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Emerging Adults' Discussion of Substance Use and Sexual Behavior with Providers

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Abstract

Emerging adulthood (ages 18–25) is a time of increased autonomy and associated with a high rate of risky substance use and sexual behavior. As emerging adults (EA) increasingly have more independence, they have the ability to make health decisions, including whether to see a provider (primary care (PCP) and/or gynecologist (GYN)) and whether to discuss substance use and sexual behavior. The current study aimed to determine: 1) factors associated with PCP and GYN healthcare seeking by sexually-active EA who use alcohol and/or marijuana; 2) gender differences in substance use and sexual risk topics initiated by providers; 3) whether PCPs compared to GYNs discuss different topics with women. Alcohol and/or marijuana-using, sexually-active EA (n=500) were recruited as part of a health behaviors study. Among participants, 39% did not see a PCP in the previous year. Women, White individuals, and EA with health insurance were most likely to attend a PCP appointment. Even among participants who saw a provider, many participants reported that providers did not initiate a discussion about substance use (approximately half discussed substance use) and sexual behavior (about half discussed STI history, two-thirds discussed condom use, and three-quarters discussed sexual partners). Among women with a PCP and GYN provider, discussions on substance use were more likely to be initiated by a PCP while sexual issues were more likely to be initiated by a GYN. Thus, even among sexually-active, substance-using EA, central topics—specifically substance use and sexual behavior - are not routinely brought up by providers.

Keywords

young adulthood; substance use; sexual behavior; preventative care

Introduction

Emerging adulthood, the period between ages 18–25, is a time of substantial change. (Arnett, 2000; Arnett, 2007). Emerging adulthood is a time of increased risky behavior, such as substance use (Auerbach & Collins, 2006; Ralph Hingson, Heeren, Winter, & Wechsler, 2005; Lee, Mun, White, & Simon, 2010; Stone, Becker, Huber, & Catalano, 2012; Substance Abuse and Mental Health Services Administration, 2017) and sexual activity (Connor, Psutka, Cousins, Gray, & Kypri, 2013; Cooper, 2002; Dodge et al., 2010; Jozkowski & Satinsky, 2013; Marston & King, 2006; O'Hara & Cooper, 2015; Simons, Simons, Maisto, Hahn, & Walters, 2018). Substance use and sexual activity in EA are highly related to one another, and are associated with a host of negative mental health, physical health, and social problems such as development of sexually transmitted infection, unwanted pregnancy, sexual assault and violence, higher rates of anxiety and depression (De Ravello, Everett Jones, Tulloch, Taylor, & Doshi, 2014; Patel, Flisher, Hetrick, & McGorry, 2007; The Henry J Kaiser Family Foundation, 2002; Whiteford et al., 2013). However, risk-taking may decrease as individuals move into more responsible, “adult” life roles (Allem, Lisha, Soto, Baezconde-Garbanati, & Unger, 2013; Bingham & Shope, 2004).

During this time, emerging adults (EA) are able to make their own decisions about their health. Due to their increased risk of developing mental health, physical health, and social consequences, it may be even more important for EA who engage in risky behavior (such as substance use) and are sexually active to seek regular care because providers may be able to assess and treat such issues before they lead to a more longstanding pattern of problems. Epidemiological data show that EA men are less likely to receive health care services as compared to women (Fortuna, Robbins, & Halterman, 2009). For example, women are more likely to have a usual place to receive health care (77.9% vs 62.5%), and have seen a doctor in the previous 12 months (81.3% vs. 58.5%). These gender differences are replicated in research on sexual health: between 2006–2010, 24% of sexually-active women and 38% of sexually-active men did not receive services related to sexual and reproductive health (Tyler, Warner, Gavin, & Barfield, 2014). White Americans are also more likely to receive services as compared to minority groups (Clarke, Norris, & Schiller, 2017; Fortuna et al., 2009): for example, White individuals are more likely to have a regular provider and have visited the provider in the previous year (Kirzinger, Cohen, & Gindi, 2012). Epidemiological data estimates that approximately 86.3% of young adults have health insurance, with women being more likely to have insurance than men (Clarke et al., 2017). Additionally, individuals who place a higher value on health may be more likely to visit a provider and engage in fewer risky behaviors (Costa, Jessor, Fortenberry, & Donovan, 1996; Rosengard et al., 2018; Ruiz-Palomino, Giménez-García, Ballester-Arnal, & Gil-Llario, 2018; Tarrant & Butler, 2011).

EA not only make decisions about whether to utilize healthcare, they also have more independence to choose which provider to use (Garcia, Lechner, Frerich, Lust, & Eisenberg, 2014). Additionally, as adults, they can discuss pertinent issues with their providers without parental involvement. Guidelines recommend providers screen all individuals 18 and above for hazardous substance use and, if necessary, provide brief behavioral interventions (Moyer,

2004). However, these topics are not regularly discussed (Córdova et al., 2017; Fuzzell, Shields, Alexander, & Fortenberry, 2017; Hingson & Compton, 2014). For example, fewer than one-third of PCPs in a national survey reported carefully screening for substance use (Chenault, Fisher, & Fraser, 2000). Suggested evidence-based clinical practices for sexual and reproductive health visits include discussing topics such as contraceptives and STI, and HIV testing (Romero, Middleton, Mueller, Avellino, & Hallum-Montes, 2015; Shafii & Burstein, 2018). However, epidemiological data shows that less than one-third of provider visits include preventative counseling, and less than 5% of visits included information regarding mental health or STIs (Fortuna et al., 2009).

Several factors may lead to topics of discussion at a healthcare visit. Provider communication style, visit type (i.e. wellness visit, vs sick visit), and patient led vs. provider led discussion can determine what is discussed (Flocke, Kelly, & Highland, 2009; Flocke & Stange, 2004). A study of 1086 OB/GYNs and PCPs found that less than half of the sample reported regularly discussing condom use and sexual partners with patients (Haley, Maheux, Rivard, & Gervais, 1999). Indeed, results from a survey of 1,256 practitioners indicate that even between groups of practitioners, contraceptive use discussions/interventions practices varied widely: Planned Parenthood and public health departments were most likely to address contraceptive use, as compared to OB/GYNs and family physicians: in fact, only 38% of OB/GYNs and 13% of family physicians addressed contraceptives (Landry, Wei, & Frost, 2008).

The current study has several goals. The first aim is to determine factors associated with PCP and GYN healthcare seeking by EA who use alcohol and/or marijuana and are sexually-active – individuals who may be in particular need of preventative care. The second aim is to evaluate gender differences in substance use and sexual risk topics initiated by healthcare providers. Aim three is to evaluate whether, among women, different topics are initiated by PCPs vs. GYNs. It is hypothesized that:

1. EA who are heavier substance users or have riskier sexual behavior will be less likely to seek primary healthcare services.
2. EA with a higher value on health will be more likely to visit providers.
3. Providers may be more likely to initiate discussions on risky behavior and sex-related topics with women than men.
4. PCPs will initiate discussions on substance use, while GYNs are more likely to discuss sexual behavior.

Methods

The current study recruited participants between January 2012 and May 2016 with online and print media for a “health behaviors” study (Caviness, Anderson, & Stein, 2017), conducted at a research hospital in New England. Participants called a study line to be screened for eligibility. Eligible participants were between the ages of 18–25, were sexually-active within the last 6 months, were English-speaking, and lived within a 30 minute drive of the study site. Among the 2,645 individuals who called the study line for screening over the

course of 4 years, 1,217 were either uninterested or ineligible, leaving 1,428 potential participants who were invited for further in-person screening. Of participants invited, 834 individuals were uninterested (n=130 said they were not interested; n=202 either did not call back to schedule an appointment or were involved in another conflicting research study; n=502 missed the appointment). Thus, 594 individuals completed the in-person baseline interview. An additional 23 individuals were ineligible based on baseline interview and 5 individuals declined further involvement in the study, leaving a final sample of n=566. This analysis was limited to those who were current (past 30 day) alcohol or marijuana users and included 500 persons. Participants received \$40 compensation for completing the baseline interview. All methods were approved by the hospital Institutional Review Board. For a more detailed description of recruitment procedures and baseline interview, see Stein et al., (2018).

Measures

Demographics.

Participants answered questions regarding their age, sex, race, and ethnicity. Ethnicity was assessed by asking participants if they were Latino/Hispanic (yes/no). For assessment of race, although participants were given a variety of options, race was divided for the purposes of analyses into White, Black, and Other or Mixed Race. Participants were also asked if they currently had health insurance.

Value on Health.

Participants reported the importance of physical health in their lives using the 10-item Value on Health scale (Costa et al., 1996). Participants reported, on a scale of 1 (Not at all) to 5 (Extremely), the importance of health variables (e.g., “To keep yourself healthy even if it takes some extra effort?”). Items were averaged to form a Value on Health score ($\alpha = .877$).

Physical Health and Emotional Functioning.

Participants self-reported their physical and emotional health using the Short-Form 12 (SF-12) (Ware, Kosinski, & Keller, 1996).

Provider Information.

Participants reported on their past-year healthcare seeking (yes/no) of primary care physician (PCP) and gynecologist (GYN, women only). Participants were then asked about the topics of discussion initiated by their providers: “During this PCP/GYN visit in the past 12 months, did your primary care physician/gynecologist ask about your alcohol use, your marijuana use, your use of other drugs, your sexual partner(s), your use of condoms, your STI history?” Participants were also asked “Did your primary care physician/gynecologist offer HIV or Sexually Transmitted Infection (STI) testing?” and “Would you be comfortable discussing STIs with your primary care physician/gynecologist?”

Alcohol and Marijuana Use.

Marijuana and alcohol use was assessed with the Timeline Followback (TLFB; Sobell and Sobell, 1992). The TLFB is a retrospective account of substance use that uses anchor dates to help participant recall. Participants reported the quantity and frequency of alcohol and marijuana use during the previous 30 days.

Sexual Activity.

The Timeline Followback method (Sobell & Sobell, 1992) was also utilized to assess sexual activity, both protected and unprotected, over the past 30 days.

Analytical Methods

Descriptive statistics are presented to summarize the sample. Analyses included multiple logistic regression to estimate the adjusted associations of background characteristics, substance use behaviors, sexual activity, and measures related to health values and physical and emotional health on the likelihood of seeing a PCP in the past year. For females, a parallel model was utilized estimating adjusted associations with the past year likelihood of seeing a GYN. Counts and percentages of persons who reported they had discussed a range of health related topics with their PCP are presented, utilizing the Pearson χ^2 – test to compare males and female rates of topics initiated byPCPs. Among females, the number and percent who had discussed these same topics with their GYN are presented. Among females who had seen both a PCP and GYN ($n = 92$) during the past year, the exact p-value was utilized for the McNemar test of paired proportions to compare rates of discussing these topics with their PCPs vs GYNs.

Results

Participants were, on average 21.3 years old ($SD \pm 2.10$), 47.8% were male ($n=239$) and 52.8% were female ($n=261$), 67.0% were White, 11.6% were Black, 21.4% identified other or mixed racial origins, and 12.2% were Latino/a (Table 1). Mean alcohol use days during the past month was 7.36 ($SD \pm 5.38$) and mean days exceeding NIAAA guidelines for binge drinking (4+ drinks for women and 5+ drinks for men over 2 hours) was 3.31 ($SD \pm 4.07$) days. On average participants used marijuana on 12.6 ($SD \pm 12.2$) of the last 30 days, were sexually active on 6.66 ($SD \pm 7.10$) of the last 30-days, and had unprotected sex on 4.43 ($SD \pm 6.86$) of the last 30-days. About 61.2% had seen a PCP in the past year and 62.0% of the females had seen a GYN in that same period. Among females, 16.1% had not seen either a PCP or GYN, 21.8% had seen only a PCP, 18.0% had seen only a GYN, and 44.0% had seen both a PCP and GYN.

Results did not support the hypothesis that EA with higher rates of substance use and more risky sexual behavior would be less likely to see a provider, while those with a high value on health would be more likely (Table 2). Adjusting for other covariates included in the multiple logistic regression model the likelihood of seeing a PCP in the past 12-months was inversely and significantly associated with age ($OR = 0.90$, 95%CI 0.82; 0.99, $p = .037$). Males were significantly less likely than females to have seen a PCP in the past 12-months ($OR = 0.63$, 95%CI 0.42; 0.96, $p = .031$). Compared to White individuals, Black individuals

were about half as likely (OR = 0.51, 95%CI 0.277; 0.94, $p = .032$) to have seen a PCP in the past year. Compared to persons without health insurance, the estimated odds of seeing a PCP was over 5 times higher for persons with insurance (OR = 5.80; 95%CI 3.13; 10.77, $p < .001$). The likelihood of seeing a PCP was not associated with the other covariates included in the model. Among females, age was positively and significantly (OR = 1.31; 95%CI 1.13; 1.51, $p < .001$) associated with the likelihood of having seen a GYN in the past year. Black females were significantly less likely to have seen a GYN in the past year than White females (OR = 0.34; 95%CI 0.15; 0.79, $p = .012$). The likelihood of seeing a GYN was not associated significantly with any of the other covariates included in the model.

Rates of initiation of discussion by PCPs are given in Table 3. Specifically, participants were prompted to answer what topics their providers asked them about. About 54.4% reported that their PCP initiated a discussion of alcohol use, 49.5% discussed marijuana use, 44.4% discussed other drug use, 77.1% discussed their sexual partners, 68.0% discussed condom use, and 53.2% discussed STI history with their PCP in the past year. About 45.3% said their PCP had offered STI testing, and 96.6% said they felt comfortable talking about STIs with their PCP.

Although no differences in gender were found in discussions of substance use as hypothesized, results did substantiate the hypothesis that providers would be more likely to initiate a discussion of sexual topics with females: females were significantly ($\chi^2 = 5.52$, $p = .018$) more likely to say they had discussed their sexual partners with their PCP (82.1% vs 70.5%), significantly ($\chi^2 = 10.22$, $p = .001$) more likely than males to say they had discussed condom use with their PCP (75.6% vs 58.1%), significantly ($\chi^2 = 7.44$, $p = .006$) more likely to say they had discussed their STI history with their PCPs (60.1% vs 44.2%), and significantly ($\chi^2 = 10.81$, $p = .001$) more likely to say their PCP had offered STI testing. Females reported that their GYN initiated discussion at the following rates: alcohol (38.2%), marijuana (29.0%), other substance use (29.9%), sexual partners (92.8%), condom use (89.2%), and STI testing (83.3%). The majority (79.7%) reported that their GYN offered STI testing, and 97.8% reported feeling comfortable talking about STIs (Table 4).

Table 4 also compares rates of discussing health-related topics with the PCP and GYN among females who had seen both a PCP and a GYN in the past year. As hypothesized, PCPs were more likely to ask about substance use while GYNs were more likely to ask about sex-related topics: females were significantly more likely ($p < .001$) to have discussed alcohol (57.8% vs 36.7%), marijuana (46.7% vs 28.3%, $p = .002$) and other drug use (45.7% vs 28.3%, $p = .001$) with their PCP than their GYN. They were significantly (exact $p = .012$) more likely to have had a provider-initiated discussion about their sexual partners (90.2% vs 79.3%) with their GYN than with their PCP. Similarly, females who had both a PCP and GYN were significantly more likely (87.0% vs 72.8%, $p = .007$) to have discussed condom use, significantly more likely (82.6% vs 59.8%, $p < .001$) to have discussed their STI history, and significantly more likely (81.5% vs 53.3%, $p < .001$) to have been offered STI testing from their GYN than their PCP.

Discussion

Among a large, community-recruited sample of EA who use alcohol or marijuana, 61% reported seeing a PCP in the previous year and 62% of women reported seeing a GYN. Frequency of substance use and sexual activity did not significantly relate to seeking healthcare. Women and white individuals were more likely to have seen a provider, as were individuals who had health insurance. Approximately half of individuals reported having a provider-initiated discussion about substance use with their PCP. Women were more likely than men to be asked about their sexual activity and risk with their PCP and to have had STI testing offered to them. Among women who had seen a PCP and GYN in the previous year, substance use was more frequently brought up as a topic of conversation with PCP while sexual issues were more likely discussed with a GYN.

Gender discrepancies emerged in discussions of sexual health behavior, despite a lack of difference in comfort discussing STIs. It is possible that providers are more concerned with women's sexual health than men's. Other work with EA women – who are most likely to receive services – reveal that the emerging adult years are viewed as being an important time to take charge of gynecological health (Canales & Carr, 2003). Young women often want to be partners in their GYN care (Canales & Carr, 2003). Young men however, perceive significant barriers to seeking routine health care, including sexual health care (Kalmuss & Austrian, 2010) and do not put a high priority on their health during young adulthood (Marcell, Jagers, Mayden, & Mobley, 2010). The gap in receipt of “male-friendly” healthcare is a consistent finding in research (Fortuna et al., 2009; Tyler et al., 2014). More recent initiatives propose interventions to increase healthcare seeking by young men, with use of an “empowerment approach” to aid men in taking charge of their health (Armstrong & Cohall, 2011). Primary care visits during these young adult years can help set the groundwork for adult healthcare behavior, which may be especially important for men given their lower receipt of services. Given the findings on racial disparities in healthcare seeking, such initiatives may be beneficial in minority communities.

PCPs were more likely to initiate a discussion on substance use while GYNs were more likely to initiate a discussion on sexual health. Perhaps, providers assume that their patients are having particular aspects of care addressed elsewhere: GYNs may view substance use as a physical health issue while PCPs may view sexual health as a gynecologist's issue. However, it is especially important to discuss both substance use and sexual health among this at-risk population. Providers may not assess or diagnose substance use or substance use issues for a variety of reasons, including lack of training or familiarity with treatment, lack of time, and/or perception of resistance by patients (Chenault et al., 2000). Similarly, providers do not discuss sexual issues due to a variety of reasons, such as lack of knowledge and training, time constraints, comfort, or an assumption that patient will initiate discussion (Akers, Gold, Borrero, Santucci, & Schwarz, 2010; Dyer & das Nair, 2013). Given that men do not see GYNs and many are not seeking sexual healthcare elsewhere, it is important for PCPs to address sexual health as part of routine care, especially for men. Young men identify ideas of masculinity and lack of symptoms as reasons to avoid the doctor, even when engaged in risky behavior (Kalmuss & Austrian, 2010), which puts the onus on the

doctor to bring up topics related to risky behavior with patients as they may not know how, feel comfortable doing so, or feel like it should be a priority in their lives.

Future studies should evaluate promotion of provider discussions, particularly how to train providers to have such conversations and long-term implications of doing so. For example, providers can encourage use of services and promote discussion through open styles of communication, relationship building, and promoting motivation to change (Burke & Fair, 2003). A community-based trial designed to promote healthcare seeking in adolescents found that even providing an informational letter to individuals upon their 16th birthday was associated with increase service utilization (Aarseth, Dalen, & Haavet, 2014). Thus, the communication between provider and patient can be improved and lead to behavioral change. All providers (PCPs and GYNs) should routinely assess for both sexual health and substance use behaviors, regardless of patient gender.

The current study has several limitations. The sample was substance-using, sexually-active, and drawn from one region of the United States which may not be representative of all EAs. Notably however, much research in the emerging adulthood field focuses on college samples, while the current cohort was community-recruited and ethnically diverse. Participants all volunteered for a research study and met baseline requirements of that study; as such, the sample may represent a subset of the population and results may not generalize to all EAs. Second, the cross-sectional findings allow only for estimates of association rather than causality. Third, data on gender of the physicians, number of visits during the past year, or whether participants had longstanding relationships with these providers was not collected. Fourth, no data was available on other health behaviors that should also reasonably have been discussed—such as sleep or mood—as comparators. Finally, the data was self-reported and reflected on the previous year, thus may be susceptible to recall bias, and all data was derived from patients. Future studies should examine provider perspectives and provider-reported rates of initiation of these important topics, as well.

Conclusions

Emerging adults do not consistently seek preventative care services and, when they do, important topics (such as risky behavior) are not consistently discussed. Emerging adulthood is a time of change, identity development, and independence as young adults transition into adult roles. As such, it is the ideal time to encourage autonomy over one's health and establish healthcare utilization to encourage preventative care and open communication with providers.

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Table 1.

Demographic Characteristics and Descriptive Statistics (Full Sample (n = 500)).

	n (%)	Mean ($\pm$ SD)	Median	Range
Age		21.3 ($\pm$ 2.08)	21	18–25
Sex (Male)	239 (47.8%)			
Race				
White	335 (67.0%)			
Black	58 (11.6%)			
Other	107 (21.4%)			
Latino/a (Yes)	61 (12.2%)			
Health Insurance (Yes)	429 (85.8%)			
Days / 30 Used Alcohol		7.56 ($\pm$ 5.38)	7	0 – 30
Days / 30 Binged		3.31 ($\pm$ 4.07)	1.7	0 – 27
Days / 30 Used Marijuana		12.63 ($\pm$ 12.20)	8.67	0 – 30
Days / 30 Sexually Active		6.66 ($\pm$ 7.10)	4.33	1 – 30
Days / 30 Unprotected Sex		4.43 ($\pm$ 6.86)	1.00	0 – 30
Values of Health		4.03 ($\pm$ 0.61)	4.06	2.10 – 5.00
SF-12 Physical Function		53.88 ($\pm$ 6.54)	55.4	21.6 – 66.6
SF-12 Mental Function		44.13 ($\pm$ 10.63)	47.1	18.0 – 64.4
Seen PCP Past Year	306 (61.2%)			
Seen GYN Past Year ^a	162 (62.0%)			
Seen GYN and/or PCP ^a				
Neither	42 (16.1%)			
PCP Only	57 (21.8%)			
GYN Only	47 (18.0%)			
PCP & GYN	115 (44.0%)			

^aN = 261 women.

Table 2.

Multiple Logistic Regression Models Estimating the Adjusted Associations of Demographic Characteristics, Substance Use, Frequency of Sexual Activity, and Health Related Measures with Seeing a PCP or GYN in the past 12-Months.

	SEEN PCP Full Sample (n = 500)		SEEN GYN Females only (n = 261)	
	OR (95% CI)	p =	OR (95% CI)	p =
Age	0.90 (0.82; 0.99)	.037	1.31 (1.13; 1.51)	<.001
Sex (Male)	0.63 (0.42; 0.69)	.031	NA	
Race				
Black	0.51 (0.28; 0.94)	.032	0.34 (0.15; 0.79)	.012
Other	0.79 (0.45; 1.41)	.433	0.66 (0.32; 1.33)	.243
White [REF]	[1.00]			
Latino/a (Yes)	1.07 (0.53; 2.18)	.848	1.24 (0.52; 2.99)	.630
Health Insurance (Yes)	5.80 (3.13; 10.77)	<.001	2.16 (0.92; 5.06)	.077
Days / 30 Used Alcohol	0.99 (0.96; 1.03)	.756	1.02 (0.96; 1.08)	.603
Days / 30 Used Marijuana	1.00 (0.98; 1.02)	.865	0.99 (0.97; 1.02)	.526
Days / 30 Sexually Active	1.01 (0.98; 1.04)	.439	0.99 (0.96; 1.04)	.796
Values of Health	1.13 (0.81; 1.57)	.480	1.15 (0.72; 1.85)	.560
SF-12 Physical Function	0.99 (0.96; 1.02)	.574	0.98 (0.95; 1.02)	.386
SF-12 Mental Function	1.01 (0.99; 1.03)	.213	1.00 (0.98; 1.03)	.926

Table 3.

Topics Discussed with PCP by Gender among Persons who had Seen a PCP in the Past Year. (Valid n varied slightly due to item non-response).

	Full Sample	Female	Male	χ^2 (p =)
Alcohol use ^a	161 (54.4%)	94 (56.3%)	67 (51.9%)	0.56 (.456)
Marijuana Use ^b	147 (49.5%)	82 (48.8%)	65 (50.4%)	0.07 (.787)
Other Drug Use ^b	132 (44.4%)	81 (48.2%)	51 (39.5%)	2.23 (.136)
Sexual Partners ^b	229 (77.1%)	138 (82.1%)	91 (70.5%)	5.52 (.018)
Condom Use ^b	202 (68.0%)	127 (75.6%)	75 (58.1%)	10.22 (.001)
STI History ^b	158 (53.2%)	101 (60.1%)	57 (44.2%)	7.44 (.006)
Did provider offer STI testing ^a	134 (45.3%)	90 (53.6%)	44 (34.4%)	10.81 (.001)
Feel comfortable talking about STI? ^b	287 (96.6%)	161 (95.8%)	126 (97.7%)	0.76 (.383)

^aValid n = 396 for full sample.

^bValid n = 297 for full sample.

Table 4.

Topics Discussed with GYN among Women who had seen a GYN in the Past Year and Comparison of Topics Discussed with PCP and GYN among Women who had seen both a PCP and GYN in the Past Year.

	COMPARISON OF MATCHED PAIRS ^a			
	Females (n = 153)	% Discussed With		p = ^b
		PCP	GYN	
Alcohol use ^c	52 (38.2%)	57.8%	36.7%	.001
Marijuana Use ^b	40 (29.0%)	46.7%	28.3%	.002
Other Drug Use ^b	41 (29.9%)	45.7%	28.3%	.001
Sexual Partners ^b	128 (92.8%)	79.3%	90.2%	.012
Condom Use ^b	123 (89.2%)	72.8%	87.0%	.007
STI History ^b	115 (83.3%)	59.8%	82.6%	<.001
Did provider offer STI testing ^a	110 (79.7%)	53.3%	81.5%	<.001
Feel comfortable talking about STI? ^b	135 (97.8%)	95.6%	98.9%	.375

^aComparisons based on 92 women who had seen both a PCP and GYN in the past year. Only 90 matched pairs were available for the comparison involving alcohol use.

^bExact probability for McNemar's test for equality of paired proportions.

^cValid n for discussing alcohol use with GYN was 137

^dValid n for discussing other drug use with GYN was 138.