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”. The published literature does not, however, support this assertion, at least with regard to sexual behavior among men who have sex with men in resource-rich countries.

In our 2003 publication [2], we reviewed thirteen studies that examined the relationship between depressive symptomatology and sexual risk taking in this group. Of these, six found a positive association, three found no significant relationship and four 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 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 characterised by the diagnostic category of dysthymic disorder was associated with a doubling of the likelihood of reporting recent unprotected anal intercourse with a casual partner (OR: 2.36 [95%CI: 1.09–5.10]; P=0.035).

Since dysthymic disorder is subtler than major depression in its clinical presentation, health care workers engaged with populations at risk 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 two ("double depression") did not differ significantly between HIV positive and HIV negative men, suggesting that their high prevalences may be more related to the societal position of people of sexual diversity than to HIV infection.

Acknowledgements

Potential conflicts of interests: No conflicts.

Gary Rogers,¹ and Michael Curry²

¹School of Medicine, Griffith University, Gold Coast, Queensland, Australia; and ²Royal Adelaide Hospital, Adelaide, South Australia

References


Reprints or correspondence: Associate Professor Gary Rogers, School of Medicine, Griffith University, Gold Coast campus, PMB 50, Gold Coast Mail Centre, QLD, 9726, Australia (g.rogers@griffith.edu.au).