Depression Linked to Risky Sexual Behaviors

BY DIANA MAHONEY
New England Bureau

BOSTON — Adolescent boys and girls with symptoms of depression are more likely than their nondepressed peers to engage in high-risk sexual behavior, results of a recent study have shown.

These findings fuel arguments in favor of expanding depression prevention, screening, and treatment efforts in this vulnerable population, Jocelyn A. Lehrer, Sc.D., said at the annual meeting of the Society for Adolescent Medicine.

The results were based on home interview data from a sample of 4,152 sexually active, unmarried high school students who participated in Waves I and II of the National Longitudinal Study of Adolescent Health at 1-year intervals between 1995 and 1996.

Dr. Lehrer of the University of California, San Francisco, and her colleagues at the Harvard School of Public Health and Children's Hospital Boston examined associations between baseline depressive symptoms (measured as both trichotomous and continuous variables) and sexual risk behaviors over the course of the year between the first and second interviews.

This study has important implications for depression screening and sexual health counseling by mental health and primary care providers.

The researchers conducted separate analyses for boys and girls and adjusted for demographic variables, religious practices, same-sex attraction and behaviors, sexual intercourse before age 10, and baseline sexual risk behaviors.

Depressive symptoms were assessed using a 19-item modified Center for Epidemiological Studies–Depression Scale. Among the sexual risk behaviors examined were condom nonuse, birth control nonuse, and substance use—all at last sexual encounter—as well as participation with multiple sexual partners.

"In the adjusted models for both the boys and the girls, adolescents with high levels of depressive symptoms at baseline were significantly more likely than those with low or no symptom levels [to have engaged in] at least one of the sexual risk behaviors over the course of the year," Dr. Lehrer said.

Among boys, high levels of depressive symptoms predicted condom nonuse, birth control nonuse, and substance use in both the trichotomous (low, moderate, and high symptom levels) and continuous depression measure analyses, she said.

Among girls, analysis with the continuous depression measure showed significant associations between depressive symptoms and condom nonuse, birth control nonuse, participation with three or more sexual partners, and any other sexual risk behavior. In the parallel analysis with the trichotomous depression measures, moderate depressive symptoms predicted substance use at last sexual encounter. No link was seen between high depressive symptom levels and individual sexual risk behaviors, Dr. Lehrer said.

"The findings of this study suggest that elevated depressive symptom levels during adolescence may, at the very least, serve as a red flag for an increased likelihood of sexual risk behaviors," Dr. Lehrer said.

"This has important implications both for depression screening and sexual health counseling by primary care providers and mental health providers."

Additionally, because of the increased risk of STDs associated with sexual risk behaviors, the content of population-based STD and HIV prevention programs should include educational information on the signs and symptoms of depression and resources for getting help, Dr. Lehrer said. ■

Consider Montgomery-Asberg Scale for Assessing Depression

BY DAMIAN McNAMARA
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BOCA RATON, FLA. — Major depression in children and adolescents can be assessed quickly using a 10-item scale designed for adults. Results correlate well with a standard 45-minute pediatric measure, according to a study presented at a meeting of the New Clinical Drug Evaluation Unit sponsored by the National Institute of Mental Health.

Major depression in pediatric patients is typically measured with the Child Depression Rating Scale–Revised (CDRS-R). This measure is not only time consuming but it requires clinician training to administer, according to Dr. Shailesh Jain, who is a National Institute of Mental Health fellow at the Mood Disorders Research Program and Clinic at the University of Texas Southwestern Medical Center, Dallas.

Right now, typically, practitioners interview the child or adolescent first, then talk with the parent(s), and use clinical judgment to combine the components.

"It takes a long time. For busy clinicians in child psychiatry, it's difficult to spend 45 minutes," Dr. Jain said.

In addition, certain items on the scale rely on clinician judgment, and subjective assessments vary with clinician experience, according to Dr. Jain.

Dr. Jain and his associates compared the CDRS-R to the Montgomery-Asberg Depression Rating Scale (MADRS) in 96 children (aged 8-11 years old) and 123 adolescents (12-18 years).

All participants were outpatients with nonpsychotic major depressive disorder.

Participants were culled from a randomized trial of fluoxetine 10 mg/day for 1 week followed by a titration to 20 mg/day continued for 8 weeks vs. placebo.

The researchers rated depressive symptoms using both measures.

"The MADRS has advantages—it has 10 items," Dr. Jain said in an interview at his poster presentation.

"But the MADRS has been used primarily in adults, and little is known about its psychometric properties in evaluation of pediatric patients," Dr. Jain said.

Total score correlation between CDRS-R and MADRS was 0.85 at study completion for both children and adolescents, which shows that both scales agree to a considerable extent for assessment of depression, Dr. Jain said.

"When measuring the effect of antidepressants (fluoxetine), CDRS-R was statistically more sensitive in detecting changes in symptoms in response to medication in both children and adolescents," Dr. Jain said.

Effect size for CDRS-R was 0.78 in children and 0.61 in adolescents, compared with the MADRS 0.38 in children and 0.15 adolescents.

These differences are statistically significant, but the clinical difference is less important because it can take three times longer to complete the CDRS-R, Dr. Jain said.

In addition, adolescents often do not like the CDRS-R requirement that clinicians ask parents about their functioning at each visit.

"This is not to suggest that clinicians completely circumvent parents, but the MADRS provides a reasonable alternative for assessment of depression severity and response to treatment," Dr. Jain said.

"We now know how the scales correlate and, most importantly, the conversion factors between the scales."

Busy practitioners can quickly assess symptoms of major depression in adolescents with the MADRS.

Dr. Jain said the scale is also useful for children, who are typically poor historians and very influenced by environmental conditions.

The meeting was cosponsored by the American Society for Clinical Psychopharmacology. ■

Depressive Symptoms Predict Exposure to Violence

BY DIANA MAHONEY
New England Bureau

BOSTON — Adolescent girls who exhibit symptoms of depression are at greater risk for subsequent intimate partner violence than their nondepressed peers, a study has shown.

The findings suggest that preventing, identifying, and treating depression in this population, as well as preemptive counseling of high-risk adolescent girls about their peer choices and romantic relationships, "could reduce the likelihood of subsequent victimization," lead author Jocelyn A. Lehrer, Sc.D., said at the annual meeting of the Society for Adolescent Medicine.

Dr. Lehrer of the University of California, San Francisco and her colleagues from the Harvard School of Public Health and Children's Hospital in Boston reviewed home interview data from a sample of 1,659 young women ages 15-24 who participated in Waves II and III of the National Longitudinal Study of Adolescent Health. They examined the incidence and prevalence of past-week depressive symptoms measured in the Wave II data using a 19-item modified Center for Epidemiologic Studies–Depression scale (CES-D).

The investigators correlated the baseline depression information with data regarding past-year physical partner abuse from the Wave III surveys conducted about 5 years later, controlling for age, race, ethnicity, parental education, retrospective childhood and physical sexual abuse, and baseline dating violence and forced sex.

Depression symptoms were measured as both dichotomous and continuous variables, and exposure to partner violence was classified as mild (threats of violence, pushing, and/or shoving) or moderate to severe (hitting, slapping, kicking, or an injury causing action), Dr. Lehrer noted.

All of the girls in the study were in a current, opposite-sex relationship at follow-up at the time of the Wave III interview. The average age of the participants was 15.9 years at baseline and 21.3 years at follow-up.

Baseline depression measures showed that 10.2% of the young women in the sample had high levels of depressive symptoms. "In adjusted models [using the dichotomous depressive symptoms variable], high baseline symptoms were associated with 1.86 times the odds of subsequent exposure to moderate to severe partner violence," Dr. Lehrer said. With use of the continuous depressive symptoms variable, "each standard deviation increase in baseline symptom level increased the odds of exposure to both mild partner violence and moderate to severe partner violence by 24%," she said.

The National Longitudinal Study of Adolescent Health explores the causes of health-related behaviors of adolescents in grades 7-12 and their outcomes in young adulthood. The Wave I survey was completed in 1994. Waves II and III were completed in 1996 and 2002, respectively. ■