Early Education Urged to Delay Sexual Risk Taking

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Sexually risky behaviors on the part of adolescents is nothing new, but the age at which these behaviors begin is. In fact, new data suggest that sexual risk taking often begins in middle school.

Baseline data collected in spring 2005 from 4,457 middle school students aged 11-14 years at 14 urban schools participating in Project Connect, an 8-year multilevel intervention study, showed that more than 9% of the students surveyed reported ever having sexual intercourse, and 8% reported ever having oral sex.

In total, about 12% reported any sexual activity. Of those who reported having had intercourse, 36% were aged 11 years or younger at first sex, 27% were 12 years old, 28% were 13 years old, and 9% were aged 14 or older. In addition, of those who reported having had intercourse, 43% reported having had multiple sex partners.

Given their young age at sexual onset, "these youth are at very high risk for adverse health outcomes," Project Connect investigator Christine J. DeRosa, Ph.D., said at the annual meeting of the Society for Adolescent Medicine in Boston. As such, "behavioral and health education are imperative for all youth beginning early in middle school, and the involvement of parents, health care providers, and community leaders is also critical."

The goal of such interventions should be to assist those youth who have already engaged in some sexual activity to return to abstinence, said Dr. DeRosa of Health Research Association Inc., a University of Southern California affiliate that is facilitating the Centers for Disease Control–sponsored project. "For the majority of youth who have not engaged in sexual activities, the goal should be to further delay the onset of sexual initiation."

How the interventions should look and be implemented is a matter of much debate. Should they focus on abstinence or contraception? Should they be school or clinic based? Should they be voluntary or mandatory? The "best" intervention is one that identifies and targets the range of risk and protective factors that influence initiation of sex, number of partners, condom use, and contraception use, and this will vary depending on the individuals or populations being served, according to Douglas Kirby, Ph.D., a senior research scientist with ETR Associates in Scotts Valley, Calif.

In a 2001 report for the National Campaign to Prevent Teen Pregnancy called "Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy" (www.teenpregnancy.org/resources/data/pdf/emeranswsum.pdf), Dr. Kirby reviewed the results of 300 studies on risk and protective factors across multiple domains, from which emerged a complex picture of the antecedents of adolescent sexual risk taking.

Generic Version Of Venlafaxine FDA Approved

The first generic formulation of the antidepressant venlafaxine has been approved by the Food and Drug Administration.

The FDA announced in early August that it had approved the generic version of the immediate-release formulation of Effexor in 25-mg, 37.5-mg, 50-mg, 75-mg, and 100-mg tablets, the same doses available for Effexor. The generic manufacturer, Teva Pharmaceuticals USA, announced that shipment of the tablets would start immediately.

Teva has exclusive rights to market the generic formulation for 180 days after approval, after which time the FDA can approve applications for other generic formulations of venlafaxine, a serotonin norepinephrine reuptake inhibitor (SNRI).

Effexor, marketed by Wyeth Pharmaceuticals Inc., was approved for major depressive disorder in 1993; the extended-release formulation (Effexor XR) was approved in 1997.

Other recently approved first-time generic drugs include escitalopram tablets, the generic version of the selective serotonin reuptake inhibitor (SSRI) Lexapro, and sertraline in tablet and oral concentrate formulations, the generic version of the SSRI Zoloft.

—Elizabeth Mechcatie

At the community level, education, employment, income, and crime rate are important predictive factors. At the family level, family structure, dynamics, and values play a role. And at the individual level, age, hormones, peers, emotional well-being, relationship history, sexual abuse history, and attachment to school, religious groups, and proactive community organizations have an impact.

In the review, Dr. Kirby identified four groups of effective intervention programs. These included sex and HIV education programs that not only stated the target norm—whether abstinence or contraception—clearly and frequently with factual information to support it, but also engaged the youth in activities, such as role playing, to model, practice, and personalize the norm. Also effective were some programs within health, family planning, or STD clinics that similarly expressed clear norms, as well as focusing on perceived barriers, providing backup information, and offering structured follow-up.

Certain service-learning programs that include both intensive voluntary service in various capacities (tutors, teachers' aides, nursing home assistants) and ongoing small group discussions about the service, with or without discussion about sexual or contraceptive behavior, also had a demonstrable impact. The last group was long-term intensive programs with multiple components—including family life support, sexuality education, academic guidance, employment, opportunity for self-expression, and health care—in which norms were clearly stated and supported and staff consciously developed close relationships with the adolescents.

Although diverse in their focus and implementation, most of the effective intervention strategies share a conceptual framework built on social norms and an adolescent's sense of connection to those expressing the norms, Dr. Kirby said. "If a group has clear norms for or against sex or contraceptive use, then adolescents associated with this group will be more or less likely to have sex and use contraceptives depending on the norm," he said. The more closely an adolescent feels connected to the group, the greater the impact the group's norms will have.

Some identified protective and risk factors that don't easily fall within the norm/connectedness framework, such as community opportunity and poverty, hormone levels, self-efficacy, and emotional well-being, are also important intervention targets that must be considered "if we are to dramatically reduce sexual risk taking [in adolescents]," Dr. Kirby said. ■