Depression Linked to Risky Sexual Behaviors

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

The researchers interviewed a sample of 4,152 sexual-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.

At the time of the study, all of the participants were 15 to 16 years old. The average age for boys was 15.9 years and 16.1 years for girls. The Wave I survey was completed in 1994. Waves II and III 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. The Wave I survey was completed in 1994. Waves II and III interview data were completed in 1996 and 2002, respectively.

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

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 without depressive symptoms (measured as both trichotomous and continuous variables) and sexual risk behaviors over the course of the year.

The researchers then performed stratified analyses by age and sex. In both boys and girls, baseline depressive symptoms were associated with increased odds of sexual risk behaviors, even after controlling for age, race, ethnicity, parental education, retrospective childhood abuse and physical sexual abuse, and baseline dating violence and forced sexual intercourse. The findings of this study suggest that elevated depressive symptoms levels during adolescence may be 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 information on the signs and symptoms of depression and resources for getting help, Dr. Lehrer said.

Consider Montgomery-Asberg Scale for Assessing Depression

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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 the annual 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 without psychotic 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,” he said.

Jain and his colleagues were able to quickly assess symptoms of major depression in adolescents with the MADRS.

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

“When measuring was cosponsored by the American Society for Clinical Psychopharmacology, 32 Child/Adolescent Psychiatry