Addictive Behaviors Reports 4 (2016) 31–36

Contents lists available at ScienceDirect

Addictive Behaviors Reports

journal homepage: www.elsevier.com/locate/abrep

Prospective recovery of cannabis use in a psychotic population: A qualitative analysis

Shane Rebgetz [a,b,*], Leanne Hides [a], David J. Kavanagh [a], Anand Choudhary [b]

[a] School of Psychology & Counselling, Institute of Health & Biomedical Innovation, Queensland University of Technology, Brisbane, Queensland, Australia
[b] Queensland Health, Metro North Hospital and Health Service, Redcliffe-Caboolture Mental Health Service, Queensland, Australia

ARTICLE INFO

Article history:
Received 6 April 2016
Received in revised form 24 June 2016
Accepted 15 July 2016
Available online 17 July 2016

Keywords:
Psychosis
Substance use
Cannabis use
Natural recovery

ABSTRACT

Introduction: There is growing evidence for natural recovery from cannabis use by people with psychosis, but mechanisms underpinning it need further exploration. This study prospectively explored this issue.
Method: Twenty-two people with psychosis and cannabis misuse were recruited: 19 provided data for at least one follow-up assessment, and 13 of these (68%) reduced or ceased using cannabis. A semi-structured interview with the latter group explored reasons for initiating the attempt, strategies they employed, and context/s where any relapse occurred. Interpretative phenomenological analysis was used to identify themes.
Results: Participants who reduced or ceased cannabis use had fewer negative symptoms at Baseline, and were more likely to only use cannabis. Major reasons for starting an attempt were worsening mental health, relationship and lifestyle difficulties. Effective strategies fell into psychological, relationship, lifestyle and medication themes. Only three participants reported a relapse: triggers involved substance-using peers, relationship difficulties, and problems with negative emotions including ones from past trauma.
Conclusions: An encouragingly high rate of maintained reductions in cannabis use was seen. Increased awareness of the benefits across multiple life domains from addressing cannabis use may be critical to the initiation and maintenance of attempts, both to maximise motivation, and avoid over-dependence on improvements in any single domain. Negative symptoms, multiple substance use, dysphoria and pressure from substance-using peers clearly offer additional challenges for control.

1. Introduction

Up to 80% of people with psychosis report cannabis use, which has been associated with a range of adverse psychological, social, and physical health outcomes (Hjorthøj, Fohlmann, & Nordentoft, 2009; van der Meer, Velthorst, & Generic Risk and Outcome of Psychosis (GROUP) Investigators, 2015). Clinical trials of psychological treatments for cannabis use in people with psychosis have not consistently reported better outcomes than control conditions (Hjorthøj et al., 2009; Rebgetz, Kavanagh, & Hides, 2015). This indicates that some people with psychosis cease or reduce using cannabis with little or no related treatment (Childs, McCarthy-Jones, Rowse, & Turpin, 2011; Lobbana et al., 2010). An increased understanding of such 'natural recovery' could be used to strengthen current treatments.

In a recent review, we found people with psychosis had similar reasons for reducing substance use to those reported in the general population (Rebgetz, Kavanagh, et al., 2015). Any differences in these reasons were related to the presence of the psychotic disorder (e.g. symptom exacerbation) and the amplified functional problems (e.g. homelessness) that occur when someone with psychosis also misuses a psychoactive substance. However, only eight studies have examined the subjective experience of ceasing or reducing cannabis among individuals with psychosis (Rebgetz, Hides, Kavanagh, & Choudhary, 2015; Rebgetz, Kavanagh, et al., 2015), and there is little examination of mechanisms underpinning the phenomenon.

Qualitative methods have begun to provide additional insights into the strategies used by this population. Our recent study found that cessation was linked to the individual's awareness of the multiple negative consequences of cannabis use or a more specific motivator (e.g., loss of employment; Rebgetz, Hides, et al., 2015). Maintenance strategies were associated with the awareness of the impact of cannabis use on mental health symptoms, thinking about incentives and support from others. Reasons for relapse were found to be similar to non-psychotic groups including pressure from others, stressful events, coping with cravings and boredom (Rebgetz, Hides, et al., 2015).

The retrospective nature of the qualitative studies that have explored recovery from cannabis use increases the risk of recall bias. The current study prospectively explored factors influencing the decision to cease and maintain cannabis cessation over a 3-month period among people with early psychosis. Change strategies and the relapse

* Corresponding author at: Queensland Health, Locked Mail Bag 3, Caboolture, Queensland 4510, Australia.
E-mail address: shane.rebgetz@health.qld.gov.au (S. Rebgetz).

http://dx.doi.org/10.1016/j.abrep.2016.07.001

context of individuals who ceased and then resumed cannabis use were also explored.

2. Materials and methods

2.1. Participants

Participants were recruited from adult mental health services in the Metro-North Health Service District in Brisbane. They were required to (i) have a current diagnosis of a psychotic disorder (e.g., schizophrenia, schizophreniform disorder, schizoaffective disorder, psychotic disorder NOS); (ii) be in early stages of psychosis (less than three psychotic episodes measured on a Timeline Followback or medical record) and (iii) have used cannabis in the previous 4 weeks. Participants were required to be able to read and speak English without translation. Exclusion criteria were a primary diagnosis of organic psychosis or psychosis due to a general medical condition, intellectual disability, or a developmental or amnestic disorder.

2.2. Data collection

2.2.1. Demographic and clinical data

Demographic and clinical data included gender, age at interview, years of education, employment and relationship status, ethnicity, living arrangement at interview, current diagnosis, medication, family history of mental illness, psychiatric and cannabis treatment history.

2.2.2. Psychosis and symptoms

The Operational Criteria Checklist (OPCRIT; McGuffin, Farmer, & Harvey, 1991) was used to confirm the presence of a current psychotic disorder, based on the medical record. Psychiatric symptoms were monitored using the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962). BPRS positive, negative and depression-anxiety subscale scores were derived at Baseline only (Ventura, Nuechterlein, Subotnik, Gutkind, & Gilbert, 2000). BPRS items that did not require interviewer observation were included in telephone interviews during follow-up.

2.2.3. Cannabis use

Consumption of cannabis and other substances in the preceding 4 weeks was retrospectively assessed using a Timeline Followback (TLFB; Sobell & Sobell, 1992), in which recollections of past events were used to cue recall of substance use. Participants were also given a calendar to mark the days they smoked cannabis over the month between follow-up assessments.

2.2.4. Semi-structured interviews

If participants had ceased or reduced use since the previous assessment (indexed by ≥50% reduction in quantity), they were asked when this occurred, what was happening in their lives, why it occurred, any times it was hard to stay in control and how they did so. If they went back to using, they were asked what was happening and what led them to going back to using. If relapsing participants subsequently attempted to regain control of their cannabis use, the interview protocol included questions about the methods they used to do that. The qualitative interviews lasted approximately 60–70 min long.

2.3. Procedure

Participants were referred to the study by their treating team. The principal service provider gave potential participants oral and written information about the research project and asked if they would like to participate. The lead author then met with the potential participants to obtain informed consent, which included information about the assessment process. At Baseline, demographic data was obtained, and the OPCRIT, BPRS and TLFB were administered. Monthly telephone follow-up assessments were conducted using the BPRS and TLFB. Each participant was provided with a calendar to assist with the completion of the TLFB. They were asked to record days they used cannabis and other substances as well as information on any mental health symptoms they experienced during the month. The qualitative interviews were undertaken during this phone call. Participants were reimbursed $10 at Baseline, $15 at Month 1, $20 at Month 2 and $30 at Month 3. Ethical approval to conduct the study was obtained from the Brisbane Metro South and Queensland University of Technology Human Research Ethics Committees (HREC/12/QPAH/606).

2.4. Design

Participants were assessed at baseline, and attempts were made to follow them up monthly to 3 months. Those who had ceased or reduced their cannabis consumption during the previous month (indexed by ≥50% reduction in quantity from baseline levels) were asked the qualitative questions. Table 1 provides an overview of each participant's cannabis use and participation in qualitative interviews over the course of the study.

2.5. Qualitative analysis

Interviews were transcribed by the first author, and were then analysed using interpretative phenomenological analysis (IPA; Smith & Osborn, 2003). The first interview was reorganised and interpreted to identify preliminary themes and patterns, with a list of representative quotations illustrating each theme compiled. This procedure was repeated for each remaining interview, resulting in the identification of new themes. The identification of themes for each research question was completed separately. To ensure transparency and reliability, all transcripts were reread and coded by at least one other member of the research team. Coding and interpretations of the transcripts were discussed by all authors in detail until consensus was reached on the key themes. This approach allowed inconsistencies to be debated, and themes to be refined (Lobbana et al., 2010). Interconnections between interviews were examined, and a list of master themes constructed. Selection of master themes was based both on the frequency or "representativeness" of specific themes and on the richness of the theme within an individual's account (Smith & Osborn, 2003). Since all authors had training in cognitive behavioural therapy (CBT) and motivational interviewing (MI), potential related biases in the interpretation of responses were discussed.

3. Results

3.1. Participant characteristics

Twenty-two participants consented to take part in the study: 19 of these (86%) provided at least 1 month of follow-up data, and 16 (73%) completed all 3 months of assessments. Five of those who dropped out of the study were lost to contact by the researcher and the health service, and the remaining participant withdrew because of work commitments. There were no demographic or clinical differences between those who completed the study and those who dropped out of the follow-up assessments.

All participants were inpatients at the time of the baseline assessment, and were community patients at each follow-up point. All were prescribed antipsychotic medication while an inpatient, with 16 participants being prescribed paliperidone 100 mg. Only two participants reported receiving any previous cannabis use treatment and all were receiving mental health support. No participants said that they had received substance use treatment during the study, and only one participants file mentioned receiving psychoeducation for psychosis and cannabis use.