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# DEPRESSIVE MOOD AND SEXUALITY IN ADOLESCENCE

# HUMOR DEPRESSIVO E SEXUALIDADE NA ADOLESCÊNCIA

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**Abstract:** The present study aimed to analyse the influence of the psychopathological symptoms, specifically depression within sexuality, through a random sample of 254 adolescents, studying in three secondary schools near Lisbon, with an average age of 16,7 years old (SD=1,48), of which 82 were males and 172 were females. For the data gathering the following instruments were used: a Demographic Questionnaire, a Lifestyle and Youth Beliefs Questionnaire, the Children's Depression Inventory – CDI (Kovacs, 1981) and the Brief Symptom Inventory – BSI (Derogatis, 1982). Teenagers who have a lower self-esteem and more inter-personal sensibility, tend not to have had sex. Concerning the use of condom, teenagers who do not use condoms presented higher prevalence of psychological symptoms in general, feelings of negative humour, low self-esteem and phobic anxiety

**Key-words:** Adolescence; psychopathological symptoms; depression; sexual initiation; risk behaviours; condom.

**Resumo:** O presente estudo tem como objective analisar a influencia de sintomas psicopatológicos, especificamente depressão na sexualidade numa amostra aleatória de 254 adolescentes, estudantes numa escola secundária de Lisboa. Com uma média de idades de 16,7 anos (SD=1,48), 82 são rapazes e 172 raparigas. Na recolha de dados foram utilizados os seguintes instrumentos: Questionário Demográfico, Questionário de Estilos de Vida e Crenças dos Jovens, Children's Depression Inventory – CDI (Kovacs, 1981) e Brief Symptom Inventory – BSI (Derogatis, 1982). Adolescentes que têm uma auto-estima mais baixa e maior sensibilidade inter-pessoal tendem a ter relações sexuais. Relativamente ao uso do preservativo, adolescentes que não usam preservativos apresentam uma maior prevalência de sintomas psicológicos no geral, sentimentos negativos, baixa auto-estima e ansiedade fóbica.

**Palavras-Chave:** Adolescência; Sintomas Psicopatológicos; Depressão; Iniciação Sexual; Comportamentos de risco; Preservativo.

## Depressive Mood and Sexuality in Adolescence

Romantic relations in adolescence are normative and, usually, they are experienced in familiar contexts or between peers, but sometimes they may be difficult or experienced with intense emotions. To learn relational skills at an early stage, which allow adolescents to handle romantic relations and humour within relations, may contribute towards more successful relations, as well as to prevent symptoms, such as depression, which during adolescence may be caused or maintained by romantic experiences (Davila, 2008).

During this period, the growth of the sexual system also takes place and this produces transformations within an individual's sexuality. Psycho-emotional development is directly influenced by new experiences of proximity and intimacy, which s/he establishes with his/her peers (Pereira, Morais & Matos, 2008; Reis, Ramiro, Carvalho & Pereira, 2009; Collins, 2003). Behaviours adopted at this stage may be indicators of specific behaviours in the future (Moreira, 2002; Pereira, Morais & Matos, 2008).

On one hand, it is know that sexuality is determined by puberty-related transformations; on the other hand, it is the reflection of social and cultural expectations or learned standard behaviours (Sprinthall & Collins, 1999).

Adolescents, who begin their sexual activity too early are in disadvantage, both in assessing and in choosing strategies to deal with some risks inherent to active sexuality such as unwanted pregnancies and Sexually Transmitted Diseases

(STDs), among others (Steinberg, 2005). This happens because adolescents are more vulnerable at biological, psychological and social levels (Pereira, Morais & Matos, 2008) and also because they get involved in other risk behaviours, which have a negative impact in the short and long terms (Gaspar & Matos, 2010).

Although an early initiation of the sexual activity is associated to various social and demographic factors, the following should be highlighted: going out with friends at night time, urban contexts, relation with school, the norms adopted by the peer group and risk behaviours (i.e. alcohol consumption and methamphetamines). However, specific factors vary in accordance to gender, being that boys are those who initiate their sexual life earlier (Liu et al, 2006; Matos et al, 2010; Matos & Sampaio, 2009). For boys, initiating their sexual activity at an earlier age was also associated with single-parent families, having a friend they can trust in, tobacco consumption, perception of a high risk of getting HIV and high level of knowledge about STDs. On the other hand, in girls it was associated with not living with the nuclear family, not having a family member they can trust in, perception of a high risk related to STDs and having had used marihuana (Liu et al, 2006). Puberty development may be equally an indicator of an early start of sexual activity, which in these cases may be associated to less responsibility (Miller, 2002).

In this sense, an early start of the sexual activity may lead to the increase of risk behaviours in this field (Sandfort, Orr, Hirsch & Santelli, 2008; Whitaker, Miller & Clark, 2000), namely a higher number of sexual partners and involvement in sexual relations under the influence of alcohol, which may have as a consequence becoming infected with an STD and having problems related to sexual functions (Sandfort et al, 2008). On the other hand, the increase of sexual relations was associated with risk norms within the peer group, little involvement with parents and a lesser connection to school and religion (Whitaker, Miller & Clark, 2000).

The peer group has an important role in the adoption of risk behaviours (Chuang, Ennett, Bauman & Foshee, 2005), considering that the existence of a strong connection with the peer group leads the adolescent to follow peer expectations, as they follow their attitudes and behaviours (Matos et al, 2010). Male adolescents who live in neighbourhoods of a low socio-economic background report more easily that their friends adopt risk behaviours and having friends with risk behaviours has been associated with problems of conduct, including substance abuse (Chuang et al, 2005).

Both boys and girls talk about sexuality more frequently with their peers, in terms of age and gender; and boys assume a much more active posture towards personal involvement in talks about that issue. Concerning control and sexual planning, boys show less skills and a less favourable position related to condom use and higher values in relation to estimating the possibility of getting infected with an STD (Ramos et al, 2008). A study undertaken by Dunbar and collaborators (2008) showed that teenage girls who live early pregnancies, also experience menopause earlier than other adolescents.

Factors such as age-related norms, romantic relations and gender influence the effect of adolescents' first relationship in their mental health. Individual and relational situations may interact in a way that produces negative effects in mental health, after the first sexual relation, which can lead to an increase of depression and a decrease of self-esteem in some adolescents (Meier, 2007).

Vulnerability to depression, associated to the first sexual relation, is associated to factors such as the end of a socially well-known relationship or the lack of an emotional commitment even after relationships end, especially in girls and very young adolescents. However, self-esteem only decreases in girls that do not have a romantic relationship (Meier, 2007).

Adolescents may be particularly affected by this situation, as they are less prepared to deal with emotions caused by a relationship with a low emotional involvement, a separation and/or a first sexual involvement (Meier, 2007).

There are also differences between genders in relation to social prescription. In relation to boys, when they initiate their first sexual relationship, there is no complete social and emotional involvement; whilst girls are more likely to experiment their first sexual relationship as part of an emotional relationship (Sprinthall & Collins, 1999). There are also differences concerning sexual aggression, being that boys report more aggressiveness in their sexual relationships (Saini & Singh, 2008).

Sexuality's development involves learning behaviour standards and roles that are expected by both genders and the support by individuals that surround adolescents (Sprinthall & Collins, 1999). In this sense, the family, as a role model, information vehicle and emotional and social support, has a direct influence in individuals' behaviours from infancy (Matos, 2010), namely in the adoption and maintenance of protective and/or risk behaviours for youth health generally and, sexual health (Di Clemente et al, 2010; Miller, 2002) and pregnancy (Miller, 2002), specifically.

Miller (2002) argues that having a single-parent family, older brothers that are sexually active or sisters that are or have lived an early pregnancy; living in a disorganised or dangerous neighbourhood and in a family of low socioeconomic status; and being a victim of sexual abuse increases the risk of early sexual initiation, not using condoms and early pregnancy for all adolescents (Miller, 2002).

Some studies show that a supportive relation and proximity between parents and girls may lower the risk of early pregnancy, as it may reduce and decrease sexual relations, although an excessive control is associated with a higher risk of early pregnancy (Miller, 2002).

Adolescents' sexual education starts in the family through a process of social learning and modelling, by which the child learns to deal with his/her body during growth, as well as emotions, sharing and interpersonal conflicts (Matos & Sampaio, 2009). In line with this, various authors argue that it is not possible to separate the importance of different socialisation agents in the development of adolescents, considering that school, family and friends complement each other

in the educational process (Di Clemente et al, 2001; Marques, Vieira & Barroso, 2003).

Adolescents' behaviour-related problems have a higher probability of happening in families with high levels of conflict, low level of involvement and inadequate monitoring of adolescents' relations with peers (Matos & Sampaio, 2009), as well as their behaviour (Matos & Sampaio, 2009; Miller, 2002).

Consequently, the following factors may be linked to the genesis of risk behaviours in adolescence: individual, cultural, relational and academic factors, namely faults within family dynamics, the influence of risky peers or the lack of a connection with school or low success at school (Matos & Sampaio, 2009; Lohman & Billings, 2008).

At the same time, depressive symptoms also appear to be those kinds of factors, considering that adolescents who are depressive, have a lack of self-esteem or have no assertive skills are more easily involved in risk behaviours at sexual level (Rohde, Noell, Ochs & Seeley, 2001).

Sexual education may be understood as a strategy that enables to inform and train young adolescents to take adequate decisions in their sexuality (Piscalho, Serafim & Leal, 2000), learn how to manage their emotions, whilst enabling them to build life projects (Matos et al, 2010).

Based on the literature presented above, the current research aimed to study the influence of psychopathological and depressive symptoms in relation to having had sexual intercourse, initiation age of the sexual activity and adoption of risk behaviours by adolescents. In line with this, it was foreseen that adolescents who had already started their sexual activity revealed more depressive symptoms. On the other hand, adolescents who reported psychopathological symptoms adopted more risk behaviours at sexual level, namely not using condom during sexual intercourse.

## Methods

### Instruments

#### Demographics

The demographic questionnaire was composed of questions related to demographic data of the participants, namely age, gender, school year, family composition.

#### Sexual behaviour

Pupils were asked whether they had already has sexual intercourse, the age of first sexual intercourse and whether they used a condom in the last sexual intercourse

Children's Depression Inventory – CDI (Kovacs, 1981)

This self-assessment tool has twenty-seven items aiming to evaluate depressive symptoms. It is aimed at children aged between 7 and 17 and it is a revised version of the adult self-assessment Beck Depression Inventory (BDI). The questions relate to symptoms or attitudes that are assessed by the individual according to how s/he feels at the moment of assessment, through a scale varying from one to three, in the sense of higher intensity of depression. CDI has five dimensions: negative mood, interpersonal problems, inefficacy, anhedonia and negative self-esteem. Despite this, it may be used as a one-dimensional measure, whose final result varies between 27 and 81, which allows for the clinical discrimination between depressed and non-depressed adolescents (Kovacs, 1992).

Brief Symptom Inventory – BSI (Derogatis, 1982)

Psychopathological symptoms were assessed through the BSI, a self-assessment measure for adults and adolescents from 13 years old, which aims to evaluate different dimensions of psychopathological symptoms. It is a measure comprised of 53 items and each of the answers should reflect the degree in which each of the individual's problems bothered him/her during the last week. The response format is a Likert-type scale of 5 points (0=never, 1=few times, 2=sometimes, 3=several times, 4=many times). The BSI has nine dimensions: Somatisation, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid conception and Psychoticism; and three global indexes: general index of symptoms, index of positive symptoms and index of total positive symptoms. A study of adaptation of the measure was applied to the Portuguese population by Canavarro (1999)

**Procedure**

The protocol of investigation was applied to students of the 10th, 11th and 12th grades.

Consent was requested to the schools' headmasters, and parental consent was afterwards requested. The study was evaluated by the ethics committee and accepted as part of the master program where the first author was involved . The data gathering took place in three public schools near Lisbon. In each school, two classes from each year were randomly selected. The anonymity and answers' confidentiality were granted.

**Sample**

The sample was made up of 296 individuals, of both genders, between 15 and

22 years old. 42 protocols were excluded because they continuously presented blank answers or adopted systematically extreme answers. The final sample was composed of 254 individuals, 82 males and 172 females, with an average age of 16, 86 years of age (SD=1, 48). Concerning the school year of the individuals in the sample, 50, 2% were enrolled in year 10th, 21, 7% were enrolled in year 11th and 28, 1% were enrolled in year 12th. The majority of these adolescents referred that they lived with their nuclear family (75, 5%) (see Table 1).

**Table 1:** Demographics

| | N (254) | % |
|---|---|---|
| Gender | | |
| Male | 82 | 32.3 |
| Female | 172 | 67.7 |
| Grade | | |
| 10th grade | 127 | 50.2 |
| 11th grade | 55 | 21.7 |
| 12th grade | 71 | 28.1 |
| Household | | |
| Nuclear Family | 188 | 75.5 |
| Single parent family | 37 | 14.9 |
| Other types of family | 23 | 9.2 |
| | M | SD |
| Age | 16.9 | 1.48 |

In relation to sexuality, 52, 8% of youngsters reported that they had never had sexual relations, whilst 47, 2% reported that they had. The average age of the first sexual relation was 15,18 (SD=1,54), which is very close to the age referred in youngsters' opinion about initiation age, which they considered to be 14,97 years of age (SD=1,32). Regarding condom use in their last sexual relation, 75, 4% of adolescents declared having used it; 98, 8% reported that they had never had sex under the influence of alcohol or drugs (see Table 2).

**Table 2:** Adolescent Sexuality

| | N | % |
|---|---|---|
| SEXUAL INTERCOURSE | 120 | 47.2 |
| Had already had sexual intercourse yes | 134 | 52.8 |
| No | 89 | 75.4 |
| Condom use at last intercourse yes | 29 | 24.6 |
| No | | |
| | M | SD |
| Age of first intercourse | 15.2 | 1.54 |

### Data Analysis

The data was subjected to statistical procedures through the Statistical Package for Social Sciences (SPSS) 18.0 program. A descriptive statistic was conducted, followed by factorial analyses on the main measures, and alpha coefficients. ANOVAS were used to compare groups according to independent variables.

## Results

A descriptive statistic was conducted regarding the measures of evaluation used in this study (see Table 3), with the indication of their mean values and the standard deviation.

**Table 3:** Mean values and Standard deviations of measures for evaluating

| | M | SD |
|---|---|---|
| Total CDI | 37.71 | 7.37 |
| Negative mood | 8.33 | 2 |
| Interpersonal problems | 5.74 | 1.37 |
| Inefficiency | 6.59 | 1.67 |
| Anhedonia | 12.5 | 2.19 |
| Negative self-esteem | 6.52 | 1.6 |
| | | |
| Total BSI | 43.48 | 33 |
| Somatisation | 4.53 | 4.65 |
| Obsessions-compulsions | 6.49 | 3.99 |
| Interpersonal sensitivity | 3.36 | 3.21 |
| Depression | 5.02 | 4.91 |
| Anxiety | 4.54 | 4.03 |
| Hostility | 4.81 | 4.13 |
| Phobic anxiety | 2.36 | 3.06 |
| Paranoid ideation | 5.45 | 3.74 |
| Psychoticism | 3.3 | 3.6 |

Were used the author's original factorial solutions both regarding CDI and BSI and one acceptable to good internal reliability was achieved with results equal or higher than .79 in all the scales and sub scales (Nunnaly, 1978).

**Table 4:** Analysis of the reliability of the measures CDI and BSI dimensions (α Cronbach)

| | α Cronbach | Items number |
|---|---|---|
| Total CDI | .79 | 27 |
| Negative mood | .81 | 6 |
| Interpersonal problems | .82 | 4 |
| Inefficiency | .82 | 4 |
| Anhedonia | .81 | 8 |
| Negative self-esteem | .81 | 5 |
| | | |
| Total BSI | .94 | 53 |
| Somatisation | .80 | 7 |
| Obsessions-compulsions | .80 | 6 |
| Interpersonal sensitivity | .80 | 4 |
| Depression | .79 | 6 |
| Anxiety | .80 | 6 |
| Hostility | .80 | 5 |
| Phobic anxiety | .81 | 5 |
| Paranoid ideation | .80 | 5 |
| Psychoticism | .80 | 5 |

The ANOVA variance test analysis was used to compare between independent variables related to sexuality and the youngsters' depression and psychological symptoms.

Regarding the results from the sexual intercourse factor, were found significant differences in the negative mood sub-scale and in the negative self-esteem suggesting that teenagers who have never had sex have more negative mood and higher negative self-esteem. In the inter-personal sensibility scale of the BSI were also found differences where the higher levels of inter-personal sensibility were obtained by those teenagers who have never had sex (see Table 5).

**Table 5:** Differences between intercourse has already occurred or not for depression and psychopathological symptoms (ANOVA)

| | No sexual intercourse (N = 134) | | Sexual intercourse (N = 120) | | | |
|---|---|---|---|---|---|---|
| | M | SD | M | SD | F | p |
| Total CDI | 38.61 | 7.94 | 36.72 | 6.57 | 3.523 | .062 |
| Negative mood | 8.65 | 2.04 | 7.97 | 1.90 | 6.673 | .010** |
| Interpersonal problems | 5.72 | 1.47 | 5.76 | 1.27 | .051 | .822 |
| Inefficiency | 6.52 | 1.73 | 6.67 | 1.61 | .510 | .476 |
| Anhedonia | 12.64 | 2.26 | 12.35 | 2.12 | 1.056 | .305 |
| Negative self-esteem | 6.72 | 1.78 | 6.31 | 1.35 | 4.036 | .046* |

| | | | | | | |
|---|---|---|---|---|---|---|
| Total BSI | | | | | | |
| Somatisation | | | | | | |
| Obsessions-compul- | 45.04 | 31.76 | 41.79 | 34.37 | .519 | .472 |
| sions | 4.49 | 4.14 | 4.57 | 5.21 | .019 | .891 |
| Interpersonal sensitiv- | 6.50 | 4.04 | 6.48 | 3.95 | .002 | .961 |
| ity | 3.75 | 3.10 | 2.91 | 3.30 | 4.142 | .043* |
| Depression | 5.33 | 5.11 | 4.68 | 4.67 | 1.096 | .296 |
| Anxiety | 4.59 | 4.06 | 4.47 | 4.02 | .050 | .824 |
| Hostility | 4.66 | 3.97 | 4.97 | 4.31 | .328 | .568 |
| Phobic anxiety | 2.67 | 2.97 | 2.02 | 3.34 | 2.862 | .092 |
| Paranoid ideation | 5.47 | 3.82 | 5.47 | 3.67 | .010 | .922 |
| Psychoticism | 3.52 | 7.71 | 3.05 | 3.48 | 1.058 | .305 |

*p<.05; **p<.01

The use of condom was also analysed relating it with depression and psychological symptoms. Regarding this variable, differences were found in the total of the CDI and in some of the CDI sub-scales, as well as in the sub-scale of phobic anxiety of the BSI. Those teenagers who do not use condom presented a higher depressive symptomatology, more negative mood, a higher negative self-esteem and a higher phobic anxiety (see Table 6).

**Table 6:** Differences between condom use for depression and psychopathological symptoms (ANOVA)

| | Did not use condoms (N = 29) | | Used condoms (N = 89) | | | |
|---|---|---|---|---|---|---|
| | M | SD | M | SD | F | p |
| Total CDI | 38.78 | 8.03 | 36.47 | 6.97 | 4.050 | .046* |
| Negative mood | 8.70 | 2.07 | 7.84 | 1.92 | 8.410 | .004** |
| Interpersonal problems | 5.72 | 1.48 | 5.74 | 1.33 | .007 | .932 |
| Inefficiency | 6.54 | 1.75 | 6.67 | 1.61 | .287 | .593 |
| Anhedonia | 12.67 | 2.27 | 12.39 | 2.29 | .730 | .394 |
| Negative self-esteem | 6.76 | 1.80 | 6.26 | 1.37 | 4.693 | .031* |
| | | | | | | |
| Total BSI | 44.23 | 31.17 | 40.51 | 33.46 | .606 | .437 |
| Somatisation | 4.40 | 4.05 | 4.16 | 4.92 | .146 | .703 |
| Obsessions-compulsions | 6.47 | 4.02 | 6.01 | 3.92 | .703 | .403 |
| Interpersonal sensitivity | 3.76 | 3.13 | 2.93 | 3.24 | 3.463 | .064 |
| Depression | 5.31 | 5.12 | 4.48 | 4.67 | 1.458 | .229 |
| Anxiety | 4.55 | 3.96 | 4.39 | 3.94 | .090 | .764 |
| Hostility | 4.49 | 3.80 | 4.99 | 4.53 | .763 | .383 |
| Phobic anxiety | 2.66 | 2.89 | 1.77 | 2.95 | 4.825 | .029* |
| Paranoid ideation | 5.39 | 3.72 | 5.38 | 3.82 | .000 | .983 |
| Psychoticism | 3.52 | 3.75 | 2.81 | 3.08 | 2.199 | .140 |

*p<.05; **p<.01

For analysing the age in which the first intercourse experience occurred, adolescents with 17 years old or more were aggregated in one same group, and teenagers with 13 years old or less were also aggregated in one same group. Significant differences where found in the sub-scale of anhedonia, where those adolescents who had their first intercourse experience with 13 years old or less were those who presented more symptoms of anhedonia when compared to adolescents who initiated their sexual life later. However the evolution of anhedonia with age seems somehow a no linear one (see Table 7).

**Table 7:** Differences between age at first intercourse for depression and psychopathological symptoms (ANOVA)

| | 13 years or less a) (N = 14) | | 14 years b) (N = 17) | | 15 years c) (N = 37) | | 16 years d) (N = 20) | | 17 years or more e) (N = 29) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | M | SD | M | SD | M | SD | F | p | PHT |
| Total CDI | 40.27 | 14.04 | 33.93 | 4.67 | 35.69 | 4.65 | 37.59 | 4.23 | 36.83 | 4.88 | 1.810 | .133 | - |
| Negative mood | 8.45 | 3.30 | 7.40 | 1.60 | 7.76 | 1.37 | 8.33 | 1.88 | 8.00 | 1.85 | .788 | .536 | - |
| Interpersonal problems | 6.36 | 1.91 | 5.44 | 1.26 | 5.78 | 1.12 | 5.30 | .80 | 5.86 | 2.27 | 1.772 | .140 | - |
| Inefficiency | 7.29 | 2.05 | 6.18 | 1.51 | 6.64 | 1.66 | 6.78 | 1.26 | 6.64 | 1.52 | .946 | .440 | - |
| Anhedonia | 13.14 | 3.28 | 11.00 | 1.50 | 12.00 | 1.91 | 13.06 | 1.80 | 12.52 | 1.74 | 3.269 | .014* | a>b<d |
| Negative self-esteem | 6.79 | 2.55 | 5.94 | 1.20 | 6.03 | 1.18 | 6.53 | .70 | 6.50 | .96 | 1.470 | .216 | - |
| Total BSI | 51.62 | 45.33 | 31.79 | 23.83 | 35.75 | 27.29 | 45.18 | 39.01 | 48.64 | 38.39 | 1.084 | .369 | - |
| Somatisation | 5.54 | 6.49 | 3.56 | 3.27 | 4.17 | 4.43 | 4.74 | 5.45 | 5.11 | 6.26 | .390 | .815 | - |
| Obsessions-compulsions | 7.29 | 4.41 | 4.71 | 2.71 | 6.05 | 3.76 | 6.95 | 3.72 | 7.34 | 4.62 | 1.532 | .198 | - |
| Interpersonal sensitivity | 3.29 | 3.41 | 1.88 | 2.55 | 2.37 | 2.62 | 3.00 | 3.71 | 3.93 | 4.02 | 1.346 | .258 | - |
| Depression | 5.21 | 5.78 | 3.53 | 3.66 | 4.08 | 4.15 | 4.95 | 4.79 | 5.89 | 5.30 | .927 | .451 | - |
| Anxiety | 5.36 | 5.39 | 2.65 | 2.89 | 4.11 | 3.55 | 4.89 | 4.70 | 5.36 | 3.84 | 1.528 | .199 | - |
| Hostility | 6.36 | 5.30 | 4.13 | 2.83 | 4.16 | 3.53 | 5.35 | 3.99 | 5.69 | 5.49 | 1.070 | .375 | - |
| Phobic anxiety | 2.62 | 4.82 | 1.12 | 1.58 | 2.27 | 2.92 | 1.89 | 4.11 | 1.86 | 2.31 | .549 | .700 | - |
| Paranoid ideation | 6.14 | 4.17 | 4.56 | 2.97 | 5.00 | 3.46 | 5.56 | 4.53 | 5.90 | 3.59 | .584 | .645 | - |
| Psychoticism | 3.57 | 3.96 | 2.18 | 2.65 | 2.59 | 2.76 | 3.80 | 4.60 | 3.35 | 6.61 | .785 | .537 | - |

*p<.05

## Discussion

The aim of this study was to determine the influence of psychological symptoms in teenagers' sexuality and associate behaviours. It is well-known that depression is related to other types of psychological symptoms, like anxiety (Kovacs & Devlin, 1998; Matos et al., 2003) that was also found in the present study.

Regarding sexuality, contrary to what was expected, those teenagers who have never had sex seem to have more negative mood and an higher negative self-esteem, also showing more inter-personal sensibility, opposite to what Meier (2007) stated – that the beginning of intercourse experiences might potentiate the appearance of psychological symptoms. However, the obtained results of

the present study might be read in the opposite direction, teenagers that have a positive self-esteem can engage in dating behaviour earlier : Indeed Baumeister (2005) while stating that studies confirming the existence of a direct relationship between self-esteem and the earlier beginning of sexual intercourse do not really exist, points out exactly that youngsters with a higher self-esteem have a higher probability of dating, what might lead to sexual experiences.

Concerning the use of condom, teenagers who do not use it present higher prevalence of psychological symptoms in general, feelings of negative mood, higher negative self-esteem and phobic anxiety. This data corroborates the previous studies by Rohde and collaborators (2001), which indicate that young adolescent's get more easily involved in sexual risk behaviours while feeling depressed, less assertive and suffering from low self-esteem.

Regarding the age in which the first sexual experience occurred, teenagers who initiated sexual activity prior to the age of 13 where those who presented symptoms of anhedonia when compared to teenagers who initiated their sexual activity later. This result met the perspective argued by Meier (2007) that states that initiating sexual activity precociously are more vulnerable to the development psychopathology, namely feelings of depression.

The present results suggest an association of depression with an early onset of sexual intercourse ( prior to 13 years old) , but also that the initiation of sexual intercourse can be considered normative during across adolescence , the lack of this experience being also related to negative mood , higher negative self-esteem and inter-personal sensibility. However, if a safer sex strategy is considered, the non use of condom in the last sexual intercourse is in itself associated as well with negative mood, higher negative self- esteem and phobic anxiety.

Considering that adolescence represents a huge milestone in human development, rich in new experiences and emotions, and that this constantly requires the learning of new conducts and social roles according to the new cultural rules, the youngster needs to receive support and be monitored by his parents and other social agents that act has role models and support. When poorly monitored or lacking in support, adolescence namely the initiation of sexual intercourse might become one painful and risky process.

It is not possible to separate the importance of the different social agents that act on the development of one individual, since school, family and friends complement each other in the learning process. Consequently, one might consider that politics of awareness, education and competence promotion in the fields of health should, also, contemplate the various groups that constitute the educational agents as a way to eradicate false beliefs and grant them with knowledge and competences in both personal and social matter.

Regarding youngsters' sexuality, as argued by several authors, the establishment of the first intimate sexual experiences are part of a normative process and these experiences will determine future behaviours and experiences. When those experiences occur it is therefore safer if they are as safer as possible.

Sexual behaviours has a direct influence in mental and physical health and this influence is more worrying in young teenagers, since they lack knowledge and cognitive and emotional maturity to make decisions and to deal with emotions that come from the sexual involvement. Furthermore they are less able to think clearly and to resist peer pressure when they are emotionally involved (Steinberg, 2005).

Sexually speaking, youngsters constitute a group of risk, since they lack neurological maturity and they lack specific competences regarding self regulation. It is fundamental to engage political measures in order to conduct intervention projects that inform, sensitise and aware teenagers regarding the consequences of behaviours of risk and that then can help them coping with interpersonal risk situations, either by means of self assertion or by means of self regulating. Adolescence being a period where the peer group is important and where adolescents are very influenced by social pressure, group interventions peer-to-peer seem a promising feature (Matos et al, 2010).

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