Correspondence

Depression and HIV Risk Taking

To the Editor—In a recent article, published in the supplement to the 15 December 2007 issue of Clinical Infectious Diseases, entitled “Interrelation between Psychiatric Disorders and the Prevention and Treatment of HIV Infection” [1], the authors contend that “major depression increases vulnerability to HIV infection by provoking high-risk behaviors” (p. S313). However, the published literature does not support this assertion, at least with regard to sexual behavior among men who have sex with men in resource-rich countries.

In a 2003 publication [2], we reviewed 13 studies that examined the relationship between depressive symptomatology and sexual risk taking in this group. Of these, 6 found a positive association, 3 found no significant relationship, and 4 found that men who were depressed were less likely to have engaged in unsafe sexual practice.

These apparently conflicting results were clarified by our study, which was based on an Australian primary care cohort of 460 homosexually active men. We found that major depression was associated with reduced sexual activity in general and with less sexual risk taking. Among men who did not meet the criteria for major depression (n = 331), however, we found that the long-term, low-grade depressive symptomatology characterized by the diagnostic category of dysthymic disorder was associated with a doubling of sexual risk taking. Among men who were depressed were less likely to have engaged in unsafe sexual practice.

Because dysthymic disorder is subtler than major depression in its clinical presentation, health care workers engaged with at-risk populations may need to use screening tools to identify its presence. We also found that rates of major depression, dysthymic disorder and the combination of the 2 (“double depression”) did not differ significantly between HIV-infected and HIV-uninfected men, suggesting that their high prevalences may be more related to the societal position of men who have sex with men than to HIV infection.

Acknowledgments


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References


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Reply to Rogers and Curry

To the Editor—We are grateful for the opportunity to address this issue, because we agree that one of the major confounding factors in current research related to affective disorders is the confusion between depressive symptoms and defined syndromes such as major depression [1]. When one delves into this sticky issue, one finds debate about the very core issues of the nature of depression. The concept of a specific disease category referred to in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as “major depression” presumes that depressive symptoms can occur because of a variety of conditions, including psychological distress related to loss, sadness related to grief, and perhaps even a gloomy disposition. There is debate as to whether major depression occurs on a spectrum with these depressive symptoms but is a more severe version, or whether major depression is a completely discontinuous disease state that may be triggered by psychological events but does not depend on them. For centuries, clinicians have described patients without any stressors who develop episodic dramatic changes in mood associated with severe dysfunction. German empirical psychiatrists in the 1800’s saw these patients as having a disease of the brain and tried to find the neuropathological basis of the disease. Current “empirical” psychiatry has developed a set of operationally defined criteria for major depression, varying from the very restrictive criteria called “research diagnostic criteria” to the far more inclusive DSM criteria. The assumption behind research that uses depressive symptoms rather than a discontinuous “categorical” set of criteria is that depression is a continuum with mild depressive symptoms on one end and psychotic depression at the other. Supporting this view is the lack of a validated neuropathological lesion or confirming test to show a discontinuous syndrome that distinguishes major depression from depressive symptoms.

Despite this issue, research supports the view that major depression is associated with increased risk behaviors for HIV infection. Aside from the well-demonstrated association between depression and substance abuse [2], which results in an increased likelihood of high-risk sex, there