



# Clinical Considerations for Clients with CHS Symptoms

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# Recognizing CHS

- ICD-10-CM diagnosis code for Cannabinoid Hyperemesis Syndrome (CHS) went into effect on October 1, 2025.

*Important because...*

Awareness

Legitimacy

Tracking

- **Recommended treatment:** complete and permanent cessation of all cannabis use
- Despite significant symptoms and interference, **most resume use**
  - Small sample (N ≈ 200) with CHS — **79.4% resumed cannabis use** and experienced return of CHS symptoms (Russo et al., 2022)
  - Regular/high-potency cannabis use is a difficult behavior to change in general

**Overarching Question:** *What is the role of mental health providers in assessing and treating CHS?*

# Three Clinical Challenges

1

Assessment in an outpatient context



2

Catching CHS early



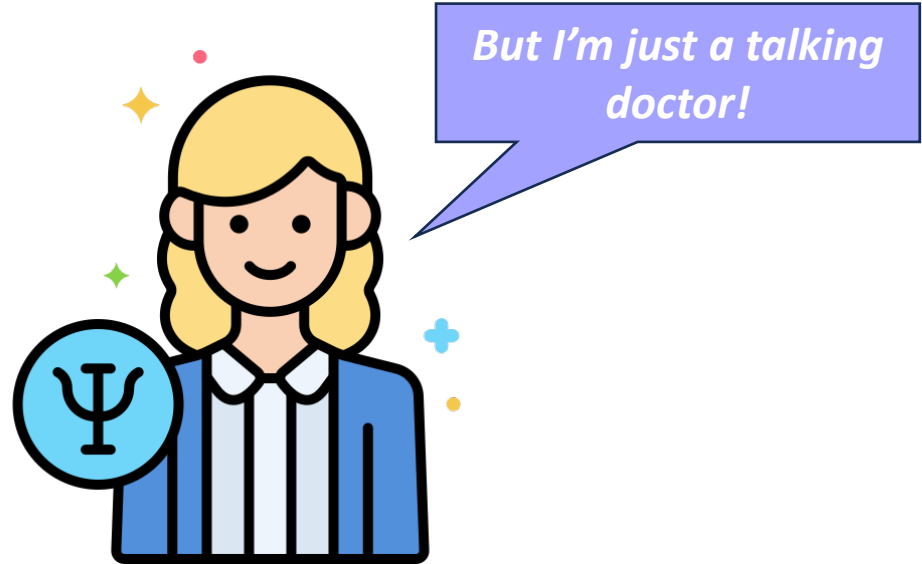
3

Lack of integrated evidence-based treatment



## Clinical Challenge #2: Assessment in a Mental Health Context

- **Long diagnostic delay** — often years, with diagnoses of “rule-outs” and misdiagnosis
  - High comorbidity with mental health concerns (Hicks et al., 2026).
- Mental health care may be a crucial early identification and intervention point — even if cannabis use is not the presenting problem.
- Bridge the gap to reduce dx delay



**Question:** *What is the role of mental health providers in assessing for CHS?*

# Case Study: Morning Sickness or CHS?

## CASE STUDY

- Patient A, mid-30s, 6 months pregnant
- Sought psychotherapy for anxiety.
- Heavy cannabis use (daily, multiple times/day, high potency); not interested in changing use.
- Also had significant “morning sickness,” used cannabis to manage it — hot baths/showers reportedly helped.
  - *Note: Saw OB and GI regularly — no one had ever mentioned CHS to her!*
- At feedback, discussed link between anxiety, nausea, and cannabis → hesitant, but set goal to stop before birth
  - Significant focus on fear of not managing nausea.
  - After stopping, nausea ceased
  - Patient desired to return to use postpartum



## TAKEAWAYS

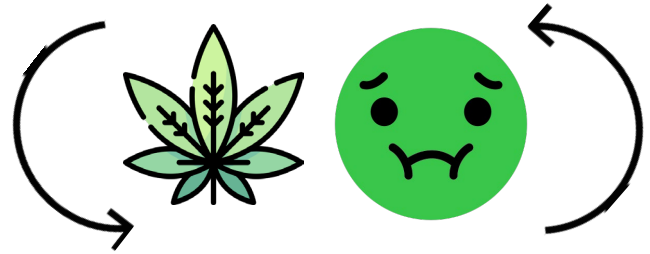
- Given increasing prevalence of CHS, screening for concurrent nausea/vomiting alongside cannabis use is key in mental health settings
- Psychoeducation on CHS at feedback increases awareness → change?
- If CHS is a concern, how do we help connect clients with next steps of care?
- Share with colleagues!

## Clinical Challenge #2: Catching CHS Early

- Repeated ER visits, high utilization of medical services, significant interference with daily activities — **can we catch and treat earlier to avoid acute CHS?**

### Prodromal CHS Phase

- Can last *months to years* – *lots of time to catch!*
- Symptoms: morning nausea, abdominal discomfort, fear of vomiting
- Leads to increases in cannabis use, often as clients try to manage symptoms



**Question:** *People with prodromal CHS may present to mental health care before medical care — how can we intervene to prevent escalation?*

# Case Study: The CHS Experiment

## CASE STUDY

- Patient B, a woman in her mid-20s.
- Psychotherapy for **anxiety** (see the pattern?)
- Heavy cannabis use (daily, multiple times/day, high potency) — wanted to stop, but feared worse nausea
- Reported **regular nausea**, stomach pain, **fear of vomiting**
  - *Planned to see OB-GYN and GI*
- Feedback on CHS — symptoms resonated with and concerned the patient
- **Behavioral experiment:** “How do my symptoms change if I stop cannabis for 2 weeks?”

## TAKEAWAYS

- Potentially prodromal, but still quite interfering
- **Visible cycle:** nausea → use → more nausea → escalated use
- Framing change as an experiment, rather than permanent cessation, lowered the barrier to trying.



## Clinical Challenge #3: Lack of Integrated Evidence-Based Treatment

- CHS is **complex** — an overlap of substance use, mental health, and physical health challenges.
- Our study of 653 women — latent class analysis identified groups based on reasons for use (R01DA058642; PI: Dyar)
  - One group emerged with the most challenges — **“using for multiple conditions”** (e.g., nausea, anxiety) — versus groups using only for physical or only for mental health conditions:
    - More likely to use for nausea/GI symptoms
    - More severe cannabis withdrawal symptoms (including nausea).
    - Higher use of concentrates
    - Less likely to attempt changing use versus other classes

***CHS doesn't occur in isolation — so our treatments shouldn't either!***

# Clinical Challenge #3: Potential Treatment Targets

## ● Awareness Building

Psychoeducation and tracking of symptoms



## ● **\*\*Cognitive Restructuring\*\***

Challenge paradoxical beliefs (“cannabis helps nausea”; “I can’t cope if I throw up”)



## ● Behavioral

Behavioral experiments and alternative nausea-management plans



## ● Bring backup

Connect with other medical providers to provide backup and support



**Question:** *How do we approach CHS treatment across different settings + with different comorbidities?*

THANKS!

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