Psychosocial and health consequences of adolescent depression in black and white young adult women

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Depression in adolescent girls may result in negative consequences in young adulthood. The Center for Epidemiologic Studies Depression Scale (CES-D) was administered to 1,727 Black and White girls ages 16 to 18 years who participated in the National Heart, Lung, and Blood Institute’s Growth and Health Study. Three years later, women in the depressed groups were more likely to be current smokers, had attained a lower level of education, and reported lower self-worth relative to the nondepressed group. Body dissatisfaction, eating concerns, and loneliness were greater in the depressed groups. Relative to Black women, White women who were moderately depressed during adolescence reported more health care services utilization in young adulthood. Prevention efforts for depressed adolescents should be broadly focused to improve young adult outcomes.

Keywords: depression, adolescence, health outcomes, young adulthood, ethnicity

An extensive literature documents the correlates of adolescent depression; however, relatively little is known about the adult sequelae of this pernicious disorder (Barnett & Gotlib, 1988; Leader & Klein, 1996; Weissman et al., 1999). Because the available studies have almost exclusively been conducted with nonminority groups, little is known about the consequences of adolescent depression in minority adolescent girls. In the current study, we examined the effects of depression during middle to late adolescence on demographic characteristics, psychosocial adjustment, and health indicators measured in a young adult sample of Black and White women.

As pointed out by Rao and colleagues (Rao, Hammern, & Daley, 1999), the years between adolescence and young adulthood represent a major developmental transition point, marked by a “juncture at which self-determined objectives and priorities as well as role demands change considerably” (p. 908). Important life decisions related to educational, occupational, and relationship choices are made during this period, making an interruption due to depression particularly problematic. In a large longitudinal study, Reinherz, Giaconia, Hauf, Wasserman, and Silverman (1999) followed a sample of participants with depression from the age of 5 years to early adulthood to examine risks and impairments associated with major depression. They reported that women who had a history of depression in adolescence still evidenced significant levels of impairment in overall functioning and interpersonal problems in early adulthood and concluded that “these findings confirm the lingering nature of vulnerability” (Reinherz et al., 1999, p. 507). A

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586

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recent Finnish study found that depressive symptoms experienced at 16 years of age predicted adult depression, comorbid disorders, psychosocial impairment, and problem drinking at 21 years of age (Aalto-Setala, Marttunen, Tuulio-Henriksson, Poikolainen, & Lonqvist, 2002). Finally, in the most comprehensive study to date, Fergusson and Woodward (2002) examined mental health, educational, and social role outcomes in over 1,200 adolescents in New Zealand. By 21 years of age, those adolescents who were depressed between the ages of 14 and 16 years were at increased risk for psychiatric disorders, nicotine and alcohol dependence, and suicidal behavior. Relative to nondepressed adolescents, they were more likely to have failed out of school, less likely to pursue higher education, and more likely to be recurrently unemployed. Thus, the literature suggests that long-term psychosocial effects of adolescent depression are quite negative, at least for White adolescent girls; however, little is known about the sequelae of depression for Black adolescent girls.

Depression has been related prospectively to poorer health status in several investigations (Bardone et al., 1998; Newman et al., 2000; Schraedley, Gotlib, & Hayward, 1999; Shrier, Harris, & Beardslee, 2002). For example, Bardone and colleagues examined health outcomes in adolescent girls with conduct disorder, depression, and anxiety disorder who were interviewed at 15 years of age and again at age 21. Relative to adolescents without psychiatric disorder, adolescents with depression had more medical problems in early adulthood, even after controlling for socioeconomic status, parental smoking, childhood and maternal health, and maternal body mass index. Over 36% of girls with depression met criteria for tobacco dependence at 21 years of age, compared with 16.7% of healthy girls. Schraedley et al. (1999) assessed health care utilization in a large nationally representative sample of adolescents and found that higher levels of depressive symptoms were associated with a greater frequency of general health visits. In fact, adolescents with the highest levels of depression were twice as likely to have seen a doctor five or more times in the previous year than were those with the lowest levels of depression.

In sum, studies consistently show the occurrence of negative sequelae in young adulthood across multiple domains for adolescents with depression. However, psychologists’ understanding of this relationship is based primarily on samples of White adolescent girls, even though depression occurs in comparable or even greater numbers in minority groups (Franko & Striegel-Moore, 2002; Roberts, Roberts, & Chen, 1997). As Franko and Striegel-Moore (2002) noted, studies have found either no Black–White difference in mean depression scores (Lester & DeSimone, 1995; Lubin & McCollum, 1994; Pumariega, Johnson, Sheridan, & Cuffe, 1996; Schraedley et al., 1999) or have found significantly higher depression scores in Black girls compared with White girls (McDonald & Gynther, 1963). Even fewer studies have examined adult sequelae in Black and White groups. To extend knowledge in this area, we examined demographic variables (e.g., educational attainment), psychosocial functioning, and indicators of health in a sample of Black and White young adults who were depressed in middle and late adolescence.

Although we recognize the importance of adult sequelae of other mental health concerns found commonly in adolescent girls, such as anxiety disorders and eating disorders, we chose to focus on depression for several reasons. First, depression is the most common mental health concern in this age group (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993). In fact, the lifetime prevalence rates of unipolar depression (27.16%) and major depression (24.80%) in adolescent girls (mean age of 16.6 years) were more than double that for anxiety disorders (11.67%) and over 20 times greater than that for eating disorders (1.35%). Further, for such a common disorder, very little is known about the consequences of depression in diverse groups. Finally, several excellent studies have recently chronicled the consequences of both anxiety disorders (Essau, 2003; Wittchen & Fehm, 2003) and eating disorders (Striegel-Moore, Seeley, & Lewinsohn, 2003) in adolescent samples.

On the basis of previous findings, we hypothesized that relative to nondepressed individuals, adolescents with depression would have more negative young adult outcomes. No hypotheses were proposed for how the level of an individual’s depression might relate to outcomes.

Method

Details of the National Heart, Lung, and Blood Institute’s Growth and Health Study (NGHS) design and sample characteristics have been reported elsewhere (NGHS Research Group, 1992). This multicenter, longitudinal study started in 1987 with a cohort of 2,379 Black and White girls who were studied annually over 10 years at three study centers (University of California, Berkeley; University of Cincinnati and Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio; and Westat, Inc., Rockville, Maryland, in association with a Washington, DC, HMO). Maryland Medical Research Institute in Baltimore served as the coordinating center for the study.

Participants

At baseline, 1,213 Black girls (539 nine-year-olds, 674 ten-year-olds) and 1,166 White girls (616 nine-year-olds, 550 ten-year-olds) were recruited at three study sites. Eligibility criteria included (a) the child and parents indicated that they were either White or Black (racial concordance of parents and child was required), (b) the girl was within 2 weeks of age 9 or 10 years, (c) the child gave assent to participate, and (d) parents gave consent and completed a household demographic sheet. The researchers at the University of California, Berkeley, recruited participants from public and parochial schools in the Richmond Unified School District (chosen on the basis of census tract data). The researchers at the Cincinnati Children’s Hospital Medical Center recruited participants from public and parochial schools chosen to be representative of Hamilton County, which includes inner city, urban, and suburban areas. Westat (Rockville, MD) participants were randomly drawn from the membership directory of families enrolled in the Group Health Association (GHA), a large Washington, DC, area HMO. Because the GHA did not have enough eligible White families with 9- or 10-year-old girls, recruitment was extended to a group of Girl Scout troops within the geographic area of a predominantly White GHA clinic participating in the study.

NGHS Procedure

Over a period of 10 years, the cohort was assessed annually at each site or, if the girl was unable to travel to the study site, at home. Participants provided information on eating patterns and dietary intake, physical activity, health beliefs and attitudes, and a range of psychosocial variables. A standard protocol was used across all sites, and standard probes were used to clarify incomplete responses.

NGHS Wave II

In 1998, a follow-up of the NGHS participants, termed Wave II, was undertaken to examine the prevalence and risk factors for eating disorders.
Procedure for NGHS Wave II

All NGHS participants were asked to participate in Wave II. High participation rates were maintained by using NGHS staff in the study and by following established NGHS cohort maintenance procedures. All participants received a letter by mail announcing the new study. Staff then contacted participants by telephone, explained the new study, and invited participation. After obtaining consent, the staff interviewed the participant over the telephone. A toll-free telephone number was provided for participants who did not have a telephone; participants who were not reached by telephone were located by means of home visits. The telephone interview took about 30 minutes for symptom-free participants and approximately 60 minutes for participants with eating-related or other psychiatric symptoms. All participants were asked to complete a brief packet of self-report instruments that were used for outcome variables in the current study (see below).

Instruments

**Predictor variable.** The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) is a 20-item self-report symptom rating scale used to measure depressive symptoms, with an emphasis on the affective, depressed mood component. Respondents indicate the frequency of occurrence of each symptom over the past week on a 4-point scale, where 0 = rarely or none of the time (less than 1 day), 1 = some or a little of the time (1–2 days), 2 = occasionally or a moderate amount of time (3–4 days), and 3 = most or all of the time (5–7 days). Scores range from 0 to 60 with higher scores indicating increased symptomatology. Two cutoff scores are generally reported in the literature (16 and 24), although some have suggested that the higher score is a more reliable indicator of depression in adolescence (Radloff, 1977). Originally developed for use in adult populations, the CES-D has been used widely with adolescents (Garrison, Schluchter, Schoenbach, & Kaplan, 1989; Roberts, Andrews, Lewinsohn, & Hops, 1990; Schoenbach, Kaplan, Grimson, & Wagner, 1982; Schoenbach, Kaplan, Wagner, Grimson, & Miller, 1983). The CES-D was administered in Waves 8 and 10 in the NGHS (when the participants were, on average, 16–17 years old and 18–19 years old, respectively) and was also administered in the NGHS Wave II study (when the participants were 21–23 years old). On the basis of CES-D cutoff points, three groups were created for purposes of this study. Group 1 (no depression) was defined as a CES-D score of 16–23 in Year 8 or Year 10. Group 2 (mild depression) was defined as a CES-D score of 16–23 in Year 8 or Year 10, and Group 3 (moderate depression) was defined as a CES-D score of 24 or greater in either Year 8 or Year 10.

**Demographic outcomes.** During the telephone screening interview of the NGHS Wave II study (Striegel-Moore, Dohm, et al., 2003), participants were asked a variety of demographic questions, including queries about their age, marital status, education, and whether the participant was receiving public assistance.

Psychosocial outcomes. The UCLA Loneliness Scale (Russell, Peplau, & Ferguson, 1978) is a 20-item general measure of loneliness and social isolation. The measure has high internal consistency and good test–retest reliability. Concurrent and construct validity for the scale are excellent. The factor structure includes three factors (intimacy, sociability, and affiliation), and higher scores indicate greater loneliness.

The Social Adjustment Scale (SAS; Weissman & Bothwell, 1976) assesses social adjustment in multiple areas of functioning, including marital, family, work, economic, social, and leisure. The scale has well-established reliability and validity and has been used with a wide variety of populations. Higher scores indicate worse psychosocial functioning.

The Self-Perception Profile for Children (Harter, 1985) is a widely used instrument that contains six subscales measuring children’s feelings of competence. The Global Self-Worth subscale, used in this study, is based on more general feelings about the self and is intended to measure a general sense of self-esteem. It was found to have excellent reliability and validity in the NGHS cohort (Schumann et al., 1999). Lower scores represent lower self-esteem.

The Eating Disorders Inventory (EDI, Garner & Olmsted, 1984) measures the psychological and behavioral dimensions typically found in eating disordered participants. Three subscales were administered in Wave II: Drive for Thinness, Body Dissatisfaction, and Bulimia. The psychometric properties of the EDI have been well-researched (Eberenz & Gleaves, 1994), and it is a highly reliable and valid measure.

Health outcomes. During the telephone screening interview of NGHS Wave II, all women were asked about their use of health care services during the previous 12 months. Participants were asked to report the number of days they had used any of the following services: emergency room visits, outpatient visits to a physician for medical care, outpatient psychotherapy, and hospital stays (in days). The total number of health care services days was calculated by summing across all types of services. Because a few participants reported very high service use, the total number of health care services days was capped at 64 days.

Smoking status was assessed by a questionnaire with three questions that addressed history of as well as current smoking (both number of days per month and quantity of cigarettes smoked per day). On the basis of this information, smoking status was coded as a two-level variable (never smoked or smoke less than once per month vs. smoking at least weekly).

Statistical Analyses

Prior to performing any analyses, we examined means, medians, standard deviations, and other statistics on all variables to check for outliers and nonnormal distributions. The variable for health care services days was skewed; thus, this variable was capped at 64 days in the analyses.

For the analysis of the categorical outcome variables, chi-square tests were used. Regression analysis was used to analyze the continuous outcome variables (e.g., loneliness, global self-worth) with depression group (no depression, mild depression, moderate depression) as the predictor of interest. Study site and group, along with the interactions of the groups and sites, were considered covariates in the model. Dummy variables created for group and site were centered (Aiken, West, Cohen, & Cohen, 2002) and scaled appropriately. Wave II CES-D scores were entered as a covariate in all regression models to adjust for current level of depressive symptoms. Two contrasts were entered into the regression models: (a) no depression versus mild depression and moderate depression and (b) mild depression versus moderate depression. To assess ethnic differences, the Ethnicity × Depression Group interaction term was included in all analyses. All analyses were performed with SAS statistical software, Version 8.2. Because of the number of analyses performed, the level of significance was set at .01.

Results

Sample Description

The sample included in the present study was composed of 1,727 females (883 Black, 844 White), representing 73% of the original NGHS cohort. Sample sizes for various analyses vary slightly because of missing data. Means (based on the average CES-D score for Years 8 and 10), standard deviations, and sample
sizes for the three depression groups for Black and White participants are presented in Table 1. CES-D scores did not differ between Black and White participants, $\chi^2(2, N = 1,727) = 5.67, p = .0588$.

**Demographic Outcomes**

Only one demographic variable differed among the groups: More of those in the nondepressed group (46%) had completed high school (or beyond) than had those in the mild (23%) and moderate (25%) groups, $\chi^2(2, N = 1,721) = 11.48, p = .0032$. No significant differences were found between any of the depression groups on marital status, $\chi^2(2, N = 1,634) = 1.76, p > .05$, or receipt of public assistance, $\chi^2(2, N = 1,629) = 2.78, p > .05$.

**Psychosocial Outcomes for Depression Groups**

Table 2 presents the means and standard deviations for the continuous psychosocial variables separately for Black women and for White women. In the initial regression analyses, significant two-way interactions with site (California; Washington, DC; and Ohio) were found for two variables ($p < .01$). Specifically, significant Site × Group interaction effects were found on the UCLA Loneliness Scale and the Drive for Thinness subscale of the EDI. Thus, the analyses for these two variables were conducted separately for each site.

Site-specific analyses resulted in a significant main effect on the UCLA Loneliness Scale for Contrast 1 (no depression vs. mild and moderate depression groups) at the California site. Means and standard deviations for the no depression, mild depression, and moderate depression groups at this site were $M = 4.85, SD = 4.02$; $M = 7.42, SD = 5.06$; and $M = 9.68, SD = 5.74$, respectively. There were no significant differences among depression groups at the other two sites on the UCLA Loneliness Scale.

For the Drive for Thinness subscale of the EDI, significant main effects were found for Contrast 1 (no depression vs. mild and moderate depression) and Contrast 2 (mild vs. moderate depression) at the California site. The means and standard deviations at this site for the Drive for Thinness subscale for the no depression, mild depression, and moderate depression groups were $M = 2.77$, $SD = 3.77$; $M = 4.18$, $SD = 4.95$; and $M = 6.67$, $SD = 5.91$, respectively. A significant main effect was found on the Drive for Thinness subscale only for Contrast 1 in Ohio, where the means and standard deviations were $M = 2.90$, $SD = 4.20$; $M = 5.38$, $SD = 5.41$; and $M = 5.69$, $SD = 5.33$, respectively. There were no significant differences found among the depression groups at the Washington, DC, site on this variable.

For the remaining continuous psychosocial variables, with the exception of the Social Adjustment Scale, a significant main effect for Contrast 1 was found (see Table 3), indicating that both the mild and moderate depression groups, relative to the nondepressed participants, had lower self-worth and more eating-related concerns. The two depressed groups (mild vs. moderate depression) did not differ from each other on these variables. Ethnicity × Depression Group interaction terms were included in all models, but none were significant.

**Health Outcomes for Depression Groups**

More of the no depression group reported never smoking (52%) than did the mild depression (25%) and the moderate depression (23%) groups, $\chi^2(2, N = 1,624) = 32.59, p < .0001$. The Ethnicity × Depression Group interaction term was significant for the health care services utilization variable (see Table 3). Thus this variable was analyzed separately for Black and White women; means can be found in Table 2. For Black women, Contrast 1 (no depression vs. mild depression and moderate depression) was of borderline significance (parameter estimate = $-1.69, SE = 0.68, p = .012$). However, Contrast 2 (mild depression vs. moderate depression) was clearly not significant (parameter estimate = 0.30, $SE = 0.96, p > .75$). For White women, the moderate depression group reported significantly more health care services days than did the mild depression group. Contrast 1 was not significant (parameter estimate = $-1.68, SE = 0.88, p > .05$); however, Contrast 2 was significant (parameter estimate = 3.39, $SE = 1.20, p < .01$). The significant interaction indicated that at higher levels of depression, White women were more likely than Black women to use health care services.

**Discussion**

In this study, we examined outcomes in young adulthood for girls who were depressed during adolescence. Differences were found on several variables between women who were not depressed as adolescents and women who were depressed as adolescents, even when we controlled for current levels of depressive symptoms. Specifically, relative to the nondepressed participants, participants who experienced mild to moderate levels of depression as adolescents attained a lower level of education, had lower self-esteem, had more eating-related concerns, and were more

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**Table 1**

<table>
<thead>
<tr>
<th>Group</th>
<th>White</th>
<th></th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>%</td>
<td>$M$</td>
</tr>
<tr>
<td>No depression</td>
<td>389</td>
<td>46</td>
<td>8.32</td>
</tr>
<tr>
<td>Mild depression</td>
<td>209</td>
<td>25</td>
<td>15.66</td>
</tr>
<tr>
<td>Moderate depression</td>
<td>246</td>
<td>29</td>
<td>24.48</td>
</tr>
</tbody>
</table>

Note. $\chi^2(1, N = 727) = 5.67, p = .0588$. Girls were put in the no depression group if their Center for Epidemiological Studies–Depression Scale (CES-D) scores were less than 16 in Years 8 and 10; the mild depression group if their CES-D scores were 16–23 in either Year 8 or Year 10, or the moderate depression group if their CES-D scores were greater than or equal to 24 in either Year 8 or Year 10.
likely to smoke in young adulthood. The results differed by ethnicity for only one variable (i.e., health care services utilization). For White women, health care services utilization was higher in those who had been moderately depressed as adolescents relative to those who had been mildly depressed, whereas the use of health care services was similar across depression groups for Black women.

Differences in educational attainment between nondepressed and depressed groups have been reported by others (e.g., Glied & Pine, 2002). For example, Kessler, Berglund, Foster, Saunders, and Stang (1997) reported higher school dropout rates in adolescents with depression than in nondepressed adolescents. Weissman et al. (1999) found that participants with depression had significantly lower educational achievement, had a lower socioeconomic status, and missed more work because of psychopathology relative to their nondepressed counterparts. However, these studies did not examine varying levels of depression but instead were based on those who either did or did not have a clinical diagnosis of major depressive disorder. We noted that both mildly and moderately depressed adolescents were less likely to graduate from high school than were nondepressed adolescents, suggesting that impairment in this area can be associated with even mild degrees of depression. It is possible that depressive symptoms in adolescence, even if only mild, may affect motivation, the ability to concentrate, and the energy level needed to attain educational goals. These results suggest that early and aggressive intervention may be needed even for mildly depressed adolescent girls. However, the causal direction of this effect needs to be clarified in future research, because it may be that low educational success leads to depression rather than the reverse.

Eating-related constructs differed among the depression groups, indicating that those who were depressed in adolescence differed from those who were not with regard to body dissatisfaction and disordered eating attitudes and behaviors in young adulthood. This finding is interesting in light of a prospective study that found body dissatisfaction in adolescence predicted depression 2 years later (Stice & Bearman, 2001). Depression and eating disorder concerns may go hand in hand for adolescent and young adult women, suggesting that combined preventive efforts directed at both of these issues may be indicated for this developmental group.

Consistent with others (Bardone et al., 1998; Fergusson & Woodward, 2002; Glied & Pine, 2002), we found that over twice as many of those who had been depressed as adolescents reported smoking at the young adulthood assessment. Those who were either mildly or moderately depressed at adolescence were equally as likely to indicate a history of smoking, with only a quarter of the participants in these groups reporting never having smoked. Tobacco use may have been initiated as a coping response to depression or life stresses, it may be that depressed teenagers are more likely to take up smoking, or it might be that another agent associated with tobacco (e.g., alcohol) causes depression. It is also possible that smoking cigarettes may directly lead to depression by as yet unknown mechanisms. Unfortunately, our data did not allow us to delineate the temporal sequencing of smoking and depression, so it is not clear which came first. Some research suggests that smoking predicts depression (Scarinci, Thomas, Brantley, & Jones, 2002), whereas others (Juon, Ensminger, & Sydnor, 2002) have not found a relationship between smoking onset and depression. Our data suggest that tobacco prevention efforts should not be distinct from other health-related prevention programs (e.g., depression) and that programming for adolescents with regard to health concerns should encompass a variety of relevant issues.

It is interesting that health services utilization differed between the mild and moderate depression groups, but only for White women.

Table 2
Means and Standard Deviations of Continuous Variables by Depression Group for Black and White Women

<table>
<thead>
<tr>
<th>Variable</th>
<th>No depression</th>
<th>Mild depression</th>
<th>Moderate depression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>UCLA Loneliness Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black women</td>
<td>411</td>
<td>4.7</td>
<td>4.0</td>
</tr>
<tr>
<td>White women</td>
<td>376</td>
<td>5.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Global Self-Worth subscale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black women</td>
<td>413</td>
<td>17.4</td>
<td>3.0</td>
</tr>
<tr>
<td>White women</td>
<td>376</td>
<td>17.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Social Adjustment Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black women</td>
<td>414</td>
<td>1.9</td>
<td>0.4</td>
</tr>
<tr>
<td>White women</td>
<td>374</td>
<td>1.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Drive for Thinness subscale (EDI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black women</td>
<td>413</td>
<td>2.6</td>
<td>3.8</td>
</tr>
<tr>
<td>White women</td>
<td>376</td>
<td>2.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Body Dissatisfaction subscale (EDI)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Black women</td>
<td>413</td>
<td>7.8</td>
<td>7.6</td>
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<tr>
<td>White women</td>
<td>376</td>
<td>8.3</td>
<td>8.0</td>
</tr>
<tr>
<td>Bulimia subscale (EDI)</td>
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<td></td>
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<tr>
<td>Black women</td>
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</tr>
<tr>
<td>White women</td>
<td>376</td>
<td>0.5</td>
<td>1.4</td>
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<tr>
<td>Health care services days</td>
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<tr>
<td>Black women</td>
<td>441</td>
<td>7.8</td>
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</tr>
<tr>
<td>White women</td>
<td>389</td>
<td>10.0</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Note. EDI = Eating Disorders Inventory.
women. White women had higher levels of health care services utilization than did Black women in every category of depression. Depression has generally been found to increase health care services utilization (Lecrubier, 2001; Rowan, Davidson, Campbell, Dobrez, & MacLean, 2002), and our results for the moderate depression (but not the mild depression) group support this finding. The higher health care services utilization for White women appears to have site effects.

In conclusion, our data suggest that there are important negative psychosocial consequences of adolescent depression for Black and White young adult women and that these sequelae cut across multiple areas of functioning. Depression appeared to be related to health care services utilization in different ways for Black and White women. White young adult women and that these sequelae cut across multiple areas of functioning. An intriguing study recently found that Black adults were less likely to trust their physicians, relative to White adults, but more likely to trust their health insurance plans (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003). Furthermore, the Black participants were more likely than the White participants to be concerned about privacy issues in hospitals. Additional research into reasons for disparities in health care services utilization may improve care for depressed Black women.

It is also notable that health care services utilization was the only variable for which we found racial differences. Our data suggest that the psychosocial consequences of depression do not differ for Black and White women. This was not unexpected, as there does not appear to be any a priori reason why one group would be anticipated to have worse outcomes than another. It is possible that coping mechanisms for dealing with depression differ between racial groups (Chapman & Mullis, 2000), although the data are limited in this regard. Future studies might investigate the ways that Black and White women deal with depressive symptoms.

The site differences obtained for two of the variables (UCLA Loneliness Scale, Drive for Thinness subscale) suggest that there may be some regional variability in the young adult consequences of adolescent depression. A growing literature suggests that health concerns and mental health disorders may vary by geographic location (Hahn, Heath, & Chang, 1998; Hogan, Maxwell, Fung, & Ebly, 2003; Miller, Verhegge, Miller, & Pumariega, 1999; Willms, Tremblay, & Katzmarzyk, 2003), and thus it is possible that the sequelae of disorders also differ across regions. Reasons for these regional differences are not well understood but may be related to local culture as well as to climate differences (Sloan, 2002). Our results suggest that generalizing findings from multisite studies should be done cautiously.

Limitations of this study include the self-report nature of the data and the fact that data collection occurred at only one time point in each of the three assessment periods. Because depression is assessed only for the past week on the CES-D and depression is a cyclical disorder, it is possible that some individuals with depression were grouped in the nondepressed category. Thus, our data may underestimate the degree of psychosocial and health problems found in individuals with depression. Sequelae of self-reported depressive symptoms may differ from those of clinical depression, which was not examined in this study. Because our study was not experimental in design, we cannot be sure of the directionality between outcomes and depression. Furthermore, it is possible that variables other than or in addition to depressive symptoms in adolescence may account for the differences observed in young adulthood.

In conclusion, our data suggest that there are important negative psychosocial consequences of adolescent depression for Black and White young adult women and that these sequelae cut across multiple areas of functioning. Depression appeared to be related to health care services utilization in different ways for Black and White women. Prevention efforts for adolescents need to be instituted early, strengthened, and focused broadly to achieve positive educational, psychosocial, mental health, and health outcomes.

### References


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New Editors Appointed, 2007–2012

The Publications and Communications (P&C) Board of the American Psychological Association announces the appointment of three new editors for 6-year terms beginning in 2007. As of January 1, 2006, manuscripts should be directed as follows:

- Journal of Experimental Psychology: Learning, Memory, and Cognition (www.apa.org/journals/xlm.html), Randi C. Martin, PhD, Department of Psychology, MS-25, Rice University, P.O. Box 1892, Houston, TX 77251.

- Professional Psychology: Research and Practice (www.apa.org/journals/pro.html), Michael C. Roberts, PhD, 2009 Dole Human Development Center, Clinical Child Psychology Program, Department of Applied Behavioral Science, Department of Psychology, 1000 Sunnyside Avenue, The University of Kansas, Lawrence, KS 66045.

- Psychology, Public Policy, and Law (www.apa.org/journals/law.html), Steven Penrod, PhD, John Jay College of Criminal Justice, 445 West 59th Street N2131, New York, NY 10019-1199.

Electronic manuscript submission. As of January 1, 2006, manuscripts should be submitted electronically through the journal’s Manuscript Submission Portal (see the Web site listed above with each journal title).

Manuscript submission patterns make the precise date of completion of the 2006 volumes uncertain. Current editors, Michael E. J. Masson, PhD, Mary Beth Kenkel, PhD, and Jane Goodman-Delahunty, PhD, JD, respectively, will receive and consider manuscripts through December 31, 2005. Should 2006 volumes be completed before that date, manuscripts will be redirected to the new editors for consideration in 2007 volumes.

In addition, the P&C Board announces the appointment of Thomas E. Joiner, PhD (Department of Psychology, Florida State University, One University Way, Tallahassee, FL 32306-1270), as editor of the Clinician’s Research Digest newsletter for 2007–2012.