Cannabis Use Disorder (CUD)

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Introduction

Cannabis is the most used psychoactive substance in both the United States and world-wide. Rates of cannabis use and the disorder that accompanies it, cannabis use disorder (CUD) have increased in the past decade and coincides with changes in the legal and political climate in favor of legalization of the drug. Approximately 19.8 million people (about the population of New York) over the age of 12 have reported use in the last 30 days with approximately 8 million current daily users (Sherman & McRae-Clark, 2016). Heavy cannabis use is associated with consequences that include an increased risk of psychotic disorders, cognitive impairments, and life dis-satisfaction amongst others. Upon collection of data that is available regarding increased use, it suggests that daily/heavy cannabis use that is more common could have potentially more negative outcomes associated for people who already have mental health issues such as anxiety and depression (Struble et al., 2019).

The most common mental health condition in the United States is depression- the prevalence of which is rising in the youth population more rapidly, as well as in other demographics. The use of cannabis by those individuals with major depressive disorder is greater than the use of those without it (Pacek et al., 2019). Although research is still being accumulated, the use of cannabis can increase the progression of depressive symptoms, and among young people has also increased the likelihood of suicidal ideations. Many different explanations have come forth as to why this may be the case, which include self-medication of depressive symptoms that may already be present, cannabis use increasing the risk of depression, which may lead to the co-occurrence of depression and CUD. There is also an inverse relationship between cannabis use and its perceived harmfulness. Individuals that feel that cannabis does not

have as negative of an impact on them (or on society as a whole) are more likely to develop a disorder.

Literature Review

Cannabis Use Disorder (CUD)

Cannabis use disorder is defined by the DSM-5 (Ciccarelli & White, 2014) as a pattern of cannabis use that leads to clinically significant impairment or distress, as evidenced by the presence of at least two of the following criteria within a 12-month period:

- The substance is taken in larger amounts or over a longer period than was intended.
- Persistent desire or unsuccessful effort to cut down or control use.
- Great deal of time spent obtaining, using, or recovering from the effects of cannabis.
- Craving, or a strong desire or urge to use cannabis.
- Recurrent use resulting in failure to fulfill major obligations at work, school, or home.
- Continued use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of use.
- Giving up or reducing important social, occupational, or recreational activities because of use.
- Recurrent use in situations that could be physically hazardous.
- Continued use despite knowledge of having a persistent or recurrent physical or psychological problem caused by or exacerbated by use.
- Need for markedly increased amounts of the substance to achieved intoxication or desired effect; or diminished effect with continued use of the same amount.
- Characteristic withdrawal syndrome for the substance (see below); or the substance is taken to relieve or avoid withdrawal symptoms.

Cannabis use has increased with the increase in legalization for both medicinal purposes and personal use. Overall, more than 27 states as well as the District of Columbia have legalized cannabis use in some form (Sherman & McRae-Clark, 2016). It is also become more accepted for individuals to use cannabis for both medical and recreational reasons, defined as "dual motives use (N.S Gendy et al., 2023)."

Major Depressive Disorder (MDD)

Depression is related to the normal emotions of both sadness and loss but does not subside when the causes of these adverse emotions dissipate. Some severe states of depression have no precipitating cause. The diagnosis of major depressive disorder requires a change in mood which may be characterized by sadness and is also accompanied by psychophysiological changes, such as sleep disturbance, loss of appetite or sexual desire, suicidal thoughts, and the loss of the ability to experience pleasure. (Belmaker) According to the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)* (American Psychiatric Association, 2013), major depressive disorder (MDD) is characterized by two primary diagnostic criteria: depressed mood and loss of interest or pleasure in activities, at least one of which must occur for a minimum of two weeks. Secondary symptoms include significant weight loss or gain or decrease in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or energy loss, feelings of worthlessness or excessive or inappropriate guilt, attention or concentration difficulties, and recurrent thoughts of death and/or suicide. In adults, of these symptoms, depressed mood, anhedonia, and feelings of worthlessness or guilt are most common.

Case Study

Daniel is a 20-year-old, biracial male recently admitted to residential treatment with Cannabis dependency. Patient grew up in CA as an only child; his parents separated when he was 2 and have a dysfunctional relationship. His father was an alcoholic when Daniele was young, so he resided with his mother for safety and comfort. When he was younger, he was bullied in school as a child because he is biracial to the extent that he had to change schools. Patient states for much of his life he has been isolated, instead of integrating in society. Patient states his mother bought Legos for him to play with instead of taking him to the park, etc. Patient reports that his first use of cannabis was at 16 years old while in high school. He reports that it became consistent while in college at age 18. Daniel says that he smokes cannabis by vape but also uses edibles occasionally. Daniel reports to treatment due to an admission to the hospital suicidal ideations, where he stated to his mother that "he didn't feel his life had a purpose and was not sure why he was alive." Patient states that he has always felt isolated, grew up an only child, moved schools several times, got COVID when he arrived at college and then had lung surgery. Patient feels he has never had a sense of belonging. Patient states that recently, while being home for summer break from college, he further isolated himself to the point of depression. Patient states he understands he has not reached out for help nor returned calls to individuals who have checked on him recently because he did not see a point to it. He does report a previous psych hospitalization last summer, for suicidal ideations as well. While Daniel understands that he has smoked cannabis, he feels that his "addiction is different than everyone else's in rehab." Daniel states, "it's just weed."

Daniel presents to treatment with depression, due to the overuse of cannabis that began at the time that COVID was setting in, where in CA where he resided the COVID restrictions were very strict. The onset of major depressive disorder, isolation, family dysfunction, and lack of

support systems outside of the family have led Daniel to residential treatment for substance abuse. Daniel exhibits signs, symptoms, and traits consistent with others that have alcoholic parents. The patient's father is currently recovered from substances but has reported past substance abuse involving alcohol. Daniel also presents himself with depression wherein he verbalizes persistent feelings of helplessness, hopelessness, and worthlessness. Daniel has displayed avoidant coping skills and is conflict avoidant. Daniel has had trouble in the past creating a support group of like-minded friends that he can trust and that understand him. While Daniel acknowledges that he has incessantly smoked weed, he does not see why this presents as an issue as he feels it is different than the other drugs people go to rehab for. The family system dynamic for Daniel must also be addressed. Daniel is an only child of a mother and father that tend to triangulate him into the middle of their disputes, which may be the reason for his conflict avoidant personality.

Case Conceptualization

Daniel first must be presented with psychoeducational material that will help to inform him of the dangers of cannabis use and the predictive factors that it either enhances current depression or it creates depression where it once did not exist (Struble et al., 2019). Daniel has a conflict avoidant personality caused by his familial history of an alcoholic father and a mother not available as a caregiver for Daniel to feel safe and secure. The patient must understand that these early memories in his formative years have created maladaptive behaviors as he moves into adulthood. Daniel needs to understand and reframe the feelings that come when he feels the need to “hide” due to his past feelings of danger and an unsafe environment. The patient does not currently have a social network of like-minded friends where he can have a place to relax and simply be himself. Because of this, he is very prone to relapse. Relapse prevention is a cognitive-

behavioral approach that requires patients and their clinicians to identify situations that place the person at greater risk for relapse – both internal experiences (e.g., positive thoughts related to substance use or negative thoughts related to sobriety that arise without effort, called "automatic thoughts") and external cues (e.g., people that the person associates with substance use). Daniel must explore his thoughts and network of people to ensure that he is surrounded by those that support and understand him and one in which he can trust. Daniel needs to overcome the feelings of fear and abandonment that he felt as a child and work to help define himself as a person, doing what it is that he wants to do and not what he feels his parents are longing for. Daniel must learn to understand that he has the agency to make decisions in his life, which need to be best for him and not what he thinks is best for him that his parents decide. Daniel has also had a challenging time identifying as "who he is" since he is biracial and did not 'fit' into any groups and did not feel accepted. Finally, if willing, the entire family system could be referred for therapy as their dysfunction is far beyond the scope of individual therapy.

While Daniel may not become abstinent from cannabis, there is a great chance that he will minimize use and become clearer headed if he is to take the appropriate steps within the treatment atmosphere. If Daniel can accept that cannabis may be the cause or furtherance of his depression and is able to monitor that closely, even if still using recreationally, Daniel has a better than average chance at a full recovery and may integrate successfully into society.

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