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Commentary on “Evaluating the Validity of DSM-5 Alcohol Use Disorder Diagnostic Criteria in a Sample of Treatment Seeking Native Americans”

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Commentary:

“Evaluating the Validity of DSM-5 Alcohol Use Disorder Diagnostic Criteria in a Sample of Treatment Seeking Native Americans” by Serier and colleagues (2018) is an important contribution not only to our understanding of alcohol use disorders but also as an important milestone in the progress of research on alcohol and other substance use disorders in American Indians.

Serier and colleagues (2018) used confirmatory factor and item response theory analyses to evaluate DSM-5 alcohol use disorder (AUD) symptoms in 79 American Indians seeking treatment for a substance use disorder at a community mental health clinic located on a reservation in the southwestern United States. Seventy-eight participants met criteria for DSM-5 AUD, and 73 met criteria for moderate or severe DSM-5 AUD. As the authors point out, this is the first such study of AUD symptoms in a treatment seeking sample of American Indians. The most striking finding of Serier and colleagues (2018) is that the eleven DSM-5 AUD symptoms in their sample load onto one factor. This finding is consistent with previous studies on DSM-IV AUD symptoms (which are the same as the DSM-5 symptoms with the exception that the legal problems symptom in DSM-IV was replaced by the craving symptom in DSM-5) in an American Indian community sample (Gilder et al., 2011) and an epidemiological sample of the U.S. general population (Saha et al., 2007).

Item response theory analysis of AUD symptoms assesses the severity of each AUD symptom along the underlying AUD severity continuum and how well each symptom “discriminates” AUD from non-AUD at its level of AUD severity. In their item response theory analysis, Serier and colleagues (2018) found that withdrawal, activities given up, much time spent, and craving were the most severe of the 11 AUD symptoms, a finding that

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is consistent with the previous study in American Indians using DSM-IV (Gilder et al., 2011). The older DSM-IV study did not examine craving. It will be of interest if future IRT studies find that craving is a severe symptom in samples from different populations. Serier and colleagues (2018) also point out that knowing a symptom's discrimination and severity may have implications for treatment selection. For example, Community Reinforcement Approach therapy (Meyers and Smith, 1995) may be particularly effective for a sample like theirs where activities given up is among the most discriminating and severe symptoms. An important area for future research is using IRT analysis to identify specific AUD symptom severity and/or discrimination parameters in ways that might be helpful for clinical screening, treatment, and community education and prevention.

The factor analytic findings of Serier and colleagues (2018) and others are consistent with the idea that the AUD syndrome is a single disorder, whether assessed in treatment and non-treatment samples, community and epidemiologic samples, and samples from different ethnicities. Those findings also mean that Euro-Americans and American Indians suffering from AUD are suffering from the same disorder. Understood as a single disorder with a defined clinical course, AUD can also be considered a medical illness, like hypertension, obesity, and diabetes, rather than a character flaw, personality type, or a societal preference. Although this way of viewing alcoholism is common and longstanding in addiction treatment and research professionals, it is not yet so in the wider lay population. If disseminated effectively, the work of Serier and colleagues (2018) and others working with American Indian populations can change how the lay population sees alcoholism and will reduce the stigma associated with AUD not only in the general population but in American Indians themselves. Reducing stigma should also facilitate further efforts at prevention and intervention in American Indian communities.

Identifying effective treatments for American Indians is important because of the high burden of morbidity and mortality that alcohol imposes on some American Indian/Alaska Native communities. (Greenfield, Venner, 2012). The main challenge confronting outside researchers and American Indian communities is how to conjoin Euro-American and American Indian knowledge and practice in ways that generate effective treatments (Venner et al., 2016; Dickerson et al., 2018). A consensus has emerged that a Community Based Participatory Research (CBPR) (Israel et al., 2013; Wallerstein et al., 2018) approach to designing and implementing culturally competent treatment programs (Venner et al., 2008; Venner et al., 2016; Dickerson et al., 2018; Ivanich et al., 2018) is most likely to be successful. CBPR is a mutually collaborative ongoing process that involves the community in all aspects of the design and implementation of the research program. Wherever possible, local tribal members should be involved, both as staff and as leaders of the research program. Dickerson and colleagues (2018) have described ways in which cultural competence can be incorporated into a research program.

This brings us to another important implication of Serier and colleagues' (2018) work: what it says about the progress of research in AUD in American Indian peoples. The last 40 years have seen remarkable advances in understanding AUD in American Indian communities. Without American Indians' willingness to participate in research, these advances would never have been possible. Progress has been due primarily to three factors: changes in

American Indian communities in which members and leaders have decided to become involved in using research for the good of the people (Westermeyer, 2008), the evolution of CBPR as a theory and practice, and the role of federal funding. Funding has come from The Office of Behavioral and Social Sciences Research, National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, and other NIH institutes. Consistent support by the federal government has been critically important to date and will continue to be so going forward. So far, progress in alcoholism research in American Indian communities has mostly been in characterizing the AUD syndrome in terms of clinical course, co-morbidity, risk and protective factors, and the like. This work has laid a solid foundation for research into prevention and treatment. Recently, two groups have demonstrated successful multi-level community programs for prevention of underage drinking in American Indian youth (Komro et al., 2017; Moore et al., 2018), a known risk factor for alcohol related morbidity in adolescence and for developing AUD later in life. We can hope that the work of Serier and colleagues (2018) is a harbinger of a vigorous effort to develop effective clinical treatment programs for AUD in American Indian communities.

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