Canadian Psychiatric Association
Association des psychiatres du Canada

The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie
2023, Vol. 68(12) 949-950

DOI: 10.1177/07067437231173211
TheCJP.ca | LaRCP.ca
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In Response to "Clinical Characteristics Associated With Early Phase Psychosis and Comorbid Substance Use": Methodological Concerns—Authors' Reply

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Keywords
early psychosis, alcohol, cannabis, substance use disorder, clinical measures, social, occupational functioning

We thank Philippe Hwang and his colleagues for their comments and feedback[1] regarding our article.[2] We agree that patients in early phase psychosis (EPP) can be complex with multiple comorbidities, including comorbid substance use. Our aim was to provide updated information about comorbid substance use in those with EPP with a wider lens that included alcohol use given the relative dearth of literature about alcohol use in this population.

Regarding the comments Hwang et al. made about our results given our use of lowered threshold cutoff scores on the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST); we based these changes on research specific to EPP populations. The lower cutoffs identify a pattern of substance use found to be clinically significant (and potentially harmful) specifically within this vulnerable population. Hwang et al.'s reference to DSM-5 criteria may be helpful for diagnostic purposes, but this is not in line with what our intention was in using these lower cutoffs. Our study examined clinically meaningful effects of substance use in this unique population, rather than to try and capture diagnostic entities. Also, as mentioned in the Hides et al.[3] paper from which we derived these lower cutoffs, this population may be uniquely sensitive to substances of abuse. This would support our approach of employing a lower threshold at which to consider substance use as potentially clinically significant. Furthermore, we completed a sensitivity analysis comparing the lower cutoff scores with the original ASSIST cutoff scores. These revealed that our age, gender, and trait-anxiety results persisted when using the original ASSIST scores, further confirming our findings.

With respect to the comments regarding the statistical analysis, we would point out that the Benjamini–Hochberg procedure assumes that the tests are independent,[4] whereas this was not the case with our study. The testing we completed was on different aspects of the same population, which is one of the reasons for using the Tukey–Kramer adjustments. Although we agree that there are always risks of type I and II errors, we feel the procedures we employed were appropriate for our analysis.

Thank you for highlighting the 2009 review,[5] which we also referenced in our study and is now 14 years old. Of note in this review, the authors did not focus on alcohol use, and they only mention the age differences as an exploratory finding. Furthermore, the authors stated that they did not focus on examining specific characteristics associated with cannabis use and, in fact, they specifically noted the lack of original data examining clinical characteristics related to substance use in this population. This highlights the importance of continuing this area of research with more contemporaneous studies such as the one that we have published.

In summary, we agree that ongoing work in exploring the impact of comorbid cannabis and alcohol use in EPP is of utmost importance to better understanding and treating this

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patient population. We are confident that the novel data from our study can continue to support this work.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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