Physical Abuse
Clinicians Additional Group differences may have been a sampling bias and should be tested in larger Other Traumatic Events PTSD Emotional Abuse Other Traumatic Events predicting diagnostic group. Age and sex were entered in step one to control for group traumas. linked to the development of depression and/or PTSD and were available across the three datasets, including age, predict diagnostic group (PTSD versus PTSD+MDD) from subject variables that were previously shown to be required; a minimum score of 12 on the PTSD original sample included 39 subjects, and 9 patients were removed for missing data. A full PTSD diagnosis was not development of Posttraumatic Stress Disorder (PTSD) and depression. Furthermore, the DSM-IV inclusion of negative emotions in the diagnostic criteria (APA, 2013) suggests a growing similar genetic propensity (Broekman, Eisen, & Boer, 2007) and some suggest that environment inclusion of negative emotions in the diagnostic criteria (APA, 2013) suggests a growing interest in identifying those youth with PTSD and MDD to those with only PTSD to identify risk factors for comorbid depression in an effort to inform treatment.

Methods: Thirty youth, ages 11 to 18 were included. A history of interpersonal trauma and a minimum score of 12 on the PTSD-Symptom Scale were required for inclusion (Foa, Johnson, F fire, & Treadwell, 2001). Youth were assessed with the KSADS-PL for presence of or current Depression Disorder (Kaufman et al., 1997). Regression models were created to predict diagnostic group (PTSD versus PTSD+MDD) from the following variables: age, sex, severity of PTSD symptoms, IQ, age at first trauma, and type of trauma. Only one group was significantly different, a greater percentage of females (Chi Square (1)= 4.22, p=.04) compared to the PTSD only group. A 2-step hierarchical regression analysis removing the effects of age and sex found that severity of PTSD was the strongest predictor of comorbidity. The presence of ‘other traumas’ in addition to the interpersonal trauma was the only other significant factor in the model (p=.036).

Conclusion: These results point out that, in addition to symptom severity, a clinician should consider a youth’s comprehensive trauma history in addition to the index trauma, when determining risk of depressive disorder, and adjust the treatment plan appropriately. It also highlights the importance of early intervention to develop coping tools aimed at preventing the onset of comorbid depression.

Introduction
Interpersonal trauma in childhood and adolescence can have a profound impact on psychological functioning and lead to the development of Posttraumatic Stress Disorder (PTSD) and depression. The prevalence of traumatic events and PTSD is striking high. According to The National Survey of Children’s Exposure to Violence (NSCEV), the only other significant factor in the model. R=.839, R Square= .704). After removing symptoms, but target depression by treating the PTSD.  A better understanding of the factors that predispose traumatized counterparts without PTSD (Runyon, Faust, & Orvaschel, 2002). Research shows that PTSD and depression share a similar genetic propensity (Broekman, Eisen, & Boer, 2007) and some suggest that environment leading to the development of PTSD+MDD group was significantly older and a greater percentage of females (Chi Square (1)= 4.22, p=.04). PTSD+MDD group was significantly older and a greater percentage of females (Chi Square (1)= 4.22, p=.04) compared to the PTSD only group. A 2-step hierarchical regression analysis removing the effects of age and sex found that severity of PTSD was the strongest predictor of comorbidity. The presence of ‘other traumas’ in addition to the interpersonal trauma was the only other significant factor in the model (p=.036).

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Methods
Subjects and Assessments: Data were aggregated from 3 related studies of youth with a history of trauma. Interpersonal Traumatic event, sexual abuse, and physical violence were considered (American Psychological Association, 2014) were identified through participant self-report, peer reports, and clinician observations. Subject data were collected through the Center for Interdisciplinary Brain Sciences Research (CIBSR) and Early Life Stress Research Program (ELSRP) at Stanford University School of Medicine, Palo Alto, CA 94305. Youth were recruited for the study at a local clinic, primarily through participant self-referral, and were included if they met criteria for PTSD, MDD, or both. Inclusion criteria included a minimum age of 11 years, a diagnosis of PTSD, MDD, or both, and a history of at least one traumatic event. Exclusion criteria included a diagnosis of schizophrenia, bipolar disorder, psychotic features, or IQ < 70. The sample consisted of 39 participants, including 18 boys and 21 girls. All participants were Caucasian, with a mean age of 14.4 years (range: 11.5-17.6 years).

Data Analysis: The PTSD diagnosis was confirmed using the PTSD symptom scale (PSS). The primary outcome measure was the presence of comorbid depression. The relationship between PTSD and depression was assessed using logistic regression analysis. Variables included in the final model were PTSD symptom severity, age, sex, and a history of physical abuse.

Results: The final model included PTSD symptom severity, age, and sex as significant predictors of comorbid depression (p<.001). The only other significant factor was ‘other traumatic events’ (p=.036).

Discussion
In our sample, comorbid MDD and PTSD was associated with being older and female. This is consistent with the heightened risk of depression for females and the typical post-pubertal onset of depression. PTSD symptom severity is the strongest predictor of depression when controlling for age and sex. This is consistent with previous findings that depression and PTSD are strongly correlated with overlapping symptoms (Foa et al., 2001). ‘Other Traumatic Events’ was the only other significant predictor of comorbidity. ‘Other Traumatic Events’ were traumas in addition to the index trauma, such as being in a serious fire or car accident, seeing a dead body, or physical fights with peers.

Not significant predictors included: SIQ, index trauma (Domestic Violence, Physical Abuse, Sexual Abuse), SES, and time since first trauma. Additional traumas may have increased the allostatic load leading to comorbid depression.

Group differences may have been a sampling bias and should be tested in larger studies.

Clinical Significance: Clinicians should look at the total traumatic load when determining risk of developing depression. This includes traumas in addition to the index trauma, and traumas that may not meet criterion A.

Highlights the importance of early intervention subsequent to the first trauma, helping the youth develop coping skills that may be utilized to process subsequent traumas and circumvent the development of comorbid depression.