANCE STUDY OF GENDER IDENTITY DISORDER (GID) IN CHILDREN AND ADOLESCENTS

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Purpose: The incidence of childhood/adolescent Gender Identity Disorder (GID) is unknown. GID is an important condition where gender identity differs from biological sex. It is associated with significant distress, particularly with puberty, with much controversy internationally over the optimal timing of hormonal treatment. We examine the incidence and clinical presentation in UK and Irish children and adolescents.
Methods: STUDY POPULATION: Children and adolescents aged 4-15.9 years in the UK and Republic of Ireland. DESIGN: Joint British Paediatric Surveillance Unit (BPSU) and Child and Adolescent Psychiatry Surveillance System (CAPSS) study. New cases of GID reported by clinicians over a 19-month reporting period (01-Nov-2011 to 01-June-2013) are validated against the authoritative DSM-IV-TR (2000). Exclusions include disorders of sexual differentiation and major psychosis. PRIMARY OUTCOME: Incidence of childhood/adolescent GID, calculated by dividing the number of validated cases by the base population of children and adolescents aged 4-15.9 years. Sources of denominator data: UK Office of National Statistics and the Central Statistics Office in Ireland. STATISTICAL ANALYSIS: Descriptive statistics and comparisons using two-sample t-tests or Mann-Whitney U tests for continuous data and Chi-squared or Fisher's exact tests for categorical data.
Results: Preliminary descriptive data from the first 15 months' surveillance (n $=$ 138 cases, 69 males) indicate that similar numbers of males and females are affected by this condition. Early estimates suggest UK and Irish incidences of 1:80,000 and $<$ 1:200,000 respectively. There is a lag of several years between median [interquartile range] onset of symptoms (7y [4-12y]) and presentation to Paediatricians or Psychiatrists (14.5y [11.9-15.2y]), with most cases presenting at 14 or 15 years. Only a quarter of all cases (n $=$ 35) were less than 12 years old at reporting, but 50% of cases reported by Paediatricians. There are high levels of psychiatric co-morbidity at presentation, with at least one other mental health diagnosis in 45%, and two or more other diagnoses in adolescents aged 12 years and over.
Conclusions: We present the first ever population-level data on the incidence, clinical features and presentation of childhood/adolescent GID. These data will inform clinical management, including the highly controversial debate around early pubertal suppression in this group.

Sources of Support: Educational grant through the Tavistock and Portman NHS Foundation Trust.

HIV

108.

PARENTAL MONITORING AS A MODERATOR OF THE EFFECT OF PARENT-ADOLESCENT SEXUAL COMMUNICATION ON UNPROTECTED ANAL INTERCOURSE AMONG YOUNG MEN WHO HAVE SEX WITH MEN

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Purpose: Among heterosexual adolescents, sexual risk behavior is moderated by caregiver parenting styles and practices including permissiveness, monitoring, and parent-adolescent communication regarding adolescent sexual behavior. The protective nature of these parenting factors may be especially complex in young men who have sex with men (YMSM) because, unlike their heterosexual counterparts, YMSM may prefer to conceal sexual behavior from their parents for fear of parental rejection or other negative psychosocial health outcomes. Given the concentrated HIV prevalence in this population, it is important to examine how monitoring, permissiveness, and parent-adolescent sexual communication interact and influence sexual risk in YMSM. This study examined the extent to which perceived parental monitoring and perceived parental permissiveness (i.e., parenting style) moderated the relationship between parent-adolescent communication about sex and sexual risk outcomes in YMSM.
Methods: This study was comprised of 233 cases selected from a community-based, longitudinal sample of YMSM (N = 450; aged 16-20) recruited through modified respondent-driven sampling. Participants completed computer-assisted self-interviews assessing male-male sexual risk behavior, their caregivers' parenting style, and parent-adolescent sexual communication. Parental permissiveness and parental monitoring scale items were modified for YMSM and their scale scores were dichotomized based on median values (e.g., high vs. low). Parent-adolescent sexual communication was also dichotomized (e.g., communication vs. no communication), as were sexual risk outcomes (e.g., risk vs. no risk). Bivariate analyses were conducted between the measures of parenting style, and parent-adolescent sexual communication. Significant bivariate outcomes informed subsequent multivariable logistic regression models predicting the likelihood of sexual risk behavior by parenting style, and parent-adolescent sexual communication.
Results: Results indicated that parenting style and parent-adolescent sexual communication influence sexual risk behavior in YMSM. Neither level of parental permissiveness was directly associated with sexual risk behavior; however, high parental permissiveness was associated with a lack of parent-adolescent sexual communication ($p < 0.05$). In contrast, YMSM who reported high parental monitoring also tended to report parent-adolescent sexual communication ($p = 0.09$). A higher proportion of YMSM with low parental monitoring reported unprotected anal sex with casual male partners ($p = 0.07$), although this association did not reach statistical significance. Adjusted for age and race/ethnicity, YMSM with high parental monitoring were less likely to engage in unprotected anal sex with casual male partners (OR = 0.46; 95% CI = 0.22, 0.97); however, this effect was only observed in those who also reported parent-adolescent sexual communication (OR = 0.36; 95% CI = 0.12, 1.04). Among participants reporting no parent-adolescent sexual communication, high parental monitoring alone was not associated with unprotected anal sex with casual male partners (OR = 1.03; 95% CI = 0.31, 3.44).
Conclusions: Consistent with literature in heterosexual adolescents, for parents to merely have "the talk" about sex is not enough as adolescent sexual behavior is most effectively influenced by parents who both monitor and talk openly to adolescents about their sexual behavior. These findings imply that HIV prevention programming could benefit from YMSM-specific, family-based interventions aimed at improving both parenting skills and practices pertaining to YMSM.
Sources of Support: This study was supported by the National Institute of Drug Abuse (Mustanski-R01DA025548).

109.

INTERACTIVE VOICE RESPONSE SYSTEM (IVRS): DATA QUALITY CONSIDERATIONS AND LESSONS LEARNED DURING A MICROBICIDE PLACEBO ADHERENCE TRIAL WITH YOUNG MEN WHO HAVE SEX WITH MEN

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Purpose: Young men who have sex with men (YMSM) account for most new HIV infections in the United States. Forthcoming biomedical prevention approaches (e.g., microbicides) may aid in reducing HIV incidence among YMSM; however, the demonstration of rectal microbicide efficacy and effectiveness is contingent on correct and consistent product use and accurate measurement of adherence. Delays in self-report, in particular, may affect the accuracy of behavioral data. Capitalizing on YMSM's mobile phone use, we examined the acceptability and use of IVRS for measuring adherence to product use with receptive anal intercourse (RAI) in a microbicide safety and acceptability trial with YMSM (ages 18-30) and documented the challenges experienced by trial participants with the system.
Methods: We enrolled 124 YMSM across three sites (Boston, Pittsburgh, San Juan). We provided them with up to 40 applicators prefilled with 4mL of hydroxyethylcellulose placebo gel for use prior to RAI and counseled them repeatedly that the study focused on product adherence and that the gel would not protect against HIV. We asked YMSM to self-report product use through an IVRS, available in Spanish and English, during a 12-week trial. Twenty-nine participants discontinued due to early termination (N = 13) or loss to follow-up (N = 16). Using IVRS data and end-of-trial interviews, we documented YMSM's IVRS experiences and their implications for data collection.
Results: We observed 1,728 calls to the IVRS over 3 months. After developing an IVRS data quality system, we found that 427 (24.7%) entries required inspection. Of these, we excluded 324 entries due to data entry errors (18.8%). Most participants (n = 71; 75.5%) did not report problems using IVRS. Of those who reported a problem (N = 24), most experienced one (N = 14; 14.9%) or two (N = 7; 7.4%) problems. Problems included phone-specific problems (e.g., dropped calls due to limited cell signal when calling into the system), and/or system-specific issues (e.g., having to answer the same question repeatedly or having incorrect answers registered if IVRS didn't recognize their voice). One participant indicated that he stopped using IVRS because it reminded him that he hadn't had any recent sexual activity. In a