

# Validity Testing of Cameron Trauma Assessment: PTSD Assessment for Veterans

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## Abstract

The purpose of this study was to validate the Cameron Trauma Assessment (CTA), a culturally adapted version of the PTSD Checklist for DSM-5 (PCL-5) designed to improve diagnostic accuracy among U.S. military Veterans. The CTA integrates a structured Criterion A interview with cultural coding (C = Culturally Normative, T = Traumatic, CT = Combined) to distinguish between normative military conditioning and trauma exposure. A total of 372 Veterans completed both the CTA and the PCL-5 in counterbalanced order. Correlation and invariance analyses evaluated item, cluster, and total-scale convergence. Results indicated strong item-level correlations ( $M r = 0.83$ ), high cluster-level equivalence ( $r = 0.86 - 0.91$ ), and excellent total-scale agreement ( $r = 0.94$ , ICC = 0.92). A small negative bias on Bland-Altman analysis ( $M \text{ diff} = >0.82$ ) suggested that cultural coding reduced false-positive symptom inflation. Confirmatory factor analyses supported measurement invariance across instruments ( $\Delta CFI \leq 0.008$ ,  $\Delta RMSEA \leq 0.01$ ). Findings support the CTA as a psychometrically sound, culturally competent assessment that maintains the DSM-5 PTSD construct while enhancing contextual precision for Veteran populations.

## Keywords

PTSD, Veterans, Cultural Competence, PCL-5, Psychometric Validation, Military Psychology, PTSD, VA

## 1. Introduction

Post-traumatic stress disorder (PTSD) remains one of the most prevalent and debilitating conditions among military Service Members and Veterans. Despite decades of research and numerous evidence-based treatments, rates of misdiagnosis, underdiagnosis, and treatment resistance remain disproportionately high within Veteran populations (Department of Veterans Affairs, 2023). A growing body of

research suggests that one contributing factor is the lack of cultural competence in both assessment and intervention approaches (Cameron, 2023; Ginzburg, 2023). Standard diagnostic measures, while psychometrically strong in civilian samples, often fail to account for the unique cultural context of military service, where exposure to training to prepare for life-threatening situations, hyper-vigilance, and changes in social dynamics can occur as part of normative occupational training.

The American Psychological Association (APA) defines the elements of cultural competence in relation to assessment and diagnosis. According to the APA, assessments must be culturally relevant and valid for the populations being tested. Providers are required to use instruments with established validity and reliability for the group being assessed and consider linguistic and cultural differences to avoid biased interpretations (American Psychological Association, 1990). The DSM-5-TR identifies that culturally normative behaviors cannot be used as criteria elements for diagnosing mental health disorders (American Psychiatric Association, 2022).

The PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) is the most widely used self-report measure of PTSD symptoms. It has demonstrated high internal consistency, convergent validity, and diagnostic utility across a range of populations. However, its reliance on self-report without contextual evaluation can lead to inflated symptom endorsement in Veterans and Service Members who interpret combat readiness, cultural normative behaviors, and military service-related conditioned responses as “traumatic”. This gap highlights the need for a culturally contextualized measure that differentiates between normative conditioning and pathological trauma within the Service Member and Veteran experience.

The Cameron Trauma Assessment (CTA) was developed to address this limitation. Adapted directly from the PCL-5 and Life Events Checklist (LEC-5), the CTA introduces two major innovations: (1) an integrated Criterion A clinical interview to classify exposures as C (culturally normative), T (traumatic), or CT (combined), and (2) additional culturally anchored items capturing moral injury, identity conflict, and reintegration stress. This design operationalizes military culture as a moderating variable in trauma assessment, allowing clinicians to discern when PTSD symptoms arise from maladaptive responses versus adaptive conditioning.

The current study sought to validate the CTA by comparing it directly to the PCL-5. It was hypothesized that (a) CTA item, cluster, and total scores would correlate strongly with PCL-5 equivalents, demonstrating construct equivalence; (b) overall CTA scores would be slightly lower due to exclusion of culturally normative responses, reflecting improved diagnostic specificity; and (c) the latent factor structure would demonstrate measurement invariance across instruments, confirming structural validity. By establishing psychometric and structural equivalence while introducing cultural refinement, the CTA aims to provide a clinically superior and culturally competent alternative for assessing PTSD in military and Veteran populations.

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## 2. Review of Related Literature

### 2.1. PTSD assessment in Veteran populations

Posttraumatic stress disorder (PTSD) remains one of the most prevalent and complex mental health conditions affecting military Veterans. Since its formal recognition, the diagnosis has evolved substantially, most recently in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; *American Psychiatric Association [APA], 2013*) and its text revision (DSM-5-TR; *APA, 2022*). The DSM-5 established four core symptom clusters—intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity, requiring exposure to a qualifying traumatic event (Criterion A). This framework continues to guide both research and clinical practice.

Despite the robustness of this model, researchers have repeatedly observed that traditional PTSD assessments developed in civilian contexts do not adequately account for the unique cultural characteristics of military service. In particular, behaviors that are adaptive or normative in combat environments—such as vigilance, emotional regulation, or compartmentalization—are often misinterpreted as pathological symptoms when Veterans transition to civilian life (*Cameron, 2023*). This lack of cultural competence has been linked to misdiagnosis, overpathologizing, and treatment resistance among Veterans (*Department of Veterans Affairs [VA], 2023*).

### 2.2. Established Measures: PCL-5, LEC-5, and CAPS-5

The PTSD Checklist for DSM-5 (PCL-5) is among the most widely used self-report measures of PTSD symptoms. It contains 20 items corresponding to DSM-5 criteria and has demonstrated excellent internal consistency ( $\alpha \approx 0.94$ ) and convergent validity across both clinical and non-clinical populations (*Blevins et al., 2015; Bovin et al., 2016*). The PCL-5's widespread adoption within VA and Department of Defense systems has standardized PTSD assessment, but it relies solely on self-report, which can inflate scores when respondents interpret culturally normative military conditioning as trauma exposure.

Complementary to the PCL-5, the Life Events Checklist for DSM-5 (LEC-5) screens for potentially traumatic events that can be linked to specific PTSD symptoms (*Department of Veterans Affairs, 2018*). However, it does not differentiate between traumatic and culturally normative exposures common to military occupations. The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), considered the gold-standard structured interview, provides diagnostic confirmation and allows exploration of Criterion A exposures in detail (*Weathers et al., 2018*). Collectively, these measures provide the empirical and diagnostic foundation for PTSD assessment but remain limited in cultural specificity for Veteran populations.

### 2.3. Factor Structure and Measurement Invariance

A large body of research has examined the latent structure of PTSD symptom

measures. Confirmatory factor analyses have generally supported the four-factor DSM-5 model, although several studies have proposed alternative six- or seven-factor hybrid models to better capture symptom complexity (Blevins et al., 2015; Soberón et al., 2016). Cross-cultural measurement invariance studies demonstrate that while the PCL-5 performs consistently across languages and populations, subtle variations can emerge due to cultural interpretations of distress (Bockhop et al., 2022; Krüger-Gottschalk et al., 2017). These findings underscore the necessity of testing invariance when adapting assessments for specific cultural groups such as Veterans—a central rationale for validating the CTA.

#### **2.4. Cultural Competence, Moral Injury, and Military Identity**

Emerging research highlights moral injury as a distinct but overlapping construct with PTSD, characterized by guilt, shame, and spiritual conflict resulting from transgressions of deeply held moral beliefs (Litz et al., 2009; Nash et al., 2013). Standard PTSD measures rarely assess moral injury or identity conflict directly, leaving a critical gap in understanding Veteran distress. The integration of such culturally grounded constructs into assessment aligns with calls for structural competency, which advocates for addressing systemic and cultural factors that shape mental health outcomes (Metzl & Hansen, 2014).

Veteran culture represents a unique sociocultural system with its own norms, language, and behavioral codes (Cameron, 2023). Failure to recognize these norms can lead to diagnostic inaccuracy and disengagement from care. Consequently, culturally competent instruments must differentiate between adaptive occupational conditioning and pathological stress responses—a distinction the Cameron Trauma Assessment (CTA) seeks to operationalize through its Criterion A coding system (C = Culturally Normative, T = Traumatic, CT = Combined).

#### **2.5. Content Validity and Expert Review**

Psychometric best practices emphasize the importance of establishing content validity during the development of new instruments. The Content Validity Index (CVI), along with the modified kappa statistic, provides a standardized method for quantifying expert agreement regarding item relevance and clarity (Polit & Beck, 2006; Zamanzadeh et al., 2015). Values of I-CVI  $\geq 0.78$  and S-CVI  $\geq 0.90$  are generally considered evidence of strong content validity. The CTA development process incorporates structured expert review consistent with these standards, ensuring that each item reflects both the theoretical PTSD construct and the lived experience of military culture.

#### **2.6. Criterion Validity and Diagnostic Accuracy**

The final step in validating a novel measure involves evaluating criterion validity, or the degree to which test scores correspond to an external diagnostic standard (Shrout & Fleiss, 1979). For PTSD assessments, the CAPS-5 remains the benchmark for establishing concurrent validity (Weathers et al., 2018). Statistical pro-

cedures such as point-biserial correlations, logistic regression, and receiver operating characteristic (ROC) curve analyses are recommended to assess alignment between self-report measures and clinician diagnoses (Chen, 2007). Past research using the PCL-5 has shown excellent diagnostic accuracy (area under the curve  $\geq 0.85$ ), with optimal cutoffs ranging from 31 to 33 in Veteran samples (Bovin et al., 2016). The CTA validation process extends these analyses to determine whether culturally informed scoring improves diagnostic precision and reduces false positives associated with normative training experiences.

### 2.7. Summary

The existing literature establishes a strong foundation for the psychometric validation of PTSD assessments but reveals clear cultural limitations when applied to Veteran populations. Integrating military cultural context, moral injury, and Criterion A coding represents a necessary evolution of PTSD measurement. The Cameron Trauma Assessment (CTA) addresses these gaps by embedding cultural competence directly into its structure while maintaining psychometric rigor through alignment with the DSM-5 model and established validation procedures.

## 3. Methodology

The study utilized an archival data set from an online quasi-experimental study on Veteran Cultural Competency conducted by Anchor Therapy Clinic titled “Healing Our Heroes” in Sacramento, California (Cameron, 2023). In addition to demographics, a key element of the study evaluated common and uncommon clinical assessments assessing PTSD in Veterans (PCL-5 and CTA) to identify cultural disparities affecting the Veteran and military populations. Military Service Member was operationally defined as an individual currently serving as a member of the Armed Forces in an Active, Reserve, or National Guard component. Veterans were operationally defined as a former member of the Armed Forces possessing a discharge or DD-214 (Cameron, 2023).

### 3.1. Subjects

Veterans were recruited from community Veteran organizations, outpatient mental-health clinics, and online Veteran support networks. Eligibility criteria included (a) being a U.S. Veteran with a DD-214, (b) a verifiable diagnosis of PTSD, and (c) English literacy sufficient to complete self-report questionnaires. Exclusion criteria included active psychosis, cognitive impairment precluding informed consent, or acute psychiatric crisis requiring immediate intervention. From the respondents, the final sample was randomly assigned, consisting of 372 participants. Military Service Member was operationally defined as an individual currently serving as a member of the Armed Forces in an Active, Reserve, or National Guard component. Veterans were operationally defined as a former member of the Armed Forces possessing a discharge or DD-214 (Cameron, 2023). Diagnosis of PTSD was verified by individuals having received a Veterans Disability Com-

pensation rating for PTSD.

The sample represented a diverse cross-section of services Army ( $n = 171$ , 45.9%), Navy ( $n = 74$ , 19.9%), Air Force ( $n = 63$ , 16.9%), Marine Corps ( $n = 52$ , 13.9%), Coast Guard ( $n = 11$ , 2.9%), Space Force ( $n = 1$ , 0.002%). Participants ranged in age from 22 to 74 years ( $M = 42.6$ ,  $SD = 11.9$ ); 78% identified as male and 22% as female. Approximately 61% reported at least one combat deployment, and 48% had previously received mental-health treatment through either the Department of Veterans Affairs or private care.

Power analysis for confirmatory factor analysis (CFA) was conducted a priori using the ratio of 15 participants per estimated parameter, indicating that  $n \geq 360$  was adequate for testing measurement invariance across instruments.

### 3.2. Measures

#### Cameron Trauma Assessment (CTA)

The Cameron Trauma Assessment (CTA) is a culturally adapted measure of post-traumatic stress symptoms developed from the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) and the Life Events Checklist for DSM-5 (LEC-5; Weathers et al., 2013). The CTA incorporates three integrated components: a Criterion A Exposure Screen with cultural coding, a symptom checklist aligned with DSM-5 clusters, and a scoring structure that differentiates cultural and traumatic responses. The CTA was developed when it was identified that Military Service Members who have completed their initial training (Basic Combat Training) could receive a false positive result on the PCL-5 without experiencing traumatic events due to the cultural insensitivity of the measure (Cameron, 2023).

#### PTSD Checklist for DSM-5 (PCL-5)

The PCL-5 (Weathers et al., 2013) is a 20-item self-report measure of PTSD symptoms consistent with DSM-5 criteria. Respondents rate symptom severity over the past month on a 5-point Likert scale (0 = Not at all to 4 = Extremely). It has well-established psychometric properties, including internal consistency ( $\alpha \approx 0.94$ ) and convergent validity with clinician-administered measures.

#### Procedure

After informed consent, participants completed demographic measures, the CTA, and the PCL-5 in counterbalanced order. For the CTA, clinicians coded each exposure as C (Culturally Normative), T (Traumatic), or CT (Combined). Assessments were completed in 45 - 60 minutes, and data was deidentified for security.

### 3.3. Data Analysis

Data analysis was conducted using IBM's Statistical Package for the Social Sciences (SPSS) to identify demographic information about the sample, trends in response categories. Pearson correlations examined item, cluster, and total-score overlap. Intraclass correlations [ICC (2,1)] assessed absolute agreement, and Bland-Altman plots tested bias. Multi-group confirmatory factor analyses (CFA) tested

configural, metric, and scalar invariance, with  $\Delta\text{CFI} \leq 0.010$  and  $\Delta\text{RMSEA} \leq 0.015$  indicating invariance.

## 4. Results

### 4.1. Construct Validity

Results indicated strong item-level correlations ( $r = 0.72 - 0.91$ ,  $M = 0.83$ ,  $SD = 0.05$ ; all  $p < 0.001$ ). Cluster-level equivalence was high across DSM-5 domains (B: 0.90; C: 0.86; D: 0.88; E: 0.91). Total-scale correlation was  $r = 0.94$ ,  $\text{ICC} (2,1) = 0.92$ . Bland-Altman analysis showed a small mean difference ( $-0.82$ ), suggesting reduced false positives. Confirmatory factor analyses supported configural, metric, and scalar invariance ( $\Delta\text{CFI} \leq 0.008$ ,  $\Delta\text{RMSEA} \leq 0.010$ ).

### 4.2. Construct Overlap between the CTA and PCL-5

To evaluate conceptual equivalence between the Cameron Trauma Assessment (CTA) and the PTSD Checklist for DSM-5 (PCL-5), item-level, cluster-level, and total-scale correlations were examined in a sample of 372 Veterans. Descriptive statistics for each item and cluster were comparable across instruments (CTA  $M = 33.21$ ,  $SD = 14.9$ ; PCL-5  $M = 34.02$ ,  $SD = 15.2$ ). Correlation and Agreement Between CTA and PCL-5 Scores can be found in **Table 1**.

**Table 1.** Correlation and agreement between CTA and PCL-5 scores ( $n = 372$ ).

Level	Correlation and Agreement Between CTA and PCL-5 Scores				
	Variable(s)	r	ICC (2,1)	95% CI	p
Item Mean	18 paired items	0.83	—	—	<0.001
Cluster B	Intrusion	0.90	—	—	<0.001
Cluster C	Avoidance	0.86	—	—	<0.001
Cluster D	Neg. Cognition/Mood	0.88	—	—	<0.001
Cluster E	Arousal/Reactivity	0.91	—	—	<0.001
Total	Total Severity	0.94	0.92	0.90 - 0.94	<0.001

Note: Bland-Altman mean difference =  $-0.82$ ; 95% limits of agreement =  $[-7.2, 5.5]$ .

#### Item-Level Associations

Correlations between matched CTA and PCL-5 items were uniformly strong ( $r = 0.72 - 0.91$ ,  $M = 0.83$ ,  $SD = 0.05$ ; all  $p < 0.001$ ), indicating that the Veteran-adapted wording preserved the symptom content of the original instrument while introducing limited unique variance attributable to cultural phrasing. The lowest overlaps occurred for avoidance items, consistent with greater contextualization in the CTA (e.g., “shutting down or compartmentalizing”).

#### Cluster-Level Correlations

DSM-5 cluster-level scores demonstrated very high associations between instruments: Intrusion (B):  $r = 0.90$ ; Avoidance (C):  $r = 0.86$ ; Negative Cogni-

tions/Mood (D):  $r = 0.88$ ; Arousal (E):  $r = 0.91$  (all  $p < 0.001$ ). These results support structural equivalence across the four major PTSD symptom domains.

#### **Total-Scale Agreement**

The total CTA and PCL-5 scores were strongly correlated,  $r = 0.94$  ( $p < 0.001$ ). The two measures showed excellent absolute agreement,  $ICC(2,1) = 0.92$  (95% CI [0.90, 0.94]), indicating functional interchangeability at the scale level. Bland-Altman analysis revealed a small mean difference of  $-0.82$  points (CTA lower than PCL-5), with limits of agreement from  $-7.2$  to  $+5.5$ . The negative bias suggests that incorporating the C/T/CT trauma-coding procedure slightly reduced overall symptom totals—consistent with the intended reduction of false-positive endorsement from culturally normative training events.

#### **Measurement Invariance**

A multi-group confirmatory factor analysis comparing the DSM-5 four-factor model across instruments demonstrated good fit for both (CTA: CFI = 0.96, RMSEA = 0.045; PCL-5: CFI = 0.97, RMSEA = 0.041). Configural, metric, and scalar invariance were supported ( $\Delta CFI \leq 0.008$ ,  $\Delta RMSEA \leq 0.010$ ), indicating that the underlying factor structure and factor loadings were statistically equivalent between the CTA and PCL-5.

The analysis provides strong evidence of construct and structural validity for the Cameron Trauma Assessment (CTA) along with supporting evidence for content, convergent, and structural validity, and sets the stage for criterion validity in future studies. Across 18 matched items, cluster totals, and overall severity scores, the CTA correlated extremely highly with the established PCL-5 while maintaining equivalent internal structure. The small downward bias in CTA totals, coupled with preserved reliability, supports the measure's goal of enhancing cultural specificity—differentiating between culturally normative combat conditioning and true traumatic exposure. Thus, the CTA appears to measure the same latent PTSD construct as the PCL-5 but with greater contextual accuracy for Veterans. Future validation will test criterion validity against clinician-administered CAPS-5 diagnoses and evaluate whether CTA-derived trauma coding (T/CT vs. C) improves diagnostic efficiency or treatment matching.

## **5. Discussion**

The present study evaluated the psychometric equivalence and cultural precision of the Cameron Trauma Assessment (CTA) in comparison to the PTSD Checklist for DSM-5 (PCL-5). Results demonstrated strong item-, cluster-, and total-scale correlations between the two instruments, indicating that the CTA successfully retained the theoretical structure and diagnostic content of the PCL-5 while introducing meaningful cultural refinements. The CTA's incorporation of a structured Criterion A interview and military-specific cultural coding (C/T/CT) provided a significant improvement in contextual accuracy without compromising psychometric strength. These findings provide strong evidence of construct validity and measurement invariance, confirming that differences in symptom totals

reflect cultural context rather than measurement error.

The small negative bias observed on Bland-Altman analysis (CTA mean < PCL-5 mean) suggests that the CTA effectively differentiates between culturally normative conditioning and pathological trauma responses. This refinement has critical implications for clinical practice. Traditional PTSD assessments often misclassify adaptive military responses—such as hypervigilance, emotional suppression, or operational compartmentalization—as symptomatic of disorder. By integrating cultural coding into the assessment process, the CTA reduces false-positive diagnoses and enhances clinical decision-making accuracy. In practice, this approach may improve treatment planning, reduce unnecessary medicalization, and strengthen trust between Veterans and clinicians.

The improved diagnostic accuracy of the Cameron Trauma Assessment (CTA) has meaningful clinical implications for both treatment planning and Veteran engagement. By distinguishing between culturally normative conditioning and pathological trauma responses, clinicians can more precisely identify the true therapeutic targets rather than pathologizing adaptive military behaviors (Cameron, 2023). This refinement allows providers to tailor interventions to the Veteran's actual needs—such as emphasizing trauma-focused therapies when warranted or prioritizing reintegration and skill-building when distress reflects cultural transition rather than psychopathology. Moreover, when Veterans recognize that their experiences are being interpreted within an authentic military cultural framework, they are more likely to view the assessment process as credible and respectful, enhancing trust, reducing stigma, and promoting sustained engagement in mental-health services (Department of Veterans Affairs, 2023; Metzler & Hansen, 2014).

The CTA advances the broader field of cultural psychopathology by illustrating how culturally embedded frameworks can coexist with established diagnostic models. Rather than replacing the DSM-5 structure, the CTA reinterprets it through a Veteran cultural lens, supporting recent calls for structural competency and contextualized assessment in mental-health research. These results extend Cameron's (2023) conceptualization of Veteran culture as an independent sociocultural system and demonstrate how psychometric adaptation can operationalize cultural competence within evidence-based practice.

Although the results provide strong initial support for the CTA, several limitations should be acknowledged. First, the study relied on self-report data and a primarily a Veteran sample; replication in active-duty populations is recommended. Second, while clinician-rated Criterion A coding enhanced validity, inter-rater reliability for cultural classifications (C/T/CT) should be empirically assessed in future research. Third, the current study established convergent and structural validity; subsequent studies should evaluate predictive validity for treatment outcomes.

Future investigations may also explore the CTA's applicability to first responders and allied cultural groups with comparable occupational conditioning. Addi-

tionally, integrating the CTA into digital assessment platforms or AI-assisted screening systems could enhance accessibility and consistency of cultural coding across clinical settings.

The Cameron Trauma Assessment (CTA) demonstrated strong construct and structural equivalence with the PCL-5 while improving cultural specificity for Veterans. High correlations across items, clusters, and total scores confirmed that the CTA measures the same latent PTSD construct as the PCL-5. By integrating cultural coding, the CTA differentiates adaptive military conditioning from pathological trauma, reducing overdiagnosis and enhancing clinical accuracy.

These findings support the CTA as the first validated culturally competent PTSD measure for Veterans and Service Members. Future studies should extend validation to active-duty personnel, assess inter-rater reliability for Criterion A coding, and examine predictive validity for treatment outcomes.

## 6. Conclusion

The Cameron Trauma Assessment (CTA) provides a culturally informed, empirically validated framework for assessing PTSD in Veterans and Military Service Members. By maintaining alignment with DSM-5 criteria while contextualizing trauma within military culture, the CTA represents a pivotal advancement in culturally competent mental health assessment.

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## Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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