



The effect of attitudinal barriers to mental health treatment on cannabis use and mediation through coping motives



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HIGHLIGHTS

- Attitudinal barriers to mental health treatment are related to a high frequency of cannabis use.
- Coping motives fully mediate the above relationship while controlling for mental health symptoms.
- Moderation does not better explain the role of coping motives in this relationship.

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ABSTRACT

Introduction: Cannabis users are at higher risk for any mental disorder than the general population. However, there remains a shortage of research that examines the relationship between reluctance to seek mental health treatment and subsequent frequent cannabis use. This study evaluates whether negative attitudes toward mental health treatment (i.e. attitudinal barriers) predict a high frequency of cannabis use and whether using cannabis to cope with mental health symptoms (i.e., coping motives) explains this relationship.

Methods: Participants were students at Washington State University (WSU) who received violations for illegal cannabis use or possession. Data were collected from participants 60 days after a mandated two-part course for cannabis harm reduction ($n = 98$). A cross-sectional path analysis was performed to assess whether coping motives mediated the relationship between attitudinal barriers to mental health treatment and frequency of cannabis use after controlling for mental health symptoms.

Results: Coping motives fully mediated the relationship between negative attitudes toward treatment and frequency of use (indirect effect: $\beta = 0.087$, bootstrap CI: 0.016–0.541). The direction of results was confirmed by switching the mediator and criterion variable. The model fit well with the data ($\chi^2(2) = 0.367$, $p = 0.83$, RMSEA = 0.00, CFI = 1, SRMR = 0.008).

Conclusions: Reluctance to seek mental health treatment may be related to higher levels of cannabis use through coping motives. Addressing attitudes toward mental health treatment may be an alternative way to decrease frequency of use or possibly promote mental health treatment-seeking behaviors when needed. Further studies are needed to confirm the implications of this finding.

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1. Introduction

Anxiety and depression are two to five times more prevalent among young adults who use cannabis or are cannabis dependent (Patton et al., 2002). Interestingly, young adults (age 15–25) with more psychological distress, compared to those with less distress, have more favorable attitudes toward substance use and are less likely to believe that using a substance to relax is harmful (Yap, Reavley, & Jorm, 2011). However,

using cannabis to cope with symptoms of stress, anxiety, or depression is associated with a higher frequency of use, marijuana-related problems, and cannabis dependence (Fox, Towe, Stephens, Walker, & Roffman, 2011; Johnson, Bonn-Miller, Leyro, & Zvolensky, 2009). Negative consequences associated with more frequent cannabis use include risk of neuropsychological decline (Lisdahl, Wright, Kirchner-Medina, Maple, & Shollenbarger, 2014; Meier et al., 2012), which can be detrimental to career goals among college-aged individuals and thereby affect mental health (Arria, Caldeira, Bugbee, Vincent, & O'Grady, 2013).

In order to limit negative consequences, reasons for use and underlying causes should be targeted in substance use disorder treatment (Marlatt & Gordon, 1985). Factors such as emotion dysregulation (limited ability to regulate one's own emotions) and low tolerance for

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distress, are considered risk factors for substance use disorders as well as for anxiety, depression, and other psychological disorders (Gratz & Tull, 2010). Furthermore, using cannabis to cope with mental health symptoms has been found to mediate the relationship between these psychological factors (e.g., anxiety sensitivity, symptoms of anhedonic depression, emotion dysregulation) and cannabis dependence (Johnson, Mullin, Marshall, Bonn-Miller, & Zvolensky, 2010; Vilhena-Churchill & Goldstein, 2014). Additional evidence suggests that people who perceived the need for mental health treatment but did not receive care had an increased risk of substance use and dependence (Mason, Keyser-Marcus, Snipes, Benotsch, & Sood, 2013).

This concept is supported by affect motivation models of drug use, which theorize that continued use of a substance may reflect problems with affect and behavior regulation (Simons & Carey, 2006; Simons, Gaher, Correia, Hansen, & Christopher, 2005). The self-medication hypothesis is also relevant; it theorizes that the particular substance that one uses is chosen (either intentionally or inadvertently) due to its effects that assist in coping with mental health symptoms (Dixon, Haas, Weiden, Sweeney, & Frances, 1990; Khantzian, 1985).

Therefore, successfully treating symptoms of anxiety or depression would reduce the need for using a substance to cope (Deas & Brown, 2006) and may subsequently reduce negative consequences related to dependence and frequency of use. However, the extent to which barriers to treatment may perpetuate cannabis use is not known. Among college students with common mental disorders (i.e., anxiety, depression), attitudinal barriers to treatment (e.g., negative or stigmatized attitudes toward mental health treatment) rather than structural barriers (e.g., access due to financial limitations) have a greater potential to be barriers to treatment in this population (Mojtabai, Chen, Kaufmann, & Crum, 2014) despite access to free mental health services often included in college tuition fees (Eisenberg, Downs, Golberstein, & Zivin, 2009). Although the associations are implied, a study that analyzes the relationship between attitudinal barriers to mental health treatment and substance use to manage mental health symptoms has not been done. A focus on cannabis use is particularly interesting and relevant given the increasingly socially acceptable views for coping-related cannabis use (Yap et al., 2011).

1.1. Specific aims

This study explores whether negative attitudes toward mental health treatment lead to higher rates of cannabis use through coping motives (mediation, aim #1) or if those with more negative attitudes toward treatment would be more likely to have a stronger association between mental health symptoms and coping motives than those with a neutral level of attitudes toward treatment (moderation, aim #2). This study uses a population of students in violation of their university's drug policy for cannabis use or possession and attended a mandatory class series or counseling session. Findings have the potential to improve our understanding of the relationships between mental health symptoms, coping motives, and frequency of use.

2. Methods

2.1. Participants

Participants are Washington State University (WSU) students who received a university conduct violation for cannabis use or possession from the Office of Student Standards and Accountability during the 2014–2015 academic year and the Fall semester of 2015. Although marijuana is legal in the state of Washington, its use is illegal on federal property (i.e. any WSU property) and for those under age 21. WSU requires students who receive their first drug policy violation to attend a workshop series, which is a two-session course in a small group format referred to as IMPACT Cannabis I and IMPACT Cannabis II (modeled after Lee et al., 2013). Students with riskier levels of use were referred to a

mandated individual counseling session in lieu of the second course. WSU's IMPACT program is unique in its focus on students with cannabis violations rather than general drug use. The course components include: expectancies for cannabis use, harm reduction strategies, education on cannabis metabolism, and discussion on motives for use and academic values. The individual counseling session included the above course components, but information was tailored to the patient's needs. It also included an assessment of substance use disorder criteria. Therefore, both modalities were largely focused on reducing frequent or harmful cannabis use.

2.2. Procedure

Participants were given a consent form at the beginning of the first IMPACT Cannabis class and informed that completion of the survey is not required to complete the courses. Data was collected at three different time points: (1) before IMPACT Cannabis I, (2) after IMPACT Cannabis II or 1:1 counseling session (depending on level of use), and (3) 60 days after IMPACT Cannabis II or counseling session. All participants were sent an email with a link to the third survey 60 days after their class or counseling session. It was administered online through SurveyMonkey.com and remained available for 3 weeks. The attrition from 276 participants at the first class/survey to 103 in the third survey is likely due to mandatory presence at the first two classes and differing online format of the third survey, which was not combined with a required class. See Fig. 1 for survey attrition data. Ninety-eight of the 103 participants completed their surveys with no more than one missing data point per variable of interest, resulting in a sample size of 98 for this study.

Both aims of this study use cross-sectional data from the third survey (60-day follow-up) because attitudinal barriers were only assessed during the third survey, and it is our aim to find out whether attitudinal barriers predict other variables of interest. To prevent participant burden, the first two surveys were limited to 15 min. The third survey is the longest at around 30 min. Participants were offered a monetary incentive to offset participant burden for the third survey (\$20 Amazon gift card), which was open to all students who completed the mandated courses or counseling session. The institutional review board at Washington State University approved this study (IRB#13274).

2.3. Survey measures

The surveys measured frequency of use, cannabis dependence, motives for cannabis use, symptoms of stress, anxiety, and depression, and structural and attitudinal barriers to treatment. Variables explained below were measured in each of the survey time points unless otherwise noted.

2.3.1. Depression Anxiety Stress Scales (DASS)

The DASS (mini version; Lovibond & Lovibond, 1995) contains 21 items that assess the severity of symptoms of depression, anxiety, and stress in the last week (e.g. "I found it hard to wind down"). Item responses are scored on a 4-point scale from 0 to 3 (from "Did not apply to me at all" to "Applied to me very much or most of the time"). The score of each item is doubled and then added. The mini version of the DASS demonstrated adequate internal consistency for the Depression, Anxiety, and Stress Scales (respectively, Cronbach's alpha = 0.94, 0.87, & 0.91; Antony, Bieling, Cox, Enns, & Swinson, 1998). Correlations of the DASS scales with other measures of depression and anxiety are high (e.g. between the DASS depression scale and BDI is 0.79; between the DASS anxiety scale and BAI is 0.85) (Antony et al., 1998).

2.3.2. Marijuana Motives Measure (MMM)

The MMM (Simons, Correia, Carey, & Borsari, 1998) consists of 25 questions and 5 factors, each of which assesses one of the following motives for cannabis use: expansion, coping, conformity, social, and

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