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Disqualified qualifiers: Evaluating the utility of the revised DSM-5 definition of potentially traumatic events among area youth following the Boston Marathon bombing

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Abstract

Background—The *DSM-5* includes a revised definition of the experiences that qualify as potentially traumatic events. This revised definition now offers a clearer and more exclusive definition of what qualifies as a traumatic exposure, but little is known about the revision's applicability to youth populations. The present study evaluated the predictive utility of the revised DSM definitional boundaries of traumatic exposure in a sample of youth exposed to the 2013 Boston Marathon bombing and related events.

Methods—Caregivers ($N = 460$) completed surveys 2 to 6 months post bombing about youth experiences during the events and youth posttraumatic stress (PTS) symptoms.

Results—Experiencing *DSM-5* qualifying traumatic events (*DSM-5* QTEs) significantly predicted child PTS symptoms (PTSS), whereas *DSM-5* non-qualifying stressful experiences (*DSM-5* Non-QSEs) did not after accounting for *DSM-5* QTEs. Importantly, child age moderated the relationship between *DSM-5* QTEs and PTSS such that children 7 and older who experienced *DSM-5* QTEs showed greater post-bombing PTSS, whereas there was no such relationship in children ages 6 and below.

Conclusions—Data largely support the revised PTSD definition of QTEs in older youth, and also highlight the need for further refinement of the QTE definition for children ages 6 and below.

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Keywords

PTSD/Posttraumatic Stress Disorder; Child/Adolescent; Trauma; Stress; Assessment/Diagnosis

Works as early as Homer's *The Odyssey* recounted the trials of posttraumatic stress reactions, describing its hero's post-war struggles as "when long years and seasons wheeling brought around that point of time ordained for [Odysseus] to make his passage homeward, trials and dangers, even so, attended him even in Ithaca, near those he loved."¹ Posttraumatic stress disorder (PTSD)—regarded by many as the modern incarnation of varied emotional syndromes that Homer and many others have described for centuries as following exposure to extreme events—remains a relatively young diagnosis with a complex history.^{2,3} First introduced in *DSM-III*,⁴ PTSD provided a unifying category for previously disparate trauma-related conditions.^{2,3} The optimal definition of a qualifying "traumatic exposure", however, has been a source of continued debate.⁵ As one of the few DSM disorders that incorporates etiology in its definition, the boundaries for defining traumatic events (as delineated in PTSD Criterion A) necessarily constrain which individuals qualify for consideration of diagnosis.

Across DSM iterations, evolving components of PTSD Criterion A have relied on shifting factors to clarify the boundaries of qualifying traumatic events (QTEs). In *DSM-III*, a QTE was described as a distressing situation falling "outside the range of usual human experience."⁴ Despite its lack of discrete guidelines and reliance on subjective distress, *DSM-III* Criterion A attempted to reduce or prevent "victim blaming," describing emotional reactions as the result of the impact and catastrophic nature of the event itself instead of individual vulnerability.⁵ However, although the wording of the *DSM-III* definition characterized QTEs as rare (i.e., outside usual human experience), evidence documents a relatively high incidence of extreme events and stressors in the general population.^{2,5,6} Accordingly, PTSD Criterion A changed across *DSM-III-R*⁷ and *DSM-IV*.⁸ *DSM-IV* and *DSM-IV-TR*⁹ included an expanded QTE definition and shifted the focus from non-normality to the subjective responses they elicit. Regrettably, clinical applications of the *DSM-IV* definition revealed this revision was considerably broader and more inclusive than previous iterations, leading to concerns regarding "bracket creep" or "criterion creep" in which less severe or less objectively threatening events (e.g., viewing frightening news) could now qualify as QTEs.^{10,11}

To address concerns, the most recent diagnostic iteration¹² now reorganizes and delineates QTEs as "exposure to actual or threatened death, serious injury, or sexual violence" via (1) direct experience, (2) witnessing, in person, the event, (3) learning that a family member/close friend experienced the event, or (4) repeated, extreme exposure to related details of a qualifying event (although not through media-based encounters). Based on the efforts of the *DSM-5* Work Group,² this current revision offers a clearer and more exclusive definition of QTEs that no longer includes subjective distress and makes explicit that indirect exposure (e.g., media-based contact) cannot qualify.

To date, most PTSD research evaluating QTE definitional boundaries has been conducted in adults.^{13–15} In fact, only 6.4% of research on stress-related disorders has examined traumatic

exposure in youth³, whereas population-based research documents a high incidence of extreme events and stressors in childhood.⁶ Moreover, although McLaughlin and colleagues⁶ found roughly two-thirds (61.8%) of U.S. children have experienced a traumatic event, with roughly one-third (32.7%) having experienced multiple such events, the rate of PTSD in the general youth population is relatively low (4.7%). This discrepancy may speak to larger concerns regarding the validity and developmental sensitivity of current PTSD criteria for child populations.¹⁶ For example, PTSD symptoms, particularly in younger children, may be more accurately identified using more behaviorally anchored symptoms, such as exhibiting extreme temper tantrums, and less reliance on cognitive and verbal expressions.¹⁶ Moreover, responses to highly stressful events not qualifying as traumatic events in *DSM-5* (i.e., non-qualifying stressful events, or Non-QSEs) may vary across child development. For example, media-based contact with traumatic events can be associated with child PTS symptoms (PTSS) in many youth,^{17–19} and it has been suggested that children at early stages of cognitive development in particular may not readily distinguish between televised and real in-person events.²⁰ However, caution is needed when interpreting group-level findings regarding child age as reflecting individual cognitive developmental factors.

Copeland and colleagues²¹ explored the effects of *DSM-IV* Non-QSEs in youth, and found four times more youth reported experiencing non-qualifying (or “low-magnitude” negative events) than qualifying (or “extreme”) stressors. Though a smaller proportion of youth who endorsed *DSM-IV* Non-QSEs reported PTSS related to these events than youth who endorsed *DSM-IV* QTEs, those endorsing *DSM-IV* Non-QSEs accounted for a larger proportion of those reporting negative outcomes due to higher prevalence; youth reporting *DSM-IV* Non-QSEs accounted for half of youth endorsing PTSS. Additionally, while some Non-QSEs conferred lower risk for PTSS than QTEs, others demonstrated similar or higher associations with endorsed symptoms. Importantly, these analyses were conducted using *DSM-IV* criteria, leaving the prognostic utility of youth Non-QSEs under the recently revised *DSM-5* definition unclear. Additionally, the evaluation of appropriate boundaries to guide the determination of impactful QTEs and Non-QSEs is further obscured by the fact that youth are typically brought to treatment by their parents, and rarely self-refer. As such, caregivers’ identification of QTEs, Non-QSEs, and PTSS holds important clinical implications for services following distressing experiences above and beyond children’s own report.

The 2013 Boston Marathon bombing and subsequent manhunt offers a unique opportunity for a large-scale evaluation of the utility for youth populations of the revised *DSM-5* QTE definition. First, the initial bombing intentionally targeted a family event, and the majority of manhunt activities unfolded in residential neighborhoods with large proportions of households with children. Accordingly, an enormous number of youth were directly and indirectly affected. Second, the Boston Marathon bombing—itsself associated with elevated PTSS and other mental health problems in Boston youth (see Comer et al.²²)—marked the beginning of a highly intense week for Boston-area families marked by a weeklong shutdown of transportation and large regions of the city, a very heavy local and federal law enforcement presence, an armed carjacking, the ambushing and killing of an officer, a large-scale interagency manhunt, an emergency shelter-in-place warning, and violent confrontations between the suspects and authorities in residential neighborhoods. Moreover,

the events marked one of the most memorable multiday breaking news spectacles in modern times, with children sampled in one study reportedly consuming roughly 1.5 hours of bombing-related television news coverage on the day of the Marathon, and 21% watched >3 hours of such coverage on the day of the Marathon.²² Accordingly, very large numbers of youth in the region experienced similar extreme events in a short period time—some of which were *DSM-5* QTEs and many were not. However, the extent to which many of these *DSM-5* Non-QTEs may account for PTSS in youth is unclear.

The present study evaluated the revised *DSM-5* definition of QTEs among Boston-area youth following the Marathon bombing by examining the contributions of *DSM-5* Non-QTEs in the prediction of youth PTSS, after accounting for the contributions of *DSM-5* QTEs. Analyses further examined whether age moderated the effects of QTEs and Non-QTEs on child outcomes.

Methods

Participants and Procedures

The Boston University IRB approved study procedures. English-speaking primary caregivers of youth between 4–19 years residing within 25 miles of the bombing site and/or the final manhunt apprehension site in Watertown were recruited 2–6 months post event. Investigators recruited participants from a broad range of school-, pediatrician-, and community settings, at a few Boston Strong rallies, and through media-based outreach. Caregiver reports were collected across participants (rather than youth reports for adolescents) so that age-related differences could not be attributable to differences in assessment methodology or varying informant perspectives. Caregivers reported their family's experiences during the week of the bombing and their child's PTSS and functioning in the interim. Those with multiple children were asked to report on their oldest child in the study age range in order to create an easy to follow and systematic selection rule for caregivers and to prevent any confounding selection bias (e.g., caregivers selecting child to report on based on exposure or symptom severity). The age of participating youth spanned the full recruitment range, from 4–19 years of age (see Table 1 for further details).

Interested area residents contacted study staff or visited a website to confirm eligibility. Of 1,105 caregivers expressing interest, 461 (41.7%) completed the survey. After providing informed consent, caregivers completed a survey through a secure browser-based data collection program using server authentication and data encryption (~45 minutes). On average, participating caregivers completed surveys 3.44 months post attack (SD=1.0). Participants were compensated \$30 for their time, and were given the option to donate their compensation directly to the One Fund Boston. The mean age of caregiver participants was 43.8 years (SD=7.8). Table 1 presents sample characteristics; full details are provided elsewhere.²²

Measures

Child PTSS—The *UCLA-PTSD-Reaction Index (PTSD-RI)*, *Parent Report* was used to assess youth PTSS. The PTSD-RI is the most commonly used post-disaster PTSD

assessment for youth,²³ and has demonstrated strong reliability and convergent validity²⁴ (Cronbach's $\alpha=.95$ in present sample). Total scores provide a continuous indicator of children's PTSS.

Bombing/manhunt-related QTEs—In accordance with the *DSM-5* QTE definition, investigators assessed whether children directly experienced actual or threatened death/serious injury (A1), witnessed, in person, actual or threatened death/serious injury occurring to others (A2), or learned that actual or threatened death/serious injury occurred to a close family member or friend in a violent or accidental manner (A3; note: A4 experiences apply to individuals in high-risk professions and were not presently assessed). Specifically, caregivers reported whether their child experienced any of the 13 QTEs included in Table 2. As in the *DSM-5* PTSD definition, a child was considered to have experienced a QTE if any event was endorsed. Thus, QTEs were coded as a dichotomous variable indicating whether the child experienced any QTEs or not.

Bombing/manhunt-related Non-QSEs—Similarly, caregivers reported whether their child experienced any of the 13 Non-QSEs in Table 2. For consistency with the *DSM-5* dichotomous approach to assessing the presence/absence of QTEs, a child was considered to have been exposed to a Non-QSE if their caregiver endorsed any one of these experiences.

Analyses

A hierarchical multiple regression was conducted in the prediction of PTSS. Given the *DSM-5* age distinction in PTSD for child ages 6 and below, child age was coded dichotomously identifying youth as over six or six and younger. This categorical representation of age was used throughout analyses except where stated otherwise. Demographic factors potentially related to PTSS^{16,25} (i.e., child age, household income, and race/ethnicity) and caregiver reporting (i.e., maternal education) were entered as covariates in Step 1 to examine the main and interacting effects of the variables of interest and rule out associations that may be due to confounding factors. The variable representing presence/absence of *DSM-5* QTEs was added in Step 2 to evaluate the predictive contribution of Criterion A QTEs, and the variable representing the presence/absence of *DSM-5* Non-QSEs was added in Step 3 to evaluate the incremental predictive contribution of non-qualifying stressful experiences on outcomes. In a final step, product terms representing the interactions of (1) age and QTEs, and (2) age and Non-QSEs were added to evaluate potential moderating effects of age on relationships between experienced events and clinical outcomes. Predictors were mean centered. Post-hoc analyses further probed significant interactions. Additionally, among those who did not experience any QTEs ($N=380$) an independent samples *t*-test examined PTSS differences in youth who experienced Non-QSEs versus those who did not.

Results

Preliminary findings

Seven of the 461 were missing data regarding child age, and were excluded from these analyses. Table 1 presents descriptive information across variables. Of participating

caregivers, 43.0% ($N=195$, $n_{6\text{years}}=27$, $n_{>6\text{years}}=168$) finished the survey 2 months post attack, 30.2% ($N=137$, $n_{6\text{years}}=17$, $n_{>6\text{years}}=120$) at 3 months, 18.1% ($N=82$, $n_{6\text{years}}=8$, $n_{>6\text{years}}=74$) at 4 months, 8.4% ($N=38$, $n_{6\text{years}}=11$, $n_{>6\text{years}}=27$) at 5 months, and 0.4% ($N=2$, $n_{6\text{years}}=0$, $n_{>6\text{years}}=2$) at 6 months. Participation timing was not related to total PTSS ($r=0.05$, $p=0.30$). Roughly one-fifth of Boston-area youth sampled experienced a QTE, whereas a majority of sampled youth experienced a Non-QSE. Of youth who did not experience a QTE, 91% ($N=346$) experienced a Non-QSE. Experiencing a QTE was not significantly associated with any demographic covariates. Experiencing a Non-QSE demonstrated small but significant correlations with child race/ethnicity (minority youth were more likely to have experienced a Non-QSE $r=0.09$, $p<.05$), and child age, such that older youth were more likely to have experienced a Non-QSE ($r=0.11$, $p<.05$).

Predicting youth PTS

In predicting *UCLA PTSD-RI* scores, the four covariates in Step 1 provided a significant predictive contribution, $F(4, 446)=5.974$, $p<.001$, $R^2=0.051$. Experiencing a QTE accounted for significant additional variance [$F(5, 445)=30.31$, $p<.001$, $R^2=0.25$, $F(1, 445)=121.22$, $p<.001$, $R^2=0.203$], accounting for roughly 20% of the variance in child PTSS (see Table 3). In contrast, experiencing a Non-QSEs did not account for any additional variance in Step 3, $F(1, 444)=1.668$, $p=0.20$, $R^2=0.003$. The addition of the interaction terms of age and QTEs and Non-QTEs in Step 4, however, did add significant predictive contributions, $F(8, 442)=21.38$, $p<.001$, $F(2, 442)=6.796$, $p<0.01$, $R^2=0.022$, accounting for 2% of variance in child PTSS. Specifically, while there was not a significant interaction effect of child age groups and Non-QSEs on PTSS, the interaction of child age groups and QTEs was significantly associated with PTSS scores, demonstrating a significant difference in the relationship between QTEs and PTSS as a function of child age. Post-hoc probing showed that the positive relationship between QTEs and PTSS was significantly stronger in older youth ($B=14.08$, $SE=1.245$, $\beta=0.492$, $t=11.32$, $p<.001$) than in younger children ($B=0.220$, $SE=2.993$, $\beta=0.010$, $t=0.074$, $p=.94$), supporting the qualitative DSM-5 age cutoff at 6 years. Further analyses did not find this effect when using a continuous variable for age ($B=0.16$, $SE=0.31$, $\beta=0.02$, $t=0.51$, $p=.61$).

Non-QSEs in the Absence of QTEs

An independent samples *t*-test revealed that among youth who did not experience a QTE, those who were exposed to Non-QSEs presented with significantly higher PTSD symptoms than those who were not, $t(378)=2.36$, $p<.05$.

Discussion

This study offers the first empirical evaluation of the utility of the *DSM-5* revised definition of PTSD QTEs in a large youth sample following a stressful event that overwhelmed an entire community. Experiencing *DSM-5* QTEs predicted child PTSS, whereas *DSM-5* Non-QSEs did not add to the prediction of PTSS, lending support to the current revised definition of *DSM-5* QTEs. Moreover, moderator analyses found that whereas experiencing QTEs was positively related to higher PTSS among older youth (>6 years old), the relationship was not

significant among younger (6 years old) children, providing preliminary evidence to support the *DSM-5* introduction of separate criteria for children below the age of 6.

At the same time, findings demonstrate that in the absence of QTEs, youth who experience Non-QSEs can exhibit greater PTSS than those who have not. These results point to the potential need to expand the current boundaries of QTEs for youth populations to ensure that youth experiencing considerable PTSS following a Non-QSE are not precluded from a needed diagnosis and associated services. Thus, while the present work supports the revised *DSM-5* definition of a qualifying traumatic exposure at a nomothetic level following community trauma, it also highlights the vulnerability of individual youth not directly exposed to qualifying traumatic events who may nonetheless exhibit elevated PTSS. Indeed, continued evaluations of QTE definitional boundaries across child development (and the effects of these boundaries on PTSD caseness) are needed in order to best serve affected youth.

The optimal approach to defining a QTE when diagnosing PTSD has been a source of continued debate.⁵ Though the *DSM-5* now offers a clearer and more exclusive definition of what qualifies as a traumatic exposure, current results add to previous literature that similarly underscores the need for additional research regarding trauma in early childhood.¹⁶ For example, whereas the experience most related to high-perceived life threat in relation to an extreme event may seem clear (e.g., the moment the event occurs), many children identify the “worst or most frightening moment” of highly stressful events as the subsequent disclosure of those events, or observation of parental distress related to the events.²⁶

Taken together, the present findings demonstrate (1) general support for the revised *DSM-5* definitional boundaries of traumatic exposure with regard to youth PTSS following community trauma in older youth; (2) the potential need for a revised definition of QTEs for youth ages 6 and below; and (3) the importance of examining the potential impact of Non-QSEs of traumatic events on youth when QTE exposure is absent.

Limitations

Several limitations warrant comment. First, we employed a parallel assessment methodology across participants so that age-related differences could not be attributed to methodological differences. Accordingly, reports on child symptoms were only collected from caregivers. Previous research has demonstrated poor parent-child agreement in the reporting of PTSS and related internalizing symptoms,^{27,28} and future work would do well to incorporate child reports, observations, and structured interview methods. That said, literature supporting the validity of PTSS parent-reports¹⁶ somewhat tempers concerns regarding reliance on caregiver reports. Moreover, given that youth rarely self-refer for services and it is caregiver reports that most commonly inform treatment decisions, we were explicitly interested in caregiver reports of child exposure and symptoms. Second, population-based sampling was not applied, and thus results may not generalize to the larger population. Concerns about the sample’s representativeness are somewhat tempered given that the sample’s demographic composition was roughly comparable to the demographic composition of those areas most affected (e.g., 84.9% and 74.9% of residents of Watertown and Back Bay, respectively, are Caucasian; 55.6% and 51.3% of families in Watertown and Back Bay, respectively, earn <

\$100,000 annually). Beyond demographic composition, however, it is possible that participants who completed the survey may have been more affected by the bombing than those who did not. Third, the response rate was only 42%, however this is consistent with response rates reported in other studies of post-disaster communities^{29,30} and may reflect intrinsic difficulties recruiting families after community traumas. Nonetheless, because we did not collect information about individuals who did not consent and participate, nor did we collect information regarding why individuals declined to participate, differences between participants and non-participants could not be assessed. Fourth, the current cross-sectional design cannot speak to prospective changes, nor can it speak to temporal relationships between study variables. Future work utilizing longitudinal designs is needed. Fifth, a coding error during survey development precluded our ability to collect data on child gender, rendering it not possible to evaluate differential relationships across boys and girls. Future work in this area should evaluate whether girls show more PTSD symptoms than boys following non-QSEs. Sixth, caregivers were systematically instructed to complete reports about their oldest child within the study age range in order to prevent the introduction of any selection biases based on child exposure or symptom severity. However, using random selection to determine which child for caregivers to report on would have been a more rigorous way to eliminate extraneous sources of bias.

Seventh, because the bombing occurred prior to the release of the *DSM-5*, the measure used to evaluate PTSS was developed for *DSM-IV* criteria. Although there are not many differences between the *DSM-IV* and *DSM-5* versions of the *UCLA-PTSD-RI*, we only evaluated relationships between stressful events and PTSS (assessed cumulatively and continuously), rather than evaluating relationships between stressful events and formal diagnosis of *DSM-5* PTSD. Future work is needed to evaluate relationships between stressful events and formally diagnosed PTSD, as present findings predicting PTSS may not hold in the prediction of diagnosed PTSD. Similarly, prior mental health and/or trauma exposure were not assessed. Future research incorporating pre-event histories is needed to further elucidate subgroups most vulnerable to the impact of QTEs and Non-QSEs on youth PTSS. Seventh, although there was no evidence of a dissolution effect of non-QSEs on symptoms across the 4-month study period, it is possible that non-QSEs did exert an effect on symptoms that offset prior to 2-months post-event (when data collection began).

Finally, these analyses use PTSS as the outcome of interest. Recent studies, however, link disaster exposure to a diverse range of child mental health problems.^{22,31–34} Although youth PTSS is currently the most commonly studied outcome,³⁵ past literature also indicates that the expression of reaction to trauma in youth, not just the definition of trauma itself, may vary across development.¹⁶ Thus, while the present study contributes to an improved understanding of QTEs and their associations with PTSS as traditionally defined, we did not examine relationships between QTEs and Non-QSEs with other developmentally relevant sequelae of traumatic exposure and acute stressors. Future research should more closely examine child difficulties beyond PTSS in pursuit of developmentally sensitive characterizations of responses to acute stressors and traumatic exposure.

Conclusions and Future Directions

Despite limitations, these findings offer important data supporting the general utility of the *DSM-5* revised definition of QTEs in a large sample of youth affected by community trauma, and highlight the need for continued work examining the developmental appropriateness of the definitional boundaries of QTEs for youth ages 6 and below. Despite serious concerns about several recent revisions to DSM definitions of various child internalizing disorders^{36,37}; present findings suggest that the revised *DSM-5* definition of QTEs may yield meaningful boundaries of traumatic exposure with predictive utility for youth populations ages 7 and over.

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Table 1

Sociodemographic and clinical characteristics across Boston-area youth sampled after the Boston Marathon bombing and manhunt (N=460)

	M	SD	N	%
Child age, years	11.1	3.8		
6 years			63	13.7
7–11 years			191	41.4
12–16 years			154	33.4
17–19 years			46	10.0
Race/ethnicity				
Non-Hispanic White			374	81.3
Ethnic/racial minority			86	18.7
Annual household income				
\$100K			245	53.3
< \$100K			215	46.7
Caregiver education				
Completed college			374	81.3
Did not complete college			86	18.7
Experienced a DSM-5 QTE ¹			80	17.4
Experienced a DSM-5 Non-QSE ¹			426	92.4
Youth posttraumatic stress symptoms ²	8.2	10.6		
Total youth difficulties ³	7.8	5.9		

¹Qualifying traumatic event = QTE; Non-qualifying stressful event = Non-QSE

²Assessed via the UCLA PTSD Reaction Index (RI), Parent Report Symptom Scale

³Assessed via the Strengths and Difficulties Questionnaire-Total Difficulties Scale

Table 2

Exposure to qualifying traumatic events (QTEs) and non-qualifying stressful events (Non-QSEs) during the Boston Marathon bombing and manhunt that were presently assessed

<i>DSM-5 QTE^{1,2}</i>		<i>DSM-5 Non-QSEs³</i>	
1	Injured in bombing (A1)	1	Directly saw law enforcement activities immediately post-bombing
2	Evacuated from blast site at finish line (A1)	2	Saw immediate televised news coverage of bombing
3	Heard gunshots and/or the explosions outside home related to manhunt (A1)	3	Consumed immediate online news coverage of bombing
4	Saw the gunfire and/or explosions outside home related to manhunt (A1)	4	Was unable to successfully contact family/friends to confirm their safety in first hour post-bombing
5	Directly saw someone at blast killed by the bombing (not on TV/Internet; A2)	5	Was worried for first hour post-bombing of harm befalling a loved one
6	Directly saw someone at the blast injured by bombing (not on TV/Internet; A2)	6	Saw a much heavier police presence in the Boston area during the week post-attack
7	Directly saw people at blast running in panic from bomb site (not on TV/Internet; A2)	7	Saw a much heavier police presence in their neighborhood during the week post-attack
8	Directly saw medical personnel attending to someone injured in blast (not on TV/Internet; A2)	8	Saw uniformed servicemen/women or federal authorities not typically found in the area (e.g., National Guard, F.B.I, S.W.A.T., A.T.F., Homeland Security)
9	Directly saw blood related to manhunt (not on TV/Internet, A2)	9	Heard heavy siren activity related to manhunt
10	Has parent or sibling injured in bombing (A3)	10	Saw officers with guns drawn related to manhunt
11	Had relative or friend killed in bombing (A3)	11	Had officers knock on their door for manhunt-related activity
12	Was relative of M.I.T. officer slain during manhunt (A3)	12	Had officers enter/search their home as part of manhunt
13	Was relative of transit officer injured in manhunt (A3)	13	Heard helicopters overhead related to manhunt

¹QTE= Qualifying traumatic event

²Corresponding *DSM-5* Criterion A item in parentheses

³Non-QSE=Non-qualifying stressful event

Table 3

Details of hierarchical regressions examining the contributions of DSM-5 QTEs and DSM-5 Non-QSEs—and the moderating effects of age—in predicting child PTSD symptoms.

	<i>B</i>	<i>SE(B)</i>	β	<i>t</i>
Model 1: Predicting UCLA-PTSD-RI Total Scores				
Step 2 ¹				
<i>DSM-5</i> QTE	12.77	1.16	0.45	11.01***
Step 3 ¹				
<i>DSM-5</i> Non-QSE	2.21	1.71	0.05	1.29
Step 4 ¹				
<i>DSM-5</i> QTE $\times$ Child age ²	14.50	3.93	0.16	3.69***
<i>DSM-5</i> Non-QSE $\times$ Child age ²	-2.27	3.91	-0.03	-0.58

Note: Step 1 included the following demographic covariates as predictors: child age (coded dichotomously as 6 and below versus 7 and above), household income, maternal education, and race/ethnicity (data not shown)

¹Steps 2–4 also includes the following demographic covariates as predictors: child age, household income, maternal education, and race/ethnicity (data not shown)

²Age coded dichotomously as 6 and below versus 7 and above in the creation of interaction terms to reflect *DSM-5* age distinctions

*
 $p < .05$,

 $p < .001$