



2019

A randomised controlled trial of vaporised Δ^9 -tetrahydrocannabinol and cannabidiol alone and in combination in frequent and infrequent cannabis users: acute intoxication effects

Nadia Solowij

University of Wollongong, Australian Centre for Cannabinoid Clinical and Research Excellence, nadia@uow.edu.au

Samantha J. Broyd

University of Wollongong, sbroyd@uow.edu.au

Lisa-Marie Greenwood

University of Wollongong, lgreenwo@uow.edu.au

Hendrika H. van Hell

University of Wollongong, erikavh@uow.edu.au

Dave Martelozzo

University of Wollongong

See next page for additional authors

Publication Details

Solowij, N., Broyd, S., Greenwood, L., van Hell, H., Martelozzo, D., Rueb, K., Todd, J., Liu, Z., Galettis, P., Martin, J., Murray, R., Jones, A., Michie, P. T. & Croft, R. (2019). A randomised controlled trial of vaporised Δ^9 -tetrahydrocannabinol and cannabidiol alone and in combination in frequent and infrequent cannabis users: acute intoxication effects. *European Archives of Psychiatry and Clinical Neuroscience*, 269 (1), 17-35.

A randomised controlled trial of vaporised Δ^9 -tetrahydrocannabinol and cannabidiol alone and in combination in frequent and infrequent cannabis users: acute intoxication effects

Abstract

Access to cannabis and cannabinoid products is increasing worldwide for recreational and medicinal use. Two primary compounds within cannabis plant matter, Δ^9 -tetrahydrocannabinol (THC) and cannabidiol (CBD), are both psychoactive, but only THC is considered intoxicating. There is significant interest in potential therapeutic properties of these cannabinoids and of CBD in particular. Some research has suggested that CBD may ameliorate adverse effects of THC, but this may be dose dependent as other evidence suggests possible potentiating effects of THC by low doses of CBD. We conducted a randomised placebo controlled trial to examine the acute effects of these compounds alone and in combination when administered by vaporisation to frequent and infrequent cannabis users. Participants ($n = 36$; 31 male) completed 5 drug conditions spaced one week apart, with the following planned contrasts: placebo vs CBD alone (400 mg); THC alone (8 mg) vs THC combined with low (4 mg) or high (400 mg) doses of CBD. Objective (blind observer ratings) and subjective (self-rated) measures of intoxication were the primary outcomes, with additional indices of intoxication examined. CBD showed some intoxicating properties relative to placebo. Low doses of CBD when combined with THC enhanced, while high doses of CBD reduced the intoxicating effects of THC. The enhancement of intoxication by low-dose CBD was particularly prominent in infrequent cannabis users and was consistent across objective and subjective measures. Most effects were significant at $p < .0001$. These findings are important to consider in terms of recommended proportions of THC and CBD in cannabis plant matter whether used medicinally or recreationally and have implications for novice or less experienced cannabis users.

Disciplines

Medicine and Health Sciences

Publication Details

Solowij, N., Broyd, S., Greenwood, L., van Hell, H., Martellozzo, D., Rueb, K., Todd, J., Liu, Z., Galettis, P., Martin, J., Murray, R., Jones, A., Michie, P. T. & Croft, R. (2019). A randomised controlled trial of vaporised Δ^9 -tetrahydrocannabinol and cannabidiol alone and in combination in frequent and infrequent cannabis users: acute intoxication effects. *European Archives of Psychiatry and Clinical Neuroscience*, 269 (1), 17-35.

Authors

Nadia Solowij, Samantha J. Broyd, Lisa-Marie Greenwood, Hendrika H. van Hell, Dave Martellozzo, Kuna Rueb, Juanita Todd, Zheng Liu, Peter Galettis, Jennifer H. Martin, Robin Murray, Alison L. Jones, Patricia Michie, and Rodney J. Croft

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

A randomised controlled trial of vaporised Δ^9 -tetrahydrocannabinol and cannabidiol alone and in combination in frequent and infrequent cannabis users: acute intoxication effects.

Nadia Solowij^{1,2}, Samantha Broyd¹, Lisa-marie Greenwood¹, Hendrika van Hell¹, Dave Martellozzo¹, Kuna Rueb¹, Juanita Todd³, Zheng Liu^{4,5}, Peter Galettis^{2,4}, Jennifer Martin^{2,4}, Robin Murray⁶, Alison Jones⁷, Patricia T Michie³ and Rodney Croft¹.

¹ School of Psychology and Illawarra Health and Medical Research Institute, University of Wollongong, Wollongong NSW Australia

² The Australian Centre for Cannabinoid Clinical and Research Excellence (ACRE), New Lambton Heights NSW Australia

³ School of Psychology, University of Newcastle, University Drive, Callaghan NSW Australia.

⁴ School of Medicine and Public Health, University of Newcastle, Hunter Medical Research Institute, New Lambton Heights NSW Australia

⁵ Clinical Pharmacology, Department of Medicine, The Royal Children’s Hospital Melbourne VIC Australia

⁶ Institute of Psychiatry, Kings College London, UK

⁷ Faculty of Science, Medicine and Health, University of Wollongong, Wollongong NSW Australia

Corresponding author: Nadia Solowij, School of Psychology, University of Wollongong NSW Australia; e-mail: nadia@uow.edu.au; Tel. +61 2 4221 3732

Abridged title: Acute effects of vaporised THC and CBD alone and in combination

Acknowledgments

The study was funded by the National Health and Medical Research Council of Australia (NHMRC Project Grant 1007593). NS was supported by the Australian Research Council (ARC Future Fellowship FT110100752). The authors are grateful to Professor Antonio Zuardi and Dr Arno Hazekamp for advice around dosing and drug administration at the commencement of the study; to Clare Bate, Camilla Beale, Andrew Bonney, Gary Chan, Francesca Fernandez, Sarah Gallagher, David Garne, Madeleine Godber, Stuart Johnstone, Lisa Lole, Elke Macdonald, Philip McGuire, Jelena Novakovic, Nagesh Pai, Gabrielle Puckett, Karina Rovere, Beth Shaw and Lara Tramazzo for assistance with participant, trial and data management and logistics; and to Storz & Bickel, Tuttlingen, Germany for supplying a Volcano® Vaporiser used in this study. Cannabinoid compounds were purchased from STI Pharmaceuticals, UK.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32

Abstract (250 words)

Access to cannabis and cannabinoid products is increasing worldwide for recreational and medicinal use. Two primary compounds within cannabis plant matter, Δ^9 -tetrahydrocannabinol (THC) and cannabidiol (CBD), are both psychoactive, but only THC is considered intoxicating. There is significant interest in potential therapeutic properties of these cannabinoids, and of CBD in particular. Some research has suggested that CBD may ameliorate adverse effects of THC, but this may be dose-dependent as other evidence suggests possible potentiating effects of THC by low doses of CBD. We conducted a randomised placebo controlled trial to examine the acute effects of these compounds alone and in combination when administered by vapourisation to frequent and infrequent cannabis users. Participants (n=36; 31 male) completed 5 drug conditions spaced one week apart, with the following planned contrasts: Placebo vs CBD alone (400mg); THC alone (8mg) vs THC combined with low (4mg) or high (400mg) doses of CBD. Objective (blind observer ratings) and subjective (self-rated) measures of intoxication were the primary outcomes, with additional indices of intoxication examined. CBD showed some intoxicating properties relative to Placebo. Low doses of CBD when combined with THC enhanced, while high doses of CBD reduced the intoxicating effects of THC. The enhancement of intoxication by low dose CBD was particularly prominent in infrequent cannabis users and was consistent across objective and subjective measures. Most effects were significant at $p < .0001$. These findings are important to consider in terms of recommended proportions of THC and CBD in cannabis plant matter whether used medicinally or recreationally, and have implications for novice or less experienced cannabis users.

Trial registration ISRCTN Registry Identifier: ISRCTN24109245

Keywords (4-6)

Δ^9 -tetrahydrocannabinol (THC), cannabidiol (CBD), cannabis, cannabinoids, intoxication, synergistic effects

1 Introduction

2

3 Cannabis and cannabinoid products are increasingly becoming available as jurisdictions around the world ease
4 restrictions on use recreationally and medicinally. There is significant interest currently in the therapeutic application
5 of cannabinoids, while the focus of attention of the scientific and medical community in the recent past has been on
6 harms associated with exposure, including the development of psychosis [1]. The two primary constituents of cannabis
7 plant matter, Δ^9 -tetrahydrocannabinol (THC) and cannabidiol (CBD), are thought to show opposing effects in this
8 regard. THC is a partial agonist at CB1 receptors, while CBD is a low-affinity CB1 and CB2 receptor ligand and
9 negative allosteric modulator of CB1, that reduces the binding of CB1 agonists, while augmenting endocannabinoid
10 tone in an indirect manner [2,3]. THC has been shown to be psychotogenic [4,5], and responsible for cognitive
11 impairment and brain structural alterations in long term users of cannabis [6-8]. High potency THC cannabis products
12 are thought to underlie the development of psychotic-like symptoms or overt psychosis in vulnerable individuals who
13 use cannabis [9]. CBD is considered to be non-intoxicating, but is psychoactive in that it can induce brain functional
14 alterations that are opposite to those induced by THC [10]. CBD has also been shown to possess neuroprotective and
15 antipsychotic properties [11-13]. A by-product of the development of high potency strains of cannabis has been the
16 breeding out of CBD in plant matter, such that either nil or very low levels of CBD are now present in typical street
17 cannabis [14]. It has been posited that this absence of CBD in cannabis of high THC potency may contribute to
18 psychosis-like outcomes [9,15], and a lack of protection from brain harms [8]. Recommendations have been made for
19 the reinstatement of CBD into cannabis-plant matter and cannabis products as a harm minimisation strategy and for
20 maximising benefits therapeutically [15,16].

21

22 A number of animal and human studies have shown that CBD may ameliorate some of the adverse effects of THC
23 [12]. In human studies of naturalistic exposure, greater concentrations of CBD determined by hair analysis in regular
24 cannabis users, by analysis of plant matter, or by estimation of proportional exposure, have been associated with better
25 cognitive performance, especially memory [17], and fewer psychotic symptoms [18,19]. Controlled administration
26 studies have shown that pre-treatment with oral CBD reduced the cognitively impairing and paranoia-inducing effects
27 of intravenously administered THC [20] and simultaneous infusion of THC and CBD blocked THC-related anxiety and
28 subjective alterations [21]. In the preclinical literature, CBD has been shown to reverse THC-induced adverse effects
29 on social and cognitive tasks [2,12,22]. Co-administration of CBD with THC, 3mg each, daily for 3 weeks during
30 adolescence prevented the development of THC-induced cognitive and behavioural impairments in mice [23], and an
31 open-label trial of prolonged CBD administration in humans (200mg/day for 10 weeks) improved psychological
32 symptoms and cognition, and increased hippocampal subfield volumes in cannabis users [24,25].

1

2 While many studies have focused on the amelioration of THC effects by CBD, there is also evidence to suggest that
3 CBD can potentiate the effects of THC. Antinociceptive and some neuroendocrine effects of THC in mice or rats were
4 exacerbated by CBD [26-28]. Medium and high doses of CBD (10 and 50mg/kg) exacerbated the impairing effects of
5 low (1mg/kg) dose THC on spatial memory, hypoactivity and hypothermia in mice via a CB1 receptor mechanism
6 [29]. CBD co-administered with THC did not reverse THC-induced spatial working memory impairment in rhesus
7 monkeys, and may have exacerbated it, although it did ameliorate impairments on other cognitive tasks [30]. Klein and
8 colleagues [31] demonstrated pre-treatment with CBD to potentiate weight gain, anxiogenic and locomotor suppressant
9 effects of THC when both were administered to adolescent rats over 21 days in ascending matched doses (1, 3 and 10
10 mg/kg); CBD was administered 20 min prior to each THC injection. Todd and Arnold [32] also showed that CBD
11 potentiated the locomotor suppressant effects of THC, while simultaneously diminishing other neuropharmacological
12 effects of THC, and in a subsequent study suggested that the potentiating effect of CBD on THC-induced locomotor
13 suppression was due to prolongation of those effects over time [33]. This study also demonstrated synergistic
14 interactions between CBD and THC at 1:1 and 5:1 ratios on epigenetic and neuroadaptive changes in the mesolimbic
15 pathway, suggesting long-term molecular changes that may be supra-additive, and the authors suggested that
16 potentiating effects of CBD may be observable in measures sensitive to changes in the mesolimbic pathway, including
17 the rewarding effects of cannabis. CBD has been reported not to modulate the subjective high induced by THC [34,35],
18 although with prolonged administration of high doses of CBD (200mg/day for 10 weeks), we reported a subjective
19 lowering of intoxication experienced from cannabis use external to the trial [25].

20

21 Many biphasic effects of THC and of CB1 receptor stimulation have been demonstrated (e.g. [36-38] and an inverted
22 bell-shaped dose-response curve for CBD has been reported in a number of acute administration studies. In animal
23 models of anxiety, Guimaraes et al [39] showed that low doses of CBD (2.5-10mg/kg), but not higher doses, reduced
24 anxiety, and in models of anxiety and depression, Campos and Guimaraes [40] showed the involvement of differing
25 neurochemistry and receptor activation at higher doses (e.g. TRPV1 receptors) compared to lower doses (e.g. 5-HT1A
26 or CB1). In human studies using the Simulated Public Speaking Test, doses of 100-150, 300, and 600- 900mg CBD
27 given orally produced an inverted bell-shaped curve response with the medium dose showing greatest efficacy in
28 reducing anxiety [41,42]. The authors highlighted the need to establish accurate therapeutic dose ranges for CBD in
29 treating individual clinical conditions.

30

31 Interactions between THC and CBD appear to be highly complex, and the ability of CBD to block or potentiate the
32 effects of THC has been explained by a range of potential mechanisms, largely involving the endocannabinoid system

1 [2,3,43-45]. Importantly, these differential effects are thought to be dependent upon absolute dose, ratio of CBD:THC,
2 route of administration, and timing (in terms of temporal proximity to exposure to THC, whether as a pre-treatment,
3 simultaneous or subsequent) [46-49] but no definitive pattern has yet emerged. As one example, pulmonary
4 administration of THC+CBD to rats increased, while oral administration decreased, an index of anxiety relative to
5 THC or CBD alone, however only subcutaneous and oral co-administration of these compounds, and not pulmonary,
6 resulted in increased serum and brain levels of THC relative to THC alone [50]. Both high and low doses of CBD have
7 been shown to raise THC concentrations in blood and brain, prolonging THC disposition in the central nervous system
8 [28,31,51,52] and suggesting that CBD inhibits the metabolism of THC [32,49].

9
10 Intrapulmonary administration of cannabinoids (e.g. by smoking or vaporising) is considered to be an effective mode
11 of delivery in humans due to high systemic bioavailability, fast onset of action, short duration of peak effects and time
12 limited duration of effects relative to other noninvasive methods (oral, sublingual, transdermal) [53]. Vaporisation has
13 been suggested as a safer intrapulmonary delivery system than smoking, since by heating rather than combusting plant
14 matter or pure compounds it avoids the formation of pyrolytic toxic compounds [54], but see [55,56]. Vaporisation of
15 cannabinoid compounds provides an efficient means of administering cannabinoid compounds simultaneously for
16 experimental purposes, producing immediate effects, and emulating the effects of smoked cannabis while avoiding the
17 harms of smoking. Vaporisation is increasing in popularity among recreational cannabis users, and being applied
18 medicinally in clinical trials. Few studies in humans have examined interactive effects of vaporised THC and CBD.

19
20 Hindocha and colleagues [35] administered vaporised doses of 8mg THC and 16 mg CBD, each alone and combined,
21 and examined effects on an emotional facial recognition task in frequent and infrequent cannabis users, who scored
22 high or low on schizotypy. CBD alone improved emotional facial affect recognition, while THC was detrimental, and
23 THC+CBD produced no impairment. Subjective intoxication was equivalent between the THC and THC+CBD
24 conditions, and no interactions with frequency of cannabis use or schizotypy were observed. Most recently, Morgan
25 and colleagues [57] reporting on the same sample as Hindocha et al [35], showed no attenuation by the 16mg CBD of
26 psychotomimetic or cognitively impairing effects of the 8mg THC. They conclude that at a ratio of 2:1, CBD does not
27 attenuate the acute psychotic and memory impairing effects of vaporised THC. They also reported a blunted
28 antipsychotic response to CBD in frequent users, while infrequent users showed reduced scores on the
29 Psychotomimetic States Inventory (PSI) following CBD alone. No interactions with schizotypy were found. The dose
30 of CBD administered in these studies may be considered low-medium. It is at the higher end of what may be present in
31 cannabis plant matter, but far lower than doses of CBD that have been shown to have therapeutic (e.g. antipsychotic
32 and anxiolytic) efficacy or modulate brain function (e.g. 600mg [10]).

1
2 In the double-blind randomised placebo controlled trial that we report here, we tested a substantially higher dose of
3 CBD alone and co-administered with 8mg THC, as well as a substantially lower dose of CBD co-administered with
4 8mg THC. The low dose of CBD that we selected, 4mg, was chosen to emulate the 2:1 THC:CBD ratio that had been
5 more common in street level cannabis, before the development of high potency THC strains [58,59]. For the high dose
6 CBD we aimed to vaporise doses equivalent to those that had been demonstrated to have antipsychotic efficacy and to
7 show opposite effects on brain function (e.g. 600mg, administered orally) [10,11]. As one of the first studies of
8 vaporised high doses of CBD, significant protocol development was undertaken toward refining methods for this trial
9 [60]. Our pilot work showed that 200mg CBD was the maximum that could be vaporised into a single balloon; as such,
10 we administered two balloons to deliver 400mg CBD.

11
12 The overall aim of this randomised controlled trial was to examine effects of vaporised high dose CBD, and low and
13 high doses of CBD delivered simultaneously with THC, on a broad range of measures pertinent to understanding
14 associations between cannabis or cannabinoid compounds and psychotic-like outcomes. These included assessments of
15 electroencephalography, cognition and neurochemistry, to be reported elsewhere. This paper reports subjective and
16 objective intoxication outcomes, and their association with psychotic-like, depressive and anxiety symptoms. We
17 investigated the effects of these cannabinoids in a sample comprised of frequent and infrequent cannabis users and
18 non-naïve nonusers, with an aim to examine any differential effects of these compounds according to the extent of
19 prior experience with cannabis. Based on mixed findings from animal and human studies, we formulated the following
20 hypotheses: 1) that high dose CBD alone would not be intoxicating relative to placebo; 2) that low dose CBD
21 combined with THC may potentiate the intoxicating effects of THC; and 3) that high dose CBD combined with THC
22 may attenuate the intoxicating effects of THC. In further support of our second hypothesis, we note that in human
23 studies, users of low CBD strains of cannabis perform significantly worse on cognitive tests [57], show higher
24 psychotic-like symptoms [19] and reduced grey matter concentration in hippocampus [61] than users of higher CBD
25 strains. While the interpretation that these observations indicate a protective nature of higher concentrations of CBD
26 may indeed be correct, whether these data might indicate a possibility of low doses potentially exacerbating effects of
27 THC has not been considered. Given the range of evidence in the literature reviewed above, we sought to test this
28 hypothesis.

29
30
31
32

1 **Methods**

2

3 *Participants*

4

5 Current cannabis users and non-naïve nonusers were recruited via flyers and advertisements placed around the
6 University of Wollongong, in local newspapers, and through word of mouth. Current cannabis users must have used
7 cannabis at least once per month for 2 years. Non-naïve nonusers were required to have used at least once in the past 2
8 years with 5-10 lifetime uses. Self-reported substance use, other than cannabis, alcohol or tobacco, in the 2 weeks prior
9 to testing and positive urine drug screens on days of testing were exclusionary. Further exclusion criteria were: any
10 previous adverse reaction to cannabis (i.e., that required medical attention or induced subjective distress), having a first
11 degree relative with a history of any psychotic disorder, personal psychiatric diagnoses or medications, significant head
12 injuries, neurological conditions, cardiovascular disease, asthma, pregnancy, alcohol dependence and significant use of
13 any illicit substance other than cannabis (>50 occasions in the past 12 months; the final sample had a median of 2
14 occasions of other illicit drug use, range 0-35). Participants were required to abstain from cannabis and alcohol for at
15 least 12 hrs prior to testing and nicotine and caffeine during test sessions.

16

17 Thirty-six participants (31 male; median age 21, range 18 – 51) were subsequently divided into groups of Frequent
18 users (n=18; 17 male; median age 21.8, range 21-44) and Infrequent users/non-naïve nonusers (henceforth referred to
19 as Infrequent users; n=18; 14 male; median age 20.5, range 18-51) via median split on lifetime cannabis use (128
20 occasions). Frequent users had 133--8000 lifetime occasions of use, were currently using cannabis on a median 10
21 days per month (range 2-28) and had been using at least once/month for a median 3 years (range 1.4-25.5). Infrequent
22 users had 6-123 lifetime occasions of use, were currently using cannabis on a median 0 days per month (range 0-5) and
23 had a median 0 years of at least monthly use (range 0-4.5). Participants were required to attend 6 sessions in total at the
24 University: a baseline assessment session and five drug administration sessions, during which a range of outcome
25 measures were obtained (e.g. electroencephalography, neuropsychological testing; to be reported elsewhere). They
26 provided written consent prior to each session and were reimbursed AUD\$80 per session for their time involvement.
27 The trial was approved by the University of Wollongong and Illawarra Shoalhaven Local Health District Human
28 Research Ethics Committee.

29

30 *Clinical, cannabis and other substance use and demographic measures*

31

1 Participants were telephone screened for exclusion criteria. Eligible participants were invited to attend a substantive
2 baseline assessment at the University. This involved a semi-structured interview to assess demographic information,
3 medical history and detailed history of current and previous substance use, including a 30-day timeline follow-back
4 (TLFB) [62] and the Alcohol Use Disorders Identification Test (AUDIT) [63]. The M.I.N.I. International
5 Neuropsychiatric Interview – PLUS [64] screened for psychiatric disorders, whilst symptoms of anxiety and mood
6 dysregulation were assessed by the State-Trait Anxiety Index (STAI) [65] and Beck Depression Inventory (BDI) [66].
7 Participants completed the Community Assessment of Psychic Experiences (CAPE) [67] and Schizotypal Personality
8 Questionnaire (SPQ) [68] to assess psychosis liability. Any participants scoring in the very high range of psychosis
9 liability on the CAPE (>50) were excluded from proceeding with drug sessions. They completed the Severity of
10 Dependence Scale (SDS) [69] for cannabis, and Cannabis Experiences Questionnaire (CEQ) [70] to retrospectively
11 assess symptoms experienced whilst intoxicated. Height and weight were measured and used to calculate body mass
12 index (BMI).

13

14 *Drug administration sessions*

15

16 There were five drug administration sessions in which the following compounds were administered by vaporisation,
17 with a one week washout: Placebo (ethanol vehicle 400 μ l), THC alone (8 mg), CBD_{high} alone (400 mg), THC+CBD_{low}
18 (THC: 8 mg, CBD: 4 mg) and THC+CBD_{high} (THC: 12 mg; CBD: 400 mg). THC and CBD were dissolved in an
19 ethanol solution, 4% for THC and 10% for CBD. Ethanol was blown off by vaporisation at a lower temperature prior to
20 vaporising the cannabinoids at a higher temperature for administration to participants (see [60]). All solutions were
21 purchased from STI Pharmaceuticals (Essex, UK) and administered via a Volcano Vaporiser® (Storz and Bickel,
22 Tuttlingen, Germany). The THC+CBD_{low} dose was equivalent to proportions found in some strains of cannabis plant
23 matter [71] while the high dose of CBD was selected to approximate therapeutic oral doses from the literature (see [60]
24 for dose and protocol development).

25

26 Following consent signing at each session, participants provided a urine sample to corroborate self-reported abstinence
27 from substances other than cannabis. Females were pregnancy tested for exclusion. To minimise individual differences
28 in drug metabolism, all participants were requested to refrain from eating the morning of their session and were
29 provided a standardised light meal on arrival. An intravenous cannula was placed in the non-dominant arm for
30 collecting blood samples at regular intervals. Plasma was analysed by LC-MS/MS for CBD, THC, and THC metabolite
31 concentrations [72]. Heart rate (HR) and blood pressure (BP) were measured using an automated cuff placed on the

1 opposite arm to blood sampling cannulation. Participants were seated in an upright position for a minimum of 2 min
2 prior to recording HR and BP. Three consecutive measurements were recorded at each timepoint (Fig. 1) and the
3 median was analysed.

4
5 The order of drug conditions was pseudo-counterbalanced between groups and randomly assigned for each participant.
6 Administration procedures included a 'main dose' and two 'top-up' doses approximately 65 and 120 min following the
7 main dose to maintain intoxication across all experimental protocols (not reported here). To ensure blinding to drug
8 conditions, participants were administered two normal sized Volcano® Easy Valve balloons to deliver the main dose
9 and one balloon to deliver top-up doses at each session, with the balloon covered by opaque fabric to prevent
10 identification of vapour colour or density (see [60] for further details). Drug doses were discretely prepared and
11 vaporised into the balloons by the principal investigator, and handed to research staff with the opaque cover to
12 administer to participants. In this way, the research staff responsible for data collection were blinded to the drug
13 conditions. Participants were instructed to inhale a comfortable amount and hold their breath for 10 seconds before
14 exhaling. Drug administration for the main dose took ~10 min, involving 6-10 inhalations from each balloon. Fig. 1
15 provides a schematic showing protocols across the entire session, which lasted approximately 3.5 hrs. The primary
16 focus of this manuscript is on the first hour after administration of the main dose. Baseline measures, prior to drug
17 administration, are referred to as Time 0, with outcomes of interest at Time 1, Time 2, Time 3 and during Recovery
18 (approximately 3 hrs after the main dose), as described further below. In between times, participants underwent
19 electroencephalography while watching a silent film or button pressing to auditory stimuli, and performed cognitive
20 tasks after the second top-up dose.

21 Fig. 1 about here

23 *Intoxication measures*

24
25 Primary outcomes were objective and subjective measures of intoxication. The objective measures were obtained by
26 independent observers blinded to drug condition and group, rating participants from 0 (not at all) to 4 (extremely) on
27 the 8 observer items of the Clinician Administered Dissociative States Scale (CADSS) [73]. Scores on the 8 items were
28 summed to produce a composite score out of a total possible 32, reflecting the extent to which they observed the
29 participant to be intoxicated. Example items include: “Did the subject appear to be separated or detached from what is
30 going on, as if not a part of the experience or not responding in a way that you would expect?” and “Did the subject say
31 something bizarre or out of context, or not speak when you would have expected it?”. The independent observers were
32 trained psychologist members of the research team, assisting with daily project management, but not involved in drug

1 administration. The CADSS observer items were administered at Time 0, again ~ 55 min after main dose drug
2 administration (Time 2) and during the Recovery period (after two additional top-ups were administered as per Fig. 1).

3
4 The primary measure of subjective intoxication was participant self-rated response to the question “On a scale from 1 –
5 10, where 10 is the most stoned you've ever been, how stoned do you feel now?”. The participant was provided with a
6 visual analogue scale (VAS) with end points marked as “Not at all stoned” at 1 and “The most stoned you’ve ever
7 been” at 10 and asked to verbally report a score between 1 and 10. This item was administered at Time 0, immediately
8 after administration of the main dose (Time 1), again ~55 min later at Time 2 (at the same time as the CADSS), and
9 during the Recovery period. (Raw scores from additional administration time points across the session for this measure
10 are depicted in Fig. 4a, but were not analysed for this paper).

11
12 Further self-report measures of intoxication were included to aid interpretation of the nature of the primary subjective
13 intoxication score. Other VAS items (adapted from, [74]) rated from 0 (not at all) to 4 (extremely) measured internal
14 perception (6 items), reflecting inner feelings that do not correspond with reality, external perception (6 items),
15 reflecting misperception of external stimuli or changes in the awareness of the environment [75], and drowsiness (1
16 item). The CADSS provided 19 self-report ratings from 0 (not at all) to 4 (extremely) contributing to subscales that
17 measure depersonalisation, derealisation and amnesia. The VAS and the CADSS were administered at Time 0, Time 2
18 and during Recovery, and the VAS was also administered at Time 1. One further measure of intoxication was obtained
19 at a different time point to the VAS and CADSS: the 48-item Psychotomimetic States Inventory (PSI) [76] was
20 administered at Time 0, ~15 min after the first top-up dose (Time 3), and at Recovery. The items, rated from 0 (not at
21 all) to 3 (strongly), form six sub-scales: delusional thinking, perceptual distortion, cognitive disorganisation,
22 anhedonia, mania and paranoia.

23
24 The Brief Psychiatric Rating Scale (BPRS) [77], BDI and STAI were administered at the start of each weekly drug
25 session to monitor change or variations in psychiatric symptom status over the course of participation in the trial, but
26 not immediately following drug administration. No significant changes were observed over the course of the trial.
27 These measures were examined in association with intoxication outcomes within each drug session.

28
29 Participants were retained beyond the recovery period indicated in Fig. 1 until their score on the primary VAS item of
30 subjective intoxication returned to baseline levels.

31
32 *Data analysis*

1
2 All analyses utilised change scores from Time 0 to Time 1, Time 2, Time 3 and/or Recovery (as appropriate for each
3 measure). Missing values (of which there were few) were not replaced. Spearman's correlations tested associations
4 between dose delivered and plasma concentrations at Time 1. HR and BP changes were examined at Time 1 only,
5 using simple and linear contrasts as described below. In the Results, we report outcomes from statistical analysis in the
6 following order: hypothesis 1 (CBD_{high} vs Placebo); hypotheses 2 and 3 (contrasts between the three THC conditions),
7 each explored also as interacting with group (Frequent vs Infrequent users/non-naïve nonusers). Effect sizes are
8 reported as partial eta-squared (η^2), where values $>.02$, $>.13$ and $>.26$ are considered small, medium and large,
9 respectively.

10

11 Primary experimental analyses

12 We tested the hypotheses that CBD_{high} would not be more intoxicating than placebo, and that low and high doses of
13 CBD when added to THC would respectively increase or attenuate intoxication, by analysing change scores from
14 baseline for the objective and subjective measures of intoxication. We used planned simple or linear contrasts within
15 repeated measures analyses of variance (rmANOVAs), with drug Condition the within-subject factor and Group the
16 between-subjects factor (using SPSS Version 24). Many of the outcome measures were not normally distributed and
17 could not be adequately transformed to normality. However, as the above parametric analyses provide greater
18 flexibility with which to address the research hypotheses, and as rmANOVA is generally robust (in terms of Type I
19 error) to normality violations, the above parametric approach was used, and significant results confirmed using
20 equivalent non-parametric analyses (Friedman's, Wilcoxon signed-rank, Kruskal-Wallis and Mann-Whitney U tests).
21 The pattern of results reported below did not change when conducting confirmatory non-parametric tests. For each of
22 the following, both the contrast and the interaction between the contrast and Group from the rmANOVA were
23 examined. Simple contrasts compared Placebo vs THC (to verify that the experimental design was appropriate for
24 eliciting THC-induced intoxication), and Placebo vs CBD_{high} (to determine whether high dose CBD induces
25 intoxication; hypothesis 1). In line with our hypotheses (2 and 3) that, relative to THC alone, low doses of CBD added
26 to THC would increase intoxication whereas high doses of CBD would reduce intoxication, a linear contrast was
27 conducted where the drug conditions were entered in the order THC+CBD_{low}, THC then THC+CBD_{high}. Tests for
28 interactions with Group do not directly test the hypotheses set out in the Introduction, but are included here due to their
29 strong relevance to the literature described above. To account for any potential order effects, analyses were first
30 conducted on data sorted by session (drug sessions 1 – 5, to which drug conditions were randomised). For both primary
31 objective and subjective intoxication measures, the linear contrast for session and its interaction with group were
32 nonsignificant (both $p>.91$ and $p>.41$, respectively). Age did not differ between Frequent and Infrequent users ($p=.47$)

1 and was not correlated with objective or subjective intoxication outcomes in any drug condition (all $p > .14$); age was
2 therefore not included as a covariate or considered further.

3

4 Exploratory Analyses

5 Exploratory analyses using additional self-report measures of intoxication (VAS, CADSS, PSI) were conducted using
6 planned contrasts as described in the primary experimental analysis section. Spearman's rho tested associations
7 between the primary objective and subjective measures of intoxication and these additional self-report measures to
8 inform the qualitative nature of intoxication. Additional correlations between the primary objective and subjective
9 intoxication change scores at Time 1 and/or 2, and both cannabis use measures (lifetime occasions of use, hours since
10 last use of cannabis) and BMI, as well as between intoxication and CAPE total frequency and distress scores, SPQ total
11 score, CEQ subscales, BPRS, BDI and STAI (State and Trait) were conducted to determine whether psychosis-
12 proneness or mood measures may predict intoxication effects for any drug condition.

1 Results

2

3 *Doses and plasma concentrations*

4

5 Drug conditions with doses loaded into the vaporiser, estimates of actual dose delivered, and plasma concentrations of
 6 THC, THC-metabolites and CBD are provided in Table 1. Some participants experienced difficulty in inhaling the full
 7 contents of the balloons administered, either due to feeling too intoxicated already from the dose inhaled, or due to
 8 throat irritation, particularly in the high dose CBD conditions. Actual dose delivered was estimated from the proportion
 9 of the balloon inhaled, confirming clear separation between the drug conditions of our experimental design, as
 10 intended. That is, despite lesser doses being consumed by some participants, the drug conditions nevertheless clearly
 11 represented Placebo, high dose CBD alone, THC alone, THC with low dose CBD and THC with high dose CBD. The
 12 estimated dose of THC (mg) delivered did not differ between the THC and THC+CBD_{low} conditions ($Z=1.07, p=.29$),
 13 while that in the THC+CBD_{high} condition was significantly lower than in the THC condition ($Z=4.13, p<.0001$).
 14 Despite this, Infrequent and Frequent users did not differ in the estimated dose delivered in any condition (CBD:
 15 $Z=1.73, p=.09$; THC: $Z=1.0, p=.32$; THC+CBD_{low}: $Z=0.04, p=.97$; THC+CBD_{high}: $Z=1.51, p=.13$), indicating that
 16 between group comparisons were unconfounded by any dose differences. For between condition contrasts, analyses
 17 were repeated on a subsample who did not differ in proportional dose consumed in the THC and THC+CBD_{high}
 18 conditions ($n=16$; 5 Infrequent users, 11 Frequent users) to confirm condition effects.

19

20 Plasma CBD concentration correlated with the estimated dose of CBD delivered in the CBD_{high} condition ($\rho=.425,$
 21 $p=.012$) and in the THC+CBD_{high} condition ($\rho=.415, p=.016$), but not in the THC+CBD_{low} condition ($p=.38$). Plasma
 22 concentrations of THC or THC metabolites, however, did not correlate with the estimated dose of THC delivered in
 23 any condition (all $p>.10$). Strong positive correlations were observed between plasma THC and CBD concentrations in
 24 both of the combined conditions (THC+CBD_{low}: $\rho=.726, p<.0001$; THC+CBD_{high}: $\rho=.920, p<.0001$).

25

26 *Heart rate and blood pressure*

27

28 HR across the session for each drug condition is depicted in Fig. 2. There was no Condition effect for the simple
 29 contrast between Placebo and CBD_{high} conditions and no main effect or interaction with Group (all $p>.10$). The simple
 30 contrast between Placebo and THC showed a highly significant Condition effect ($F(1,34)=100.86, p<.0001$) which
 31 interacted with Group ($F(1,34)=10.20, p=.003$), while the main effect of Group was not significant ($p=.12$). This
 32 indicated that THC significantly elevated HR relative to Placebo, and did so more strongly in Infrequent users. For the

1 three THC conditions, the linear contrast showed a Condition effect ($F(1,34)=34.97, p<.0001$), with greater change in
 2 HR for the THC and THC+CBD_{low} conditions than in the THC+CBD_{high} condition. There was a main effect of Group
 3 ($F(1,34)=8.57, p=.006$) with Infrequent Users showing greater HR change than Frequent, which tended to be more
 4 evident in the THC and THC+CBD_{low} conditions ($p=.075$). The linear contrast between the three THC conditions
 5 remained significant, showing the same pattern, in the subsample matched for dose in the THC and THC+CBD_{high}
 6 conditions ($F(1,14)=7.37, p=.017$), but did not interact with Group ($p=.52$).

7
 8 There were no significant differences in blood pressure (BP) across conditions (all $p>.37$). Frequent users showed an
 9 overall increase in diastolic BP in the simple contrast between CBD_{high} and Placebo ($F(1,34)=7.11, p=.012$) and a trend
 10 level reduction in systolic BP in the THC conditions ($p=.057$), but there were no Condition by Group interactions (both
 11 $p>.23$).

12 Fig. 2 about here

13

14 *Objective and subjective measures of intoxication*

15

16 Objective intoxication scores

17

18 There were no significant differences between CBD_{high} and Placebo; CBD_{high} showed a trend toward a higher
 19 intoxication rating than Placebo ($p=.092$), which did not interact with Group ($p=.67$) (Fig. 3a). No effects were
 20 observed at Recovery (all $p>.16$). Whilst the contrast between CBD_{high} and THC was not planned at the outset, a
 21 significant intoxicating effect of CBD_{high} relative to placebo was found in the analysis of subjective intoxication scores
 22 as reported below. It was therefore deemed prudent to examine further the degree of intoxication from CBD_{high} by
 23 contrasting it with THC, and this contrast was therefore also performed on the objective measure. Objectively
 24 measured intoxication was rated significantly higher for THC than for CBD_{high} ($F(1,34)=22.58, p<.0001, \eta^2=.399$),
 25 with a tendency for this contrast to be greater in Infrequent users ($p=.067$). No difference between THC and CBD_{high}
 26 was evident during Recovery (both $p>.49$).

27

28 Higher intoxication ratings were obtained for the THC than Placebo condition ($F(1,34)=26.19, p<.0001, \eta^2=.435$),
 29 with this effect marginally greater in Infrequent users ($F(1,34)=3.78, p=.06$). There was a significant linear reduction
 30 across the three THC conditions, with intoxication rated highest in the THC+CBD_{low} condition, lower in the THC
 31 alone condition, and lowest in the THC+CBD_{high} condition ($F(1,34)=6.87, p=.013, \eta^2=.168$). This pattern interacted
 32 with Group, such that it was greatly accentuated in Infrequent users, and relatively absent in Frequent users

1 (F(1,34)=5.81, $p=.021$, $\eta^2=.146$) (Fig.3b). Infrequent users had marginally higher intoxication ratings overall ($p=.06$).
 2 No effects remained at Recovery (all $p>.34$). Similar results were found using the subsample matched for THC dose,
 3 differing only in that the linear contrast over THC conditions was reduced to trend-level ($p=.087$; Condition by Group
 4 F(1,14)=4.59, $p=.05$, $\eta^2=.247$; main effect of Group $p=.09$).

5 Fig. 3 about here

6 Subjective intoxication scores

7
 8
 9 Subjective intoxication scores for the entire sample across the testing protocol are depicted graphically in Fig. 4a for
 10 each drug condition. Only change from Time 0 to Time 1, Time 2 and Recovery timepoints are considered here. Fig.
 11 4b and Fig. 4c show change scores from Time 0 to Time 1 for subjective intoxication by group for the primary drug
 12 condition comparisons.

13 Fig. 4 about here

14
 15 Participants' intoxication scores were significantly higher for CBD_{high} than Placebo at Time 1 (F(1,34)=52.55, $p<.0001$,
 16 $\eta^2=.607$), and remained significantly higher one hour later at Time 2 (F(1,34)=20.61, $p<.0001$, $\eta^2=.377$), as well as
 17 during Recovery (F(1,34)=5.49, $p=.025$, $\eta^2=.139$). There were no interactions with Group (all $p>.71$) and no main
 18 effects of Group (all $p>.12$) (Fig. 4b). After removing seven participants who had plasma THC concentrations
 19 (>5ng/ml) in the CBD alone condition, CBD_{high} remained significantly more intoxicating than Placebo at Time 1
 20 (F(1,27)=31.10, $p<.0001$, $\eta^2=.535$) and Time 2 (F(1,27)=11.74, $p=.002$, $\eta^2=.303$), but not at Recovery ($p=.109$), and
 21 there were no Group effects or interactions (all $p>.16$). Given this unexpected finding of CBD being intoxicating, the
 22 simple contrast between CBD_{high} and THC was also tested. The intoxication with CBD_{high} was rated lower than with
 23 THC at Time 1 (F(1,34)=17.29, $p<.0001$) and Time 2 (F(1,34)=87.28, $p<.0001$, $\eta^2=.720$), both times interacting with
 24 Group (F(1,34)=5.16, $p=.030$, $\eta^2=.132$, and F(1,34)=4.160, $p=.049$, $\eta^2=.109$, respectively), with a relatively greater
 25 degree of intoxication with THC in Infrequent users. This contrast between CBD_{high} and THC remained significant
 26 during Recovery (F(1,34)=29.35, $p<.0001$, $\eta^2=.463$), also interacting with Group (F(1,34)=4.70, $p=.037$, $\eta^2=.121$).
 27
 28 The THC condition induced significantly higher intoxication ratings than Placebo at Time 1 (F(1,34)=97.89, $p<.0001$,
 29 $\eta^2=.742$) and Time 2 (F(1,34)=201.93, $p<.0001$, $\eta^2=.856$), and this interacted with Group at both times
 30 (F(1,34)=5.75, $p=.022$, $\eta^2=.145$, and F(1,34)=7.29, $p=.011$, $\eta^2=.176$, respectively), being greater in Infrequent users.
 31 These effects were sustained into the Recovery period (Condition: F(1,34)=39.35, $p<.0001$, $\eta^2=.536$; Condition by
 32 Group: F(1,34)=4.53, $p=.041$, $\eta^2=.117$).

1
 2 For the three THC conditions, the linear decrease across Conditions was not significant at Time 1 ($p=.30$), but an
 3 interaction between Condition and Group ($F(1,34)=7.906, p=.008, \eta^2=.189$) indicated a significant linear decrease in
 4 intoxication scores from THC+CBD_{low} to THC alone to THC+CBD_{high} in Infrequent users, that was absent in Frequent
 5 users (Fig. 4c). At Time 2, this pattern was significant overall with a Condition effect ($F(1,34)=20.63, p<.0001,$
 6 $\eta^2=.189$) that did not interact with Group ($p=.11$), but a main effect of Group indicated that Infrequent Users were
 7 significantly more intoxicated than Frequent users across all three THC conditions ($F(1,34)=7.03, p=.012, \eta^2=.171$).
 8 The main effect of Group was not significant at Time 1 ($p>.09$). There were no significant effects at Recovery (all
 9 $p>.14$). In the subsample matched for THC dose delivered in THC and THC+CBD_{high} conditions, the linear contrast
 10 between the three THC conditions continued to show a significant Condition by Group interaction at Time 1
 11 ($F(1,14)=7.81, p=.014, \eta^2=.358$), while the Condition effect at Time 2 was reduced to trend level ($p=.064$).

12

13 *Additional measures of subjective effects*

14

15 VAS

16 Fig. 5a shows change scores from baseline at Time 2 for each subscale on the VAS, displayed by group separately for
 17 CBD_{high} vs Placebo and the three THC conditions.

18

19 At Time 1, scores for CBD_{high} were higher than Placebo for *Internal Perception* ($F(1,34)=14.32, p=.001, \eta^2=.296$)
 20 only (all other $p>.45$). At Time 2, both *Internal* and *External Perception* scores were higher for CBD_{high} than Placebo
 21 ($F(1,34)=8.86, p=.005, \eta^2=.207$; and $F(1,34)=6.48, p=.016, \eta^2=.160$, respectively). A trend Condition effect for
 22 *Drowsiness* at Time 2 ($p=.079$), marginally significantly interacting with Group ($F(1,34)=4.11, p=.051, \eta^2=.088$),
 23 indicated higher drowsiness in Infrequent users with CBD_{high} relative to Placebo, but the reverse pattern in Frequent
 24 users; this interaction pattern continued into the Recovery period at trend level ($p=.078$). *External perception* scores
 25 also trended toward being higher for CBD_{high} during Recovery ($F(1,34)=4.06, p=.052$). No other effects or interactions
 26 were significant at any time point (all $p>.10$).

27

28 For the THC conditions, significant linear contrasts were observed for Condition at Time 1 for *Drowsiness*
 29 ($F(1,34)=5.52, p=.025, \eta^2=.140$), and at Time 2 for *Internal* and *External Perception* ($F(1,34)=9.39, p=.004,$
 30 $\eta^2=.216$; and ($F(1,34)=4.66, p=.038, \eta^2=.121$, respectively), with highest scores for THC+CBD_{low}, followed by
 31 THC, and lowest scores for THC+CBD_{high}. A trend toward a Condition by Group interaction at Time 1 for *Internal*

1 *Perception*, supported the above pattern being most prominent in Infrequent users ($p=.068$). All other effects and
 2 interactions were nonsignificant (all $p>.12$).

3 Fig. 5 about here

4 Clinician Administered Dissociative States Scale (CADSS)

5 Fig. 5b shows change scores from baseline at Time 2 for CADSS total score, derealisation and amnesia subscales,
 6 displayed by group separately for CBD_{high} vs Placebo and the three THC conditions.

7
 8
 9 At Time 2, CBD_{high} scores were higher than for Placebo for *Total score* ($F(1,34)=6.52, p=.015, \eta^2=.161$) and *Amnesia*
 10 ($F(1,34)=5.49, p=.025, \eta^2=.139$), trending also for *Derealisation* ($p=.058$). *Total score* remained elevated at Recovery
 11 ($p=.079$), with no other effects or group interactions (all $p>.10$).

12
 13 There was a significant linear reduction across the three THC conditions at Time 2 for *Total score* ($F(1,34)=4.89,$
 14 $p=.034, \eta^2=.126$) and *Derealisation* ($F(1,34)=6.63, p=.015, \eta^2=.163$), with highest scores for THC+CBD_{low},
 15 followed by THC alone, and lowest scores for THC+CBD_{high}. For *Amnesia* this contrast interacted with Group
 16 ($F(1,34)=4.29, p=.046$), whereby Infrequent users showed the above pattern, whereas Frequent users showed the
 17 reverse pattern: highest scores for THC+CBD_{high}, followed by THC and lowest scores in THC+CBD_{low}. No effects
 18 remained at Recovery (all $p>.15$), and all other effects and interactions were nonsignificant (all $p>.22$).

19 Psychotomimetic Symptom Inventory (PSI)

20 The main drug effects measured by this scale correspond to a different time point (Time 3) to the above scales: ~15
 21 min after a top up dose was given in each condition (as described in the Methods).

22
 23
 24 In the CBD_{high} vs Placebo contrasts, Condition effects were observed on the *Perceptual Distortion* scale ($F(1,33)=5.05,$
 25 $p=.031, \eta^2=.133$), *Cognitive Disturbance* scale ($F(1,33)=4.99, p=.032, \eta^2=.131$) (which persisted at Recovery,
 26 $F(1,33)=4.73, p=.037, \eta^2=.125$), and on the *Mania* scale ($F(1,33)=10.31, p=.003, \eta^2=.238$), with higher scores for
 27 CBD_{high} than Placebo. Frequent users had trend-level higher scores on the *Mania* scale than Infrequent users ($p=.06$). A
 28 significant Condition by Group simple contrast was observed on the *Anhedonia* scale ($F(1,34)=9.19, p=.005,$
 29 $\eta^2=.218$) with Infrequent users showing higher scores for CBD_{high} than Placebo, but the reverse pattern evident in
 30 Frequent users, and this pattern tended to persist into the Recovery period ($p=.064$).

31

1 For the three THC conditions, two linear contrasts were significant: on the *Perceptual Distortion* scale $F(1,33)=9.36$,
 2 $p=.004$, $\eta^2=.221$) and on the *Mania* scale ($F(1,33)=6.44$, $p=.016$, $\eta^2=.163$) (for all other scales, Condition $p>.12$). In
 3 each case highest scores were observed for THC+CBD_{low}, followed by THC, and lowest scores for THC+CBD_{high}.
 4 There were no significant main effects or interactions with Group (all $p>.088$) and no effects at Recovery.

5

6 *Exploratory correlations*

7

8 Objective intoxication change scores were positively correlated with subjective intoxication change scores at Time 1
 9 and 2 in the THC+CBD_{low} and THC conditions, only at Time 2 in the THC+CBD_{high} condition (Table 2). In the CBD
 10 alone condition, objective measures correlated with subjective measures at Time 1 ($\rho=.395$, $p=.017$), but not Time 2
 11 ($p=.29$). HR correlated with all objective and subjective intoxication change scores in the THC+CBD_{low} condition
 12 (respectively: $\rho=.370$, $p=.026$; Time 1 $\rho=.503$, $p=.002$; Time 2 $\rho=.589$, $p=.0002$), mostly in the THC condition
 13 (respectively: $\rho=.388$, $p=.020$; Time 1 $\rho=.304$, $p=.072$; Time 2 $\rho=.511$, $p=.001$), not in the THC+CBD_{high}
 14 condition at Time 1 (all $p>.30$) but at trend level with subjective intoxication at Time 2 ($\rho=.327$, $p=.052$). These
 15 associations support the validity of the blind observer ratings for the THC and THC+CBD_{low} conditions.

16

17 A negative association was observed between lifetime occasions of cannabis use and both objective and subjective
 18 intoxication scores at both time points in the THC+CBD_{low} and THC conditions only (Table 2). The associations
 19 indicate greater intoxication in those with lesser exposure to cannabis, with the strongest correlations evident in the
 20 THC+CBD_{low} condition. These associations were not evident in the THC+CBD_{high} condition (Table 2), nor in the
 21 CBD_{high} condition (all $p>.12$).

22

23 Associations were observed with hours since last use of cannabis prior to drug administration in the THC and
 24 THC+CBD_{low} conditions only; for objective and subjective intoxication at Time 2, but only THC+CBD_{low} at Time 1
 25 (Table 2). These findings indicate that greater intoxication was induced the longer ago that cannabis was last used, and
 26 particularly so in the THC+CBD_{low} condition. There were no associations with hours since last use of cannabis in the
 27 CBD_{high} condition (all $p>.27$).

28

29 Neither subjective nor objective intoxication scores correlated with BMI in any condition (all $p>.09$). Objective
 30 intoxication was not correlated with CAPE total or subscale scores in any condition (all $p>.09$). For subjective
 31 intoxication scores, the only association with CAPE scores was observed at Time 1 in the CBD_{high} condition, with
 32 intoxication being greater among those scoring highly on positive symptom frequency and positive symptom distress

1 ($\rho=.382, p=.021$ and $\rho=.347, p=.038$, respectively). SPQ total score was not correlated with objective or subjective
2 intoxication at either time (all $p>.24$, aside from a trend level association for THC+CBD_{low} at Time 1, $p=.092$). CEQ
3 showed significant associations between psychotic-like effects and subjective intoxication at Time 2 for THC+CBD_{low}
4 ($\rho=-.37, p=.028$), supported by a trend level association also with objective intoxication ($\rho=-.33, p=.051$), and
5 between psychotic-like effects and subjective intoxication at Time 1 for THC+CBD_{high} ($\rho=.34, p=.045$). Of note,
6 these associations were in the opposite direction in these two drug conditions. Trend level associations were also
7 apparent in the THC+CBD_{high} condition between CEQ euphoric effects and objective intoxication ($\rho=.33, p=.052$),
8 and between CEQ after effects and subjective intoxication at Time 1 ($\rho=.29, p=.082$). All other associations in all
9 drug conditions were nonsignificant (all $p>.10$). There were no significant associations between objective or subjective
10 intoxication measures and BPRS, BDI, State or Trait Anxiety scores (all $p>.10$), other than BPRS and objective
11 intoxication in the THC+CBD_{high} condition ($\rho=.356, p=.046$) and a trend for BDI and subjective intoxication at Time
12 1 in the CBD_{high} condition ($\rho=.309, p=.067$).

13

14 The qualitative nature of objective and subjective intoxication ratings was examined through correlations with the
15 additional measures of intoxication, as depicted in Table 3.

1 Discussion

2

3 This double-blind placebo-controlled study examined two measures of intoxication, one objective and one subjective,
4 following administration of THC and CBD, each alone and in combination, to frequent and infrequent cannabis users
5 (the latter group including non-naïve nonusers). We aimed to test the hypotheses that high dose CBD alone would not
6 be intoxicating relative to placebo, and that when added to THC, low dose CBD would enhance intoxication whereas
7 high dose CBD would attenuate the intoxication due to THC. The results from both objective and subjective measures
8 indicated that the addition of CBD to THC produced differential dose-dependent effects to intoxication. In line with
9 our hypotheses, low dose CBD enhanced intoxication relative to THC alone, whereas high dose CBD reduced
10 intoxication. The potentiation by low dose CBD was most prominent in the infrequent users/non-naïve nonusers. Our
11 first hypothesis was not supported. Contrary to the literature, both frequent and infrequent users subjectively reported
12 feeling intoxicated by high dose CBD administered alone (i.e., not combined with THC), with protracted effects across
13 the 3-hr session relative to placebo, but this was not corroborated by the objective intoxication measure. Subjective
14 intoxication from CBD was nevertheless significantly less than that reported for THC.

15

16 *High dose CBD alone induced intoxication relative to placebo*

17

18 Subjective intoxication with CBD manifested largely as a dissociated state, correlating with the depersonalisation and
19 derealisation scores on the CADSS, as well as the CADSS total score, but not the amnesia subscale. Correlations were
20 also observed with the VAS internal and external perception scales, but surprisingly not with drowsiness. CBD has
21 been reported to be sedating in other studies [47,78]. Interestingly, independent observer ratings of intoxication in the
22 high dose CBD condition did correlate with participant ratings of drowsiness immediately after drug administration, as
23 well as participant ratings of changes in external perception and at trend level internal perception and CADSS total
24 score. This suggests that observers' ratings of intoxication may have been based on perceiving participants' drowsiness
25 and behaviours indicating that they were responding differently to their external environment and dissociating. The
26 independent observers inferred intoxication but had no direct insight into the internal world of the participants, who felt
27 intoxicated due to distinct feelings of depersonalisation, derealisation, and altered internal and external perceptions. No
28 such findings have been reported in the literature in relation to high doses of CBD, however most studies have
29 administered high dose CBD orally. Indeed with oral administration, 600mg of CBD was shown to specifically
30 attenuate symptoms of depersonalisation following ketamine administration [79]. It is likely that these dissociating
31 effects were rapidly induced by vaporisation of this compound, delivering CBD with high bioavailability to the
32 bloodstream and hence central nervous system, although this is likely also confounded by dose. While 400mg was

1 loaded into the vaporiser, we estimate that participants consumed slightly less – 385mg – by not inhaling all of the
2 balloons. Further, our preliminary studies for protocol development suggested that only about 40% of the CBD could
3 be vaporised due to the sticky resin produced in the process, saturation and vaporisation inefficiency [60]. This may
4 therefore have resulted in an actual dose delivered of ~150mg. It is possible that vaporised CBD may also show the
5 bell-shaped dose-response curve that has been demonstrated with oral administration [39-42]. Our protocol
6 development work, however, found 200mg of CBD to be the maximum that could be vaporised into a balloon (and
7 hence we administered two balloons) [60]. The high dose CBD condition induced significant coughing; as such,
8 participants were aware that they were being administered an active condition (as opposed to the ease of inhalation of
9 ethanol-flavoured air in the placebo condition). The changes in intoxication might therefore be surmised to be a
10 placebo effect, however, the fact that heart rate did not change (which would have provided participants with a physical
11 cue to endorsing psychological effects) and the specificity of the reported effects, suggests that indeed medium-high
12 doses of CBD when vaporised induce a dissociation-driven intoxication that may be dose-dependent, and is long
13 lasting, as subjective intoxication scores remained elevated one hour later and at the Recovery time point.

14

15 *Low and high doses of CBD added to THC respectively enhance and attenuate intoxication*

16

17 A consistent pattern of effects was observed across almost all measures in this study, whereby highest levels of
18 intoxication were evident in the THC+CBD_{low} condition, followed by THC alone, and lowest levels of intoxication
19 were observed in the THC+CBD_{high} condition. Intoxication in all three THC conditions was associated with
20 dissociation, largely CADSS total scores driven by the subjective experiences of derealisation, and to some extent
21 depersonalisation. This also appeared to drive the objective ratings of intoxication. Clearly observers rated participants
22 on the basis of their behaviour, which reflected their internal world, and provided slightly differing perspectives on
23 what was more or less prominent for observers versus participants themselves in rating degree of intoxication in the
24 different drug conditions. For example, self-reported anhedonia was only associated with subjective intoxication in the
25 THC alone condition, not surprisingly not driving any observer ratings of intoxication (as it is difficult to infer from
26 behaviour, particularly in a laboratory setting). Subjectively experienced amnesia was prominent in association with
27 subjective intoxication scores in the THC alone condition, less so in the THC+CBD_{low} condition and minor in the
28 THC+CBD_{high} condition, behaviourally influencing observer ratings in the former two conditions, but not the latter. In
29 relation to this, the cognitive disorganisation scale of the PSI was only mildly sensitive to self-reported intoxication in
30 the THC alone condition, yet was associated with observer ratings for all conditions, and self-reported intoxication in
31 both the THC+CBD_{low} and THC+CBD_{high} conditions. Observer ratings of intoxication were further associated with
32 subjective reports of perceptual distortion across all THC conditions, most prominently in the THC+CBD_{high} and THC

1 alone conditions, whereas subjective intoxication ratings were less associated with perceptual distortion in the THC
2 alone condition, and more prominently in the THC+CBD_{low} condition. Both subjective and objective intoxication
3 ratings were associated with changes to VAS internal and external perception in the THC and THC+CBD_{low}
4 conditions, less so for external perception in the THC+CBD_{high} condition. Drowsiness did not feature prominently in
5 association with intoxication measures, but perhaps more so in the THC+CBD_{low} condition. Participants did not
6 strongly endorse PSI delusions and paranoia in any condition, while mania showed associations with subjective and
7 objective intoxication in THC and THC+CBD_{low} conditions, but not THC+CBD_{high}.

8
9 It is interesting that paranoia is often cited as a frequent experience when people are intoxicated from cannabis, yet this
10 was not elevated in the sample of this study, even though half of the sample was comprised of infrequent users or
11 nonusers. This may be due to our screening and exclusion criteria, but we also tested the hypothesis that measures of
12 psychosis-proneness (CAPE, SPQ, BPRS), other psychological symptoms (BDI: depressive; STAI: state and trait
13 anxiety) and experiences when using cannabis (CEQ) may predict response in differing drug conditions, and this was
14 not upheld, at least in the current sample of relatively psychologically healthy individuals. Of note, none of these
15 qualitative aspects of intoxication differed between frequent and infrequent users (other than amnesia), and there was
16 little specific and strong differentiation between the three THC conditions according to these additional qualifiers of
17 the experience. Therefore, the linear contrast patterns of increasing intoxication effects from THC+CBD_{high} to THC to
18 THC+CBD_{low} conditions across almost all measures, and that were most prominent in infrequent users for primary
19 measures of subjective and objective intoxication, appear to reflect general composite effects of these experiences for
20 the overall experience of intoxication, or some unmeasured qualitative aspects. There appears to be some synergism in
21 the potentiating effects of adding low dose CBD to THC, and potential antagonistic effects by the addition of high
22 doses of CBD to THC.

23

24 *Possible mechanisms*

25

26 A potential mechanism to explain our findings may be via the allosteric modulation of CB1 receptors by CBD. As a
27 negative allosteric modulator [3,80], CBD may interfere with CB1R activation in terms of the kinetics of orthosteric
28 binding by THC, or receptor activation and signalling [81]. Straiker and colleagues [81] showed that CBD inhibits
29 endogenous CB1-mediated signalling in a concentration-dependent manner. Positive allosteric modulators can enhance
30 the binding, potency and efficacy of orthosteric modulators, such as THC, and CBD is known to act as a positive
31 allosteric modulator at opioid receptors [82] and has recently been demonstrated to show orthosteric partial agonism at
32 CB2 receptors, while a CBD synthetic derivative showed partial agonist activity and positive allosteric modulation at

1 CB1 and CB2 receptors [80]. Tham and colleagues [80] suggested that this synthetic CBD derivative may enhance the
2 binding of orthosteric ligands dose-dependently, reducing binding at higher concentrations to produce a bell-shaped
3 curve (which may explain the bell-shaped dose-response curve observed for CBD in a number of animal and human
4 administration studies [83]). Other cannabinoid receptor ligands (e.g. Org27569 and fenofibrate) have been shown to
5 have both negative and positive allosteric or agonist properties at CB1 receptors that vary at low and high
6 concentrations [80,84,85]. There is evidence to suggest that a yet-to-be discovered high affinity CBD binding site
7 exists on CB1 receptors that is distinct from the orthosteric site [80]; Tham and colleagues showed that CBD shared a
8 binding site with the CB1 agonist CP55,940. We were unable to assay for plasma CBD metabolites in this study, some
9 of which represent 97% of CBD-related plasma concentrations (following repeat oral administration of high doses
10 [86]; the activity of these metabolites interacting with THC and THC-metabolites remains unknown. Much remains to
11 be learned regarding the allosteric mechanisms of CBD and the conditions under which they operate differentially. For
12 example, simultaneous but not sequential inhalation of THC and CBD was shown to attenuate some effects of THC
13 [87]. While simultaneous inhalation is pertinent to this study, it was pure compounds that we administered, and
14 mechanistically much could change in the presence of the multiple other cannabinoids in plant matter. Understanding
15 these mechanisms is highly pertinent to the development of novel pure allosteric modulators that lack agonist or
16 inverse agonist activity to minimise side effects and optimise benefits in therapeutic applications of cannabinoids.
17 Tham et al [80] warn that ligand interaction with the allosteric and orthosteric sites of cannabinoid receptors is highly
18 fluid and flexible, making drug design challenging. However, there are lessons here as well for consideration of plant
19 matter and edible products (see below) that are used medicinally or recreationally.

20

21 *Implications regarding proportional exposure to THC and CBD for medicinal and recreational cannabis use*

22

23 While precise mechanisms remain to be elucidated, the finding that low doses of CBD may potentiate effects of THC
24 has significant implications for consideration of proportions of THC and CBD that may be recommended within plant
25 matter. With cannabis increasingly being used for medicinal purposes, it is important to ensure that harms are
26 minimised in favour of boosting therapeutic properties. While intoxication per se is not necessarily harmful overall, it
27 is not welcome by many clinical patients, and it may be harmful in situations such as driving under the influence of
28 cannabis. Further research is required to replicate the findings here, and indeed to establish a greater efficacy base for
29 specific cannabinoid compounds in treating specific symptoms or conditions. This would inform the development of
30 guidelines to recommend appropriate proportions of THC and CBD, and indeed other cannabinoids, in cannabis for
31 medicinal purposes. As cannabis is increasingly legalised for recreational use, clinicians, patients and recreational users
32 alike should be mindful that low doses of CBD in plant matter may be more intoxicating than using cannabis without

1 CBD, and also be mindful that the vaporisation route of administration also induces stronger effects than smoking, as
2 recently reported [56]. Given that this study used vaporisation of pure compounds, it is important to see whether our
3 findings would be replicated in a study of smoked cannabis with and without CBD, at low and high CBD levels. It
4 would not be possible to utilise doses of CBD as high as that administered here in a smoked cannabis study. Although
5 relatively high-CBD grade cannabis products are available, their absolute amount of CBD may be too low to attenuate
6 the THC intoxication. Further, this study examined acute effects of combined vaporised THC and CBD; whether the
7 effects we report would also be pertinent to longer-term administration by this or other routes (e.g. smoked or oral
8 formulations) remains to be investigated. We reported previously that prolonged oral administration of high dose CBD
9 appeared to diminish intoxication induced by cannabis smoked externally to the trial [25].

10
11 A further important finding here was that infrequent cannabis users and nonusers showed the greatest degree of
12 potentiation of THC effects by the addition of low dose CBD. This was further substantiated with the associations
13 observed between intoxication and lifetime occasions of cannabis use, and intoxication and hours since last use of
14 cannabis. Whilst not surprising, less experienced cannabis users, and those who use less frequently experienced greater
15 intoxication. But that these effects were most evident in the THC+CBD_{low} condition, indicates that less experienced or
16 novice users are most at risk of experiencing greater intoxication than may have been expected when CBD is present at
17 low levels within cannabis. Further public health concerns may arise with the proliferation of non-cannabis products
18 containing low levels of CBD on the general market, including hemp dietary products, oils, pastes, confectionary, and
19 drinks [88]. The general message to the community currently is that “CBD is good for you”. Just how this has come
20 about is unclear but likely stems from the anecdotal and lay dissemination of information about CBD’s therapeutic
21 potential. But little is currently known about the doses and their biphasic nature, to correct such potential
22 misinformation. The longer term health effects of low levels of CBD being consumed in those forms remains to be
23 determined, as does the question of whether CBD from such, mostly orally consumed, products may interact with THC
24 from smoked cannabis. The findings of this study suggest there could potentially be interactive synergistic effects in
25 terms of intoxication.

26 27 *Limitations*

28
29 Although this study provides helpful data and description around low and high doses of CBD simultaneously inhaled
30 with THC, there are important aspects to be cognisant of in the interpretation and translation of the data. For some
31 participants, blood concentrations indicated the presence of THC or metabolites, or CBD, respectively, in drug
32 administration conditions where none would be expected. It is possible that this may reflect exposure from cannabis

1 used externally to the study, or that there may have been some low level contamination occurring between conditions
2 from the vaporiser equipment, despite following manufacturer cleaning protocols and providing each participant a new
3 balloon and mouthpiece for every drug condition. A recent rat study also reported the presence of THC in serum and
4 brain when only CBD had been administered [50], adding to an ongoing debate about the potential conversion of CBD
5 to THC in vivo, which was considered unlikely. But this phenomenon was only observed following oral and
6 subcutaneous administration, not pulmonary. In any case, only a few participants showed these unexpected compounds
7 in plasma, the median plasma concentrations showed clear separation between drug conditions and mostly the effects
8 reported would have been diminished rather than enhanced by these extraneous potential sources of compounds. We
9 showed that the intoxicating effect of CBD remained after exclusion of participants with THC in plasma. Further, this
10 study was not designed specifically for pharmacokinetic investigation and the blood concentrations reported here are
11 only those from a sample collected immediately after administration of the main dose. They may not reflect the peak
12 concentrations reached, nor were collections optimised for examining metabolism of the compounds over time. Related
13 to this, there was a great deal of variation in the time that participants took to inhale the doses from the balloons,
14 ranging from a few minutes to ~20 minutes for some participants in some conditions, particularly those containing high
15 dose CBD due to throat irritation and coughing. Such delays would also have affected the various measures of
16 intoxication, since some would have been obtained at different points within the time course of intoxication between
17 participants. There is much individual variability in any case in terms of metabolism and experiences with cannabis,
18 making complete standardisation problematic; protocols were as standardised as feasible in this study. It would have
19 been unethical to force participants to take the full dose when they reported that they had had enough and were already
20 intoxicated beyond their comfort levels. This, and the throat irritation and coughing led to a lesser dose of THC being
21 consumed in the THC+CBD_{high} condition, and as such, the findings that high dose CBD added to THC reduces
22 intoxication, must be tempered by the fact that less THC was consumed in that condition. However, the follow up
23 analyses on the smaller sample matched for THC dose in this and the THC alone condition, showed that this
24 confounder was not responsible for the reduced intoxication. It should further be noted that although the primary
25 hypotheses were restricted to account for Type 1 error, exploratory analyses were not, which makes replication
26 important for the results from the exploratory analyses. The predominance of males in our sample precluded
27 examination of sex differences; future studies should investigate whether the response to these cannabinoids may differ
28 in males and females.

29

30 *Comparison with previous findings*

31

1 One final consideration must be made and that is how or why our findings differ from those of Morgan and colleagues
2 [57] in a study using similar measures. Both studies used the same dose of THC – 8mg; Morgan et al report increased
3 scores on the PSI, whereas effects in this study were minimal. It is not clear why this may be, as similar inhalation
4 protocols were followed. The biggest differences between studies are in relation to effects of CBD added to THC. The
5 CBD:THC ratio in Morgan et al’s study was 2:1 (16mg CBD), whereas here we applied a 1:2 ratio in the THC+CBD_{low}
6 condition (4mg CBD) and a 50:1 ratio in the THC+CBD_{high} condition (400mg CBD). It is possible that if CBD shows
7 biphasic effects, with synergism at low doses and antagonism at high doses when combined with THC, the low-
8 medium dose applied in the Morgan et al study may have fallen into the mid-range between these two divergent
9 actions.

10

11 *Conclusion*

12

13 In conclusion, this study reports two novel findings: 1) that high doses of CBD when vaporised led to an intoxication
14 characterised by a dissociative state; 2) that low doses of CBD when added to THC potentiated intoxication relative to
15 THC alone, particularly in infrequent cannabis users, while high doses of CBD when added to THC reduced the
16 intoxication. These findings, while specific to vaporisation and requiring replication, may have implications for
17 recommended proportions of THC and CBD in cannabis being used medicinally or recreationally within the
18 community.

1

2 Ethical standards

3

4 This study was approved by the University of Wollongong and Illawarra Shoalhaven Local Health District Health and
5 Medical Human Research Ethics Committee and registered as a clinical trial (ISRCTN24109245 [89]). Participants
6 provided written informed consent prior to participating in the study and at the start of each drug session.

7

8 Conflict of interest

9

10 The authors declare that they have no conflict of interest.

1 **References**

- 2 1. Moore TH, Zammit S, Lingford-Hughes A, Barnes TR, Jones PB, Burke M, Lewis G (2007) Cannabis use and risk
3 of psychotic or affective mental health outcomes: a systematic review. *Lancet* 370:319-328
- 4 2. McPartland JM, Duncan M, Di Marzo V, Pertwee RG (2015) Are cannabidiol and Δ^9 -tetrahydrocannabivarin
5 negative modulators of the endocannabinoid system? A systematic review. *Br J Pharmacol* 172:737-753
- 6 3. Laprairie RB, Bagher AM, Kelly MEM, Denovan-Wright EM (2015) Cannabidiol is a negative allosteric modulator
7 of the cannabinoid CB1 receptor. *Br J Pharmacol* 172:4790-4805
- 8 4. D'Souza DC, Perry E, MacDougall L, Ammerman Y, Cooper T, Wu Y-T, Braley G, Gueorguieva R, Krystal JH
9 (2004) The psychotomimetic effects of intravenous delta-9-tetrahydrocannabinol in healthy individuals:
10 Implications for Psychosis. *Neuropsychopharmacology* 29:1558-1572
- 11 5. Morrison PD, Zois V, McKeown DA, Lee TD, Holt DW, Powell JF, Kapur S, Murray RM (2009) The acute effects
12 of synthetic intravenous Δ^9 -tetrahydrocannabinol on psychosis, mood and cognitive functioning. *Psychol Med*
13 39:1607-1616
- 14 6. Broyd SJ, van Hell HH, Beale C, Yücel M, Solowij N (2016) Acute and chronic effects of cannabinoids on human
15 cognition: A systematic review. *Biol Psychiatry* 79:557-567
- 16 7. Lorenzetti V, Solowij N, Yücel M (2016) The role of cannabinoids in neuroanatomic alterations in cannabis users.
17 *Biol Psychiatry* 79:e17-e31
- 18 8. Yücel M, Lorenzetti V, Suo C, Zalesky A, Fornito A, Takagi MJ, Lubman DI, Solowij N (2016) Hippocampal
19 harms, protection and recovery following regular cannabis use. *Transl Psychiatry* 6:e710
- 20 9. Di Forti M, Marconi A, Carra E, et al (2015) Proportion of patients in south London with first-episode psychosis
21 attributable to use of high potency cannabis: a case-control study. *The Lancet Psychiatry* 2:233-238
- 22 10. Bhattacharyya S, Morrison PD, Fusar-Poli P, et al (2010) Opposite effects of delta-9-tetrahydrocannabinol and
23 cannabidiol on human brain function and psychopathology. *Neuropsychopharmacology* 35:764-774
- 24 11. Leweke FM, Piomelli D, Pahlisch F, Muhl D, Gerth CW, Hoyer C, Klosterkötter J, Hellmich M, Koethe D (2012)
25 Cannabidiol enhances anandamide signaling and alleviates psychotic symptoms of schizophrenia. *Transl Psychiatry*
26 2:e94
- 27 12. Osborne AL, Solowij N, Weston-Green K (2017) A systematic review of the effect of cannabidiol on cognitive
28 function: Relevance to schizophrenia. *Neurosci Biobehav Rev* 72:310-324
- 29 13. McGuire P, Robson P, Cubala WJ, et al (2018) Cannabidiol (CBD) as an adjunctive therapy in schizophrenia: A
30 multicenter randomized controlled trial. *Am J Psychiatry* 175:225-231
- 31 14. ElSohly MA, Mehmedic Z, Foster S, Gon C, Chandra S, Church JC (2016) Changes in cannabis potency over the
32 last 2 decades (1995-2014): Analysis of current data in the United States. *Biol Psychiatry* 79:613-619

- 1 15. Englund A, Freeman TP, Murray RM, McGuire P (2017) Can we make cannabis safer? *The Lancet Psychiatry*
- 2 4:643-648
- 3 16. Mechoulam R, Parker L (2013) Towards a better cannabis drug. *Br J Pharmacol* 170:1363-1364
- 4 17. Morgan CJA, Schafer G, Freeman TP, Curran HV (2010) Impact of cannabidiol on the acute memory and
- 5 psychotomimetic effects of smoked cannabis: naturalistic study. *Br J Psychiatry* 197:285-290
- 6 18. Morgan CJA, Curran HV (2008) Effects of cannabidiol on schizophrenia-like symptoms in people who use
- 7 cannabis. *Br J Psychiatry* 192:306-307
- 8 19. Schubart CD, Sommer IE, van Gastel WA, Goetgebuer RL, Kahn RS, Boks MP (2011) Cannabis with high
- 9 cannabidiol content is associated with fewer psychotic experiences. *Schizophr Res* 130:216-221
- 10 20. Englund A, Morrison PD, Nottage J, et al (2013) Cannabidiol inhibits THC-elicited paranoid symptoms and
- 11 hippocampal-dependent memory impairment. *J Psychopharmacol* 27:19-27
- 12 21. Zuardi AW, Shirakawa I, Finkelfarb E, Karniol IG (1982) Action of cannabidiol on the anxiety and other effects
- 13 produced by delta 9-THC in normal subjects. *Psychopharmacology* 76:245-250
- 14 22. Malone DT, Jongejan D, Taylor DA (2009) Cannabidiol reverses the reduction in social interaction produced by
- 15 low dose Delta(9)-tetrahydrocannabinol in rats. *Pharmacol Biochem Behav* 93:91-96
- 16 23. Murphy M, Mills S, Winstone J, Leishman E, Wager-Miller J, Bradshaw H, Mackie K (2017) Chronic adolescent
- 17 $\Delta(9)$ -tetrahydrocannabinol treatment of male mice leads to long-term cognitive and behavioral dysfunction, which
- 18 are prevented by concurrent cannabidiol treatment. *Cannabis Cannabinoid Res* 2:235-246
- 19 24. Beale C, Broyd SJ, Chye Y, Suo C, Schira M, Galettis P, Martin JH, Yücel M, Solowij N (2018) Prolonged
- 20 cannabidiol treatment effects on hippocampal subfield volumes in current cannabis users. *Cannabis Cannabinoid*
- 21 *Res* 3:94-107
- 22 25. Solowij N, Broyd SJ, Beale C, Prick J-A, Greenwood L-M, van Hell H, Suo C, Galettis P, Pai N, Fu S, Croft RJ,
- 23 Martin JH, Yücel M (2018) Therapeutic effects of prolonged cannabidiol treatment on psychological symptoms and
- 24 cognitive function in regular cannabis users: A pragmatic open-label clinical trial. *Cannabis Cannabinoid Res* 3:21-
- 25 34
- 26 26. Karniol IG, Carlini EA (1973) Pharmacological interaction between cannabidiol and $\delta 9$ -tetrahydrocannabinol.
- 27 *Psychopharmacologia* 33:53-70
- 28 27. Zuardi AW, Teixeira NA, Karniol IC (1984) Pharmacological interaction of the effects of delta 9-trans-
- 29 tetrahydrocannabinol and cannabidiol on serum corticosterone levels in rats. *Arch Int Pharmacodyn Ther* 269:12-19
- 30 28. Varvel SA, Wiley JL, Yang R, Bridgen DT, Long K, Lichtman AH, Martin BR (2006) Interactions between THC
- 31 and cannabidiol in mouse models of cannabinoid activity. *Psychopharmacology* 186:226-234

- 1 29. Hayakawa K, Mishima K, Hazekawa M, Sano K, Irie K, Orito K, Egawa T, Kitamura Y, Uchida N, Nishimura R,
2 Egashira N, Iwasaki K, Fujiwara M (2008) Cannabidiol potentiates pharmacological effects of Δ^9 -
3 tetrahydrocannabinol via CB1 receptor-dependent mechanism. *Brain Res* 1188:157-164
- 4 30. Wright MJ Jr, Vandewater SA, Taffe MA (2013) Cannabidiol attenuates deficits of visuospatial associative
5 memory induced by Delta(9) tetrahydrocannabinol. *Br J Pharmacol* 170:1365-1373
- 6 31. Klein C, Karanges E, Spiro A, et al (2011) Cannabidiol potentiates Δ^9 -tetrahydrocannabinol (THC) behavioural
7 effects and alters THC pharmacokinetics during acute and chronic treatment in adolescent rats.
8 *Psychopharmacology* 218:443-457
- 9 32. Todd SM, Arnold JC (2016) Neural correlates of interactions between cannabidiol and $\Delta(9)$ -tetrahydrocannabinol
10 in mice: implications for medical cannabis. *Br J Pharmacol* 173:53-65
- 11 33. Todd SM, Zhou C, Clarke DJ, Chohan TW, Bahceci D, Arnold JC (2017) Interactions between cannabidiol and Δ^9 -
12 THC following acute and repeated dosing: Rebound hyperactivity, sensorimotor gating and epigenetic and
13 neuroadaptive changes in the mesolimbic pathway. *Eur Neuropsychopharmacol* 27:132-145
- 14 34. Morgan CJ, Freeman TP, Schafer GL, Curran HV (2010) Cannabidiol attenuates the appetitive effects of Delta 9-
15 tetrahydrocannabinol in humans smoking their chosen cannabis. *Neuropsychopharmacology* 35:1879-1885
- 16 35. Hindocha C, Freeman TP, Schafer G, Gardener C, Das RK, Morgan CJ, Curran HV (2015) Acute effects of delta-
17 9-tetrahydrocannabinol, cannabidiol and their combination on facial emotion recognition: a randomised, double-
18 blind, placebo-controlled study in cannabis users. *Eur Neuropsychopharmacol* 25:325-334
- 19 36. Mechoulam R, Parker LA (2013) The endocannabinoid system and the brain. *Annu Rev Psychol* 64:21-47
- 20 37. Draycott B, Loureiro M, Ahmad T, Tan H, Zunder J, Laviolette SR (2014) Cannabinoid transmission in the
21 prefrontal cortex bi-phasicly controls emotional memory formation via functional interactions with the ventral
22 tegmental area. *J Neurosci* 34:13096-13109
- 23 38. Loureiro M, Renard J, Zunder J, Laviolette SR (2015) Hippocampal cannabinoid transmission modulates dopamine
24 neuron activity: impact on rewarding memory formation and social interaction. *Neuropsychopharmacology*
25 40:1436-1447
- 26 39. Guimarães FS, Chiaretti TM, Graeff FG, Zuardi AW (1990) Antianxiety effect of cannabidiol in the elevated plus-
27 maze. *Psychopharmacology* 100:558-559
- 28 40. Campos AC, Guimarães FS (2009) Evidence for a potential role for TRPV1 receptors in the dorsolateral
29 periaqueductal gray in the attenuation of the anxiolytic effects of cannabinoids. *Prog Neuropsychopharmacol Biol*
30 *Psychiatry* 33:1517-1521

- 1 41. Zuardi AW, Rodrigues NP, Silva AL, Bernardo SA, Hallak JEC, Guimarães FS, Crippa JAS (2017) Inverted U-
2 shaped dose-response curve of the anxiolytic effect of cannabidiol during public speaking in real life. *Front*
3 *Pharmacol* 8:259-259
- 4 42. Linares IM, Zuardi AW, Pereira LC, Queiroz RH, Mechoulam R, Guimarães FS, Crippa JA (in press) Cannabidiol
5 presents an inverted U-shaped dose-response curve in a simulated public speaking test. *Braz J Psychiatry*
- 6 43. Watanabe K, Kayano Y, Matsunaga T, Yamamoto I, Yoshimura H (1996) Inhibition of anandamide amidase
7 activity in mouse brain microsomes by cannabinoids. *Biol Pharm Bull* 19:1109–1111
- 8 44. Rakhshan F, Day TA, Blakely RD, Barker EL (2000) Carrier-mediated uptake of the endogenous cannabinoid
9 anandamide in RBL-2H3 cells. *J Pharmacol Exp Ther* 292:960-967
- 10 45. Pertwee RG (2008) The diverse CB1 and CB2 receptor pharmacology of three plant cannabinoids: Delta(9)-
11 tetrahydrocannabinol, cannabidiol and Delta(9)-tetrahydrocannabivarin. *Br J Pharmacol* 153:199-215
- 12 46. Zuardi AW, Karniol IG (1983) Effects on variable-interval performance in rats of delta 9-tetrahydrocannabinol and
13 cannabidiol, separately and in combination. *Braz J Med Biol Res* 16:141-146
- 14 47. Zuardi AW, Hallak JEC, Crippa JAS (2012) Interaction between cannabidiol (CBD) and Delta(9)-
15 tetrahydrocannabinol (THC): influence of administration interval and dose ratio between the cannabinoids.
16 *Psychopharmacology* 219:247-249
- 17 48. Arnold JC, Boucher AA, Karl T (2012) The Yin and Yang of cannabis-induced psychosis: The actions of Δ^9 -
18 tetrahydrocannabinol and cannabidiol in rodent models of schizophrenia. *Curr Pharm Des* 18:5113-5130
- 19 49. Silveira MM, Arnold JC, Laviolette SR, Hillard CJ, Celorrio M, Aymerich MS, Adams WK (2017) Seeing through
20 the smoke: Human and animal studies of cannabis use and endocannabinoid signalling in corticolimbic networks.
21 *Neurosci Biobehav Rev* 76:380-395
- 22 50. Hložek T, Uttl L, Kadeřábek L, Balíková M, Lhotková E, Horsley RR, Nováková P, Šíchová K, Štefková K, Tylš
23 F, Kuchař M, Páleníček T (2017) Pharmacokinetic and behavioural profile of THC, CBD, and THC+CBD
24 combination after pulmonary, oral, and subcutaneous administration in rats and confirmation of conversion in vivo
25 of CBD to THC. *Eur Neuropsychopharmacol* 27:1223-1237
- 26 51. Bornheim LM, Kim KY, Li J, Perotti BY, Benet LZ (1995) Effect of cannabidiol pretreatment on the kinetics of
27 tetrahydrocannabinol metabolites in mouse brain. *Drug Metab Dispos* 23:825-831
- 28 52. Jones G, Pertwee RG (1972) A metabolic interaction in vivo between cannabidiol and Δ^1 -tetrahydrocannabinol. *Br*
29 *J Pharmacol* 45 (2):375-377
- 30 53. Grotenhermen F (2003) Pharmacokinetics and pharmacodynamics of cannabinoids. *Clin Pharmacokinet* 42:327-
31 360

- 1 54. Hazekamp A, Ruhaak R, Zuurman L, van Gerven J, Verpoorte R (2006) Evaluation of a vaporizing device
2 (Volcano®) for the pulmonary administration of tetrahydrocannabinol. *J Pharm Sci* 95:1308-1317
- 3 55. Solowij N (2018) Peering through the haze of smoked vs vaporized cannabis – to vape or not to vape? *JAMA Netw*
4 *Open* 1:e184838
- 5 56. Spindle TR, Cone EJ, Schlienz NJ, et al. (2018) Acute effects of smoked and vaporized cannabis in healthy adults
6 who infrequently use cannabis: A crossover trial. *JAMA Netw Open* 1:e184841
- 7 57. Morgan CJA, Freeman TP, Hindocha C, Schafer G, Gardner C, Curran HV (2018) Individual and combined effects
8 of acute delta-9-tetrahydrocannabinol and cannabidiol on psychotomimetic symptoms and memory function. *Transl*
9 *Psychiatry* 8:181
- 10 58. Potter DJ, Clark P, Brown MB (2008) Potency of Δ^9 -THC and other cannabinoids in cannabis in England in 2005:
11 Implications for psychoactivity and pharmacology. *J Forensic Sci* 53:90-94
- 12 59. Swift W, Wong A, Li KM, Arnold JC, McGregor IS (2013) Analysis of cannabis seizures in NSW, Australia:
13 Cannabis potency and cannabinoid profile. *PLoS One* 8:e70052
- 14 60. Solowij N, Broyd SJ, van Hell HH, Hazekamp A (2014) A protocol for the delivery of cannabidiol (CBD) and
15 combined CBD and Δ^9 -tetrahydrocannabinol (THC) by vaporisation. *BMC Pharmacol Toxicol* 15:58
- 16 61. Demirakca T, Sartorius A, Ende G, Meyer N, Welzel H, Skopp G, Mann K, Hermann D (2011) Diminished gray
17 matter in the hippocampus of cannabis users: possible protective effects of cannabidiol. *Drug Alcohol Depend*
18 114:242-245
- 19 62. Sobell L, Sobell M (1992) Timeline Follow-Back: A technique for assessing self-reported ethanol consumption. In:
20 Allen J, Litten RZ (eds) *Measuring Alcohol Consumption: Psychosocial and biological methods*. Humana Press,
21 Totowa NJ, pp 41-72
- 22 63. Saunders JB, Aasland OG, Babor TF, de la Fuente JR, Grant M (1993) Development of the Alcohol Use Disorders
23 Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol
24 consumption-II. *Addiction* 88:791-804
- 25 64. Sheehan DV, Lecrubier Y, Sheehan KH, et al (1998) The Mini-International Neuropsychiatric Interview (M.I.N.I.):
26 the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *J Clin*
27 *Psychiatry* 59 Suppl 20:22-33
- 28 65. Spielberger CD, Gorsuch RL, Lushene R, Vagg PR, Jacobs GA (1983) *Manual for the State-Trait Anxiety*
29 *Inventory*. Consulting Psychologists Press, Palo Alto, CA
- 30 66. Beck AT, Ward C, Mendelson M (1961) Beck Depression Inventory (BDI). *Arch Gen Psychiatry* 4:561-571

- 1 67. Stefanis N, Hanssen M, Smirnis N, Avramopoulos D, Evdokimidis I, Stefanis C, Verdoux H, Van Os J (2002)
2 Evidence that three dimensions of psychosis have a distribution in the general population. *Psychol Med* 32:347-358
- 3 68. Raine A (1991) The SPQ: a scale for the assessment of schizotypal personality based on DSM-III-R criteria.
4 *Schizophr Bull* 17:555
- 5 69. Gossop M, Darke S, Griffiths P, Hando J, Powis B, Hall W, Strang J (1995) The Severity of Dependence Scale
6 (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine
7 users. *Addiction* 90:607-614
- 8 70. Barkus EJ, Stirling J, Hopkins RS, Lewis S (2006) Cannabis-induced psychosis-like experiences are associated
9 with high schizotypy. *Psychopathology* 39:175-178
- 10 71. Niesink RJ, Rigter S, Koeter MW, Brunt TM (2015) Potency trends of Δ^9 -tetrahydrocannabinol, cannabidiol and
11 cannabitol in cannabis in the Netherlands: 2005–15. *Addiction* 110:1941-1950
- 12 72. Galettis P (2016) Development of a simple LCMSMS method for THC and metabolites in plasma. *Asia Pac J Clin*
13 *Oncol* 12:13-34
- 14 73. Bremner JD, Krystal JH, Putnam FW, Southwick SM, Marmar C, Charney DS, Mazure CM (1998) Measurement
15 of dissociative states with the Clinician-Administered Dissociative States Scale (CADSS). *J Trauma Stress* 11:125-
16 136
- 17 74. Bowdle TA, Radant AD, Cowley DS, Kharasch ED, Strassman RJ, Roy-Byrne PP (1998) Psychedelic effects of
18 ketamine in healthy volunteers: Relationship to steady-state plasma concentrations. *Anesthesia* 88:82-8
- 19 75. Zuurman L, Roy C, Schoemaker RC, et al (2008) Effect of intrapulmonary tetrahydrocannabinol administration in
20 humans. *J Psychopharmacol* 22:707-716
- 21 76. Mason OJ, Morgan CJM, Stefanovic A, Curran HV (2008) The Psychotomimetic States Inventory (PSI):
22 Measuring psychotic-type experiences from ketamine and cannabis. *Schizophr Res* 103:138-142
- 23 77. Overall JE, Gorham DR (1962) The Brief Psychiatric Rating Scale. *Psychol Rep* 10:799-812
- 24 78. Russo E, Guy GW (2006) A tale of two cannabinoids: The therapeutic rationale for combining
25 tetrahydrocannabinol and cannabidiol. *Med Hypotheses* 66:234-246
- 26 79. Hallak JEC, Dursun SM, Bosi DC, et al (2011) The interplay of cannabinoid and NMDA glutamate receptor
27 systems in humans: Preliminary evidence of interactive effects of cannabidiol and ketamine in healthy human
28 subjects. *Prog Neuropsychopharmacol Biol Psychiatry* 35:198-202
- 29 80. Tham M, Yilmaz O, Alaverdashvili M, Kelly MEM, Denovan-Wright EM, Laprairie RB (in press) Allosteric and
30 orthosteric pharmacology of cannabidiol and cannabidiol-dimethylheptyl at the type 1 and type 2 cannabinoid
31 receptors. *Br J Pharmacol*

- 1 81. Straiker A, Dvorakova M, Zimmowitch A, Mackie K (2018) Cannabidiol inhibits endocannabinoid signaling in
2 autaptic hippocampal neurons. *Mol Pharmacol* 94:743-748
- 3 82. Kathmann M, Flau K, Redmer A, Tränkle C, Schlicker E (2006) Cannabidiol is an allosteric modulator at mu- and
4 delta-opioid receptors. *Naunyn Schmiedebergs Arch Pharmacol* 372:354-361
- 5 83. Crippa JA, Guimarães FS, Campos AC, Zuardi AW (2018) Translational investigation of the therapeutic potential
6 of cannabidiol (CBD): Toward a New Age. *Front Immunol* 9:2009
- 7 84. Baillie GL, Horswill JG, Anavi-Goffer S, et al (2013) CB(1) receptor allosteric modulators display both agonist
8 and signaling pathway specificity. *Mol Pharmacol* 83:322-338
- 9 85. Priestley RS, Nickolls SA, Alexander SPH, Kendall DA (2015) A potential role for cannabinoid receptors in the
10 therapeutic action of fenofibrate. *FASEB J* 29:1446-1455
- 11 86. Taylor L, Gidal B, Blakey G, Tayo B, Morrison G (2018) A phase I, randomized, double-blind, placebo-controlled,
12 single ascending dose, multiple dose, and food effect trial of the safety, tolerability and pharmacokinetics of highly
13 purified cannabidiol in healthy subjects. *CNS Drugs* 32:1053-1067
- 14 87. Dalton WS, Martz R, Lemberger L, Rodda BE, Forney RB (1976) Influence of cannabidiol on delta-9-
15 tetrahydrocannabinol effects. *Clin Pharmacol Ther* 19:300-309
- 16 88. Fleming A (2018) Cannabis health products are everywhere – but do they live up to the hype? *The Guardian*.
17 <https://www.theguardian.com/lifeandstyle/2018/oct/15/cannabis-health-products-live-up-to-hype-cannabidiol-cbd>.
18 Accessed 15 October 2018
- 19 89. Solowij N (2012) Vulnerability markers in the association between cannabis and schizophrenia: a randomised
20 controlled trial of acute cannabinoid administration. *Current Controlled Trials* 5:5

21

22

1 **Figure Captions**

2

3 **Fig. 1.** Schematic of the time points of various measures throughout each drug session. CADSS: Clinician
 4 Administered Dissociative States Scale; HR+BP: heart rate and blood pressure; PSI: Psychotomimetic States
 5 Inventory; VAS: Visual Analogue Scale. Time 0: baseline, ~15 min prior to drug administration; Time 1: ~1 min after
 6 inhalation of main dose; Time 2: ~55 min later; Top up 1, TU1^a: ~1 min following a top-up dose; Time 3: ~15 min
 7 after inhalation of TU1; Pre-Top up 2, Pre-TU2^a: ~45 min after TU1; Top up 2, TU2^a: ~1 min after a second top-up
 8 dose; Recovery: ~1 hr after TU2; ^aData points not analysed in this paper.

9

10 **Fig. 2** Heart rate (bpm) averaged over the entire sample across the testing protocol. The x-axis depicts approximate
 11 time in min (not to scale) from the completion of inhalation of the main dose. Time 0: baseline, ~15 min prior to drug
 12 administration; Time 1: ~1 min after inhalation of main dose; Time 2: ~55 min later; Top up 1, TU1^a: ~1 min following
 13 a top-up dose; Pre-Top up 2, Pre-TU2^a: ~45 min after TU1; Top up 2, TU2^a: ~1 min after a second top-up dose;
 14 Recovery: ~1 hr after TU2. ^aData points not analysed in this paper.

15

16 **Fig. 3.** Objective ratings of intoxication by a blind observer, rating participants on the 8 observer items of the Clinician
 17 Administered Dissociative States Scale (change scores from Time 0 to Time 2), for a) Placebo vs CBD_{high} by group; b)
 18 the three THC conditions by group. Error bars indicate SEM; and Δ , mean change or difference score.

19

20 **Fig. 4 a)** Subjective rating of intoxication (scale range 1-10) for the entire sample across the testing protocol. The x-
 21 axis depicts approximate time in minutes (min; not to scale) from the completion of inhalation of the main dose; b)
 22 Change scores for subjective intoxication (change from baseline) at Time 1 by group for Placebo vs CBD_{high}; c)
 23 Change scores for subjective intoxication (change from baseline) at Time 1 by group for the three THC conditions.
 24 Time 0: baseline, ~15 min prior to drug administration; Time 1: ~1 min after inhalation of main dose; Time 2: ~55 min
 25 later; Top up 1, TU1^a: ~1 min following a top-up dose; Pre-Top up 2, Pre-TU2^a: ~45 min after TU1; Top up 2, TU2^a:
 26 ~1 min after a second top-up dose; Recovery: ~1 hr after TU2. Error bars indicate SEM; and Δ , mean change or
 27 difference score. ^aData points not analysed in this paper.

28

29 **Fig. 5.** a) Change scores from baseline on self-report measures of intoxication at Time 2 for the Internal Perception
 30 subscale, External Perception subscale and Drowsiness subscale of the Visual Analogue Scale (VAS), displayed by
 31 group separately for Placebo vs CBD_{high}, and THC conditions; b) Change scores from baseline on self-report measures

- 1 of intoxication at Time 2 for Total score, Amnesia subscale and Derealisation subscale of the Clinician Administered
- 2 Dissociative States Scale (CADSS). Error bars indicate SEM; and Δ , mean change or difference score from baseline.

1 **Tables**

2

3 **Table 1.** Drug conditions defined by doses loaded into the vaporiser and estimates of actual dose delivered (mg), and
 4 plasma concentrations of THC, THC-metabolites and CBD (ng/ml) at Time 1; median (range).

5

Drug Condition (dose loaded)	Placebo	CBD (400mg)	THC (8mg)	THC+CBD_{low} (8mg+4mg)	THC+CBD_{high} (8mg+400mg)*
Proportion of balloon inhaled	1.0 (1.0 – 1.0)	0.963 (0.25 – 1.0)	1.0 (0.80 – 1.0)	1.0 (0.50 – 1.0)	0.625 (0.15 – 1.0)
Proportion inhaled x dose loaded	0.0	385mg (100 – 400)	8mg (6.4 – 8)	8mg THC (4 – 8) 4mg CBD (2 – 4)	5mg THC (1.2 – 8) 250mg CBD (60 – 400)
Plasma concentrations (ng/ml)					
THC	0.50 (0 – 27.6)	0.0 (0 – 44.6)	87.8 (19.7 – 275.1)	91.2 (16.9 – 173.7)	30.0 (7.2 – 127.8)
OH-THC	0.0 (0 – 10.9)	0.0 (0 – 19.4)	6.6 (1.8 – 22.1)	6.0 (2.4 – 33.7)	2.6 (0 – 18.1)
COOH-THC	0.70 (0 – 328.0)	0.70 (0 – 489.2)	20.0 (1.9 – 283.8)	18.6 (1.5 – 346.4)	11.0 (0 – 429.9)
CBD	1.2 (0 – 73.8)	525.9 (114 – 2783)	2.6 (0 – 32.2)	24.6 (4.9 – 92.1)	379.3 (89.0 – 2102.5)

6 * The actual dose loaded in the THC+CBD_{high} condition was 12mg THC with 400mg CBD to achieve equivalence

7 following vaporisation to the 8mg THC loaded in the THC and THC+CBD_{low} conditions, due to inefficiency of

8 vaporisation of THC in the presence of high doses of CBD (see [60]).

9 OH-THC: 11-hydroxy- Δ^9 -tetrahydrocannabinol; COOH-THC: 11-nor-9-carboxy- Δ^9 -tetrahydrocannabinol

10

1 **Table 2.** Spearman's correlations (*rho*) between objective and subjective intoxication measures (change scores from
 2 baseline), lifetime occasions of cannabis use and hours since last use of cannabis.
 3

		Subjective Intoxication Time 1	Subjective Intoxication Time 2	Lifetime Use	Last Use
Observer					
Intoxication Time 2					
	THC+CBD _{low}	.638***	.675***	-.523***	.537***
	THC	.468**	.526***	-.416**	.395*
	THC+CBD _{high}	.310	.403*	-.097	.014
Subjective					
Intoxication Time 1					
	THC+CBD _{low}		.696***	-.448**	.563***
	THC		.713***	-.374*	.278
	THC+CBD _{high}		.607***	.194	-.290
Subjective					
Intoxication Time 2					
	THC+CBD _{low}			-.537***	.541***
	THC			-.485**	.430**
	THC+CBD _{high}			-.253	.172

4 * $p < .05$; ** $p < .01$; *** $p < .001$. Trend level associations are presented without asterisks.

1 **Table 3.** Spearman's correlations (ρ) between objective and subjective intoxication measures, and additional
 2 measures of intoxication from the CADSS, VAS and PSI.

3

		Subjective intoxication Time 1	Subjective intoxication Time 2	Objective intoxication Time 2
CADSS	CBD _{high}	.375*	.404*	-
	Total score			
	THC+CBD _{low}	.493**	.616***	.648***
	THC	.535**	.702***	.834***
	THC+CBD _{high}	.526**	.699***	.680***
Amnesia	CBD _{high}	.309	-	-
	THC+CBD _{low}	-	.463**	.532**
	THC	.551***	.553***	.640***
	THC+CBD _{high}	.313	.391*	-
Depersonalisation	CBD _{high}	.388*	.490**	-
	THC+CBD _{low}	.378*	.383*	.525**
	THC	.304	.411*	.503**
	THC+CBD _{high}	.328	.675***	.493**
Derealisation	CBD _{high}	.348*	.423**	-
	THC+CBD _{low}	.466**	.579**	.631***
	THC	.488**	.667***	.837***
	THC+CBD _{high}	.447**	.593***	.663***
VAS	CBD _{high}	.350*	.487**	.322
	Internal perception			
	Time 1			
	THC+CBD _{low}	.453**	.365*	.423**
	THC	.623***	.651***	.773***
	THC+CBD _{high}	.525**	.439**	.330*
Internal perception	CBD _{high}	.504**	.519***	-
	Time 2			
	THC+CBD _{low}	.444**	.584***	.537**
	THC	.515**	.683***	.724***
	THC+CBD _{high}	.424*	.603***	.587***
External perception	CBD _{high}	.282	.446**	.372*
	Time 1			
	THC+CBD _{low}	.379*	-	.288
	THC	.379*	-	.419*
	THC+CBD _{high}	-	.461**	.300
External perception	CBD _{high}	-	.387*	-
	Time 2			
	THC+CBD _{low}	-	.482**	.539**
	THC	-	.388*	.528**
	THC+CBD _{high}	-	-	-
Drowsy Time 1	CBD _{high}	-	-	.367*

	THC+CBD _{low}	.338*	.356*	.358*
	THC	.383*	-	-
	THC+CBD _{high}	.337*	.310	.371*
Drowsy Time 2	CBD _{high}	-	-	-
	THC+CBD _{low}	.329*	.375*	.424**
	THC	.327	.338*	.385
	THC+CBD _{high}	-	-	-
PSI	CBD _{high}	-	-	-
Delusional thinking	THC+CBD _{low}	-	-	-
	THC	-	-	-
	THC+CBD _{high}	-	-	-
Perceptual distortion	CBD _{high}	-	-	-
	THC+CBD _{low}	.512**	.421**	.348*
	THC	.309	.376*	.637***
	THC+CBD _{high}	.313	.553***	.732***
Cognitive disturbance	CBD _{high}	-	-	-
	THC+CBD _{low}	.422**	.471**	.463**
	THC	-	-	.577***
	THC+CBD _{high}	.361*	.629***	.337*
Anhedonia	CBD _{high}	-	-	-
	THC+CBD _{low}	-	.311	.324
	THC	.333*	.459**	-
	THC+CBD _{high}	-	.306	-
Mania	CBD _{high}	-	-	-
	THC+CBD _{low}	.391*	.445**	.388*
	THC	-	.400*	.470**
	THC+CBD _{high}	-	.301	-
Paranoia	CBD _{high}	-	-.294	-
	THC+CBD _{low}	-	-	-
	THC	-	-	.414*
	THC+CBD _{high}	.323	-	.313

1 * $p < .05$; ** $p < .01$; *** $p < .001$. Trend level associations are presented without asterisks.

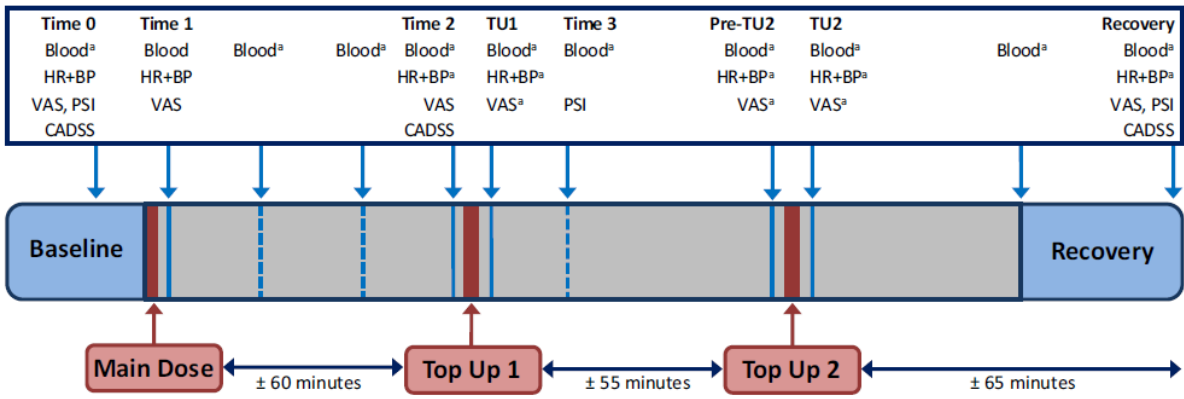


Figure 1

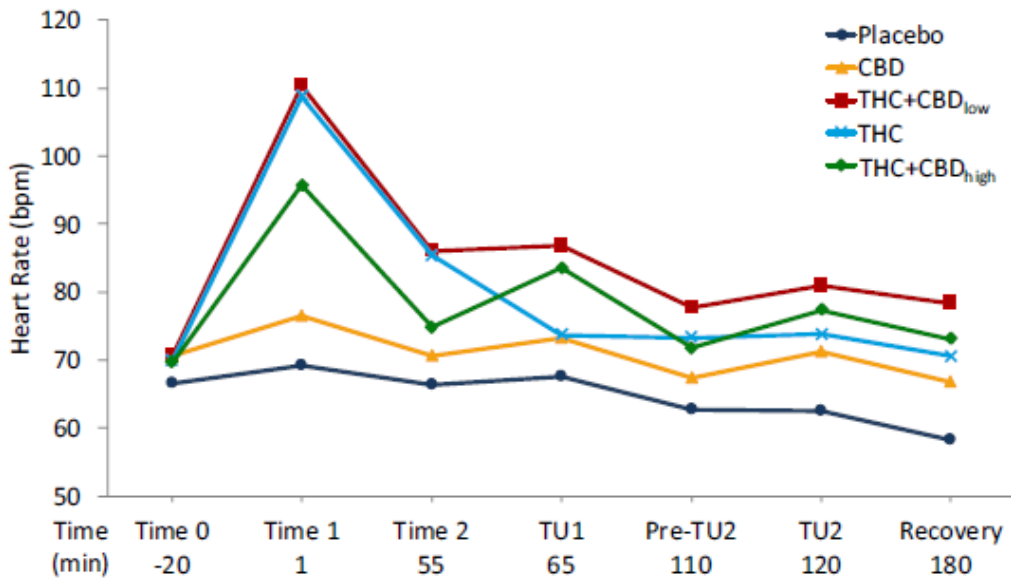


Figure 2

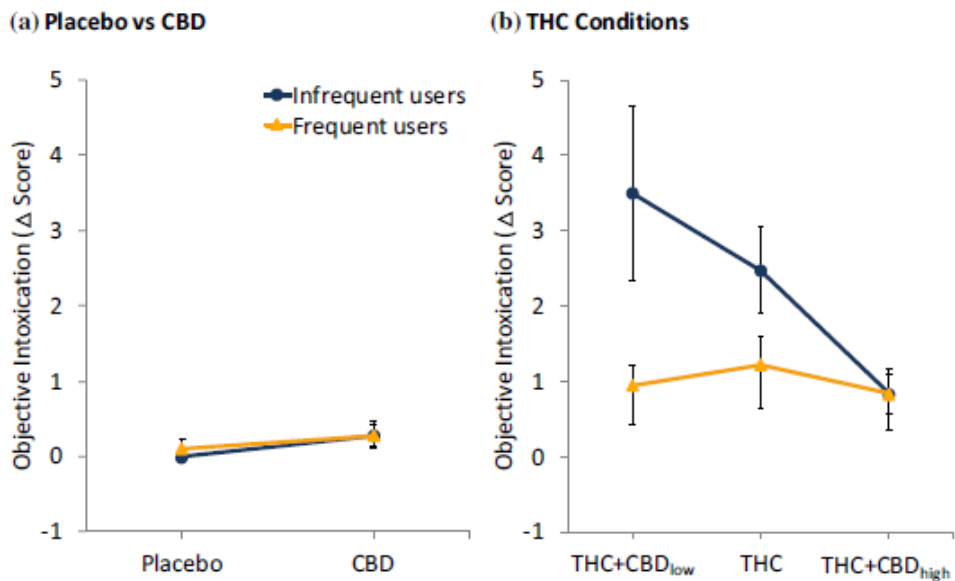
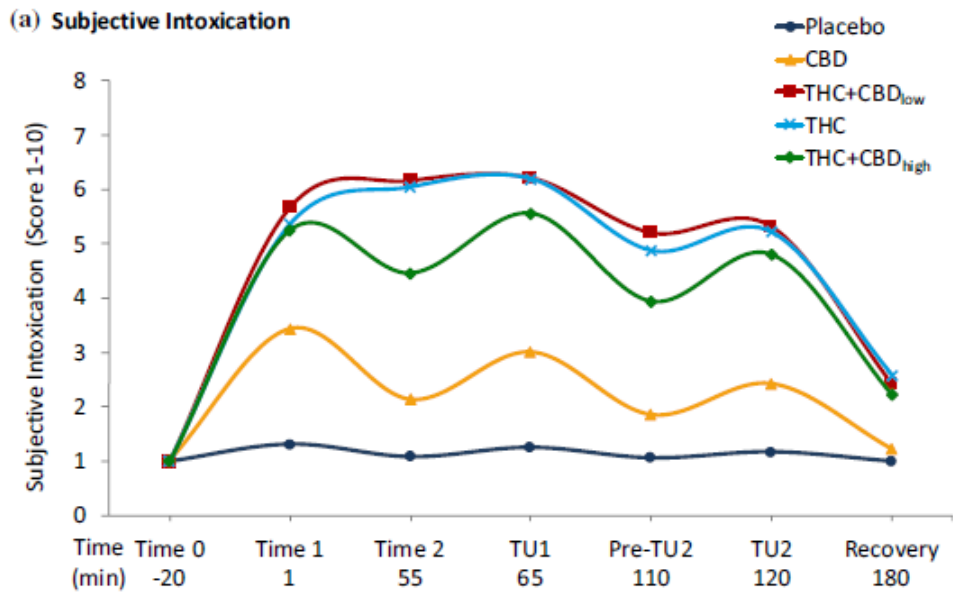
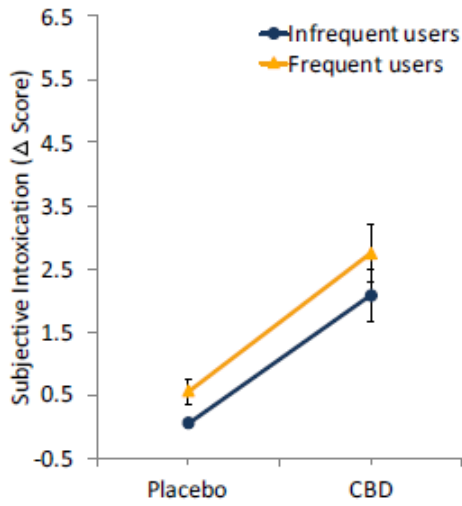


Figure 3



(b) Placebo vs CBD



(c) THC Conditions

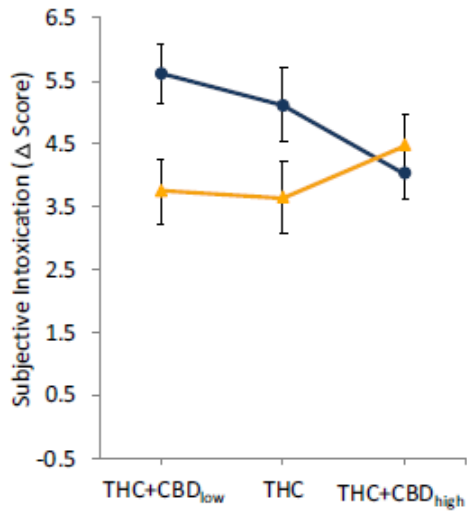


Figure 4

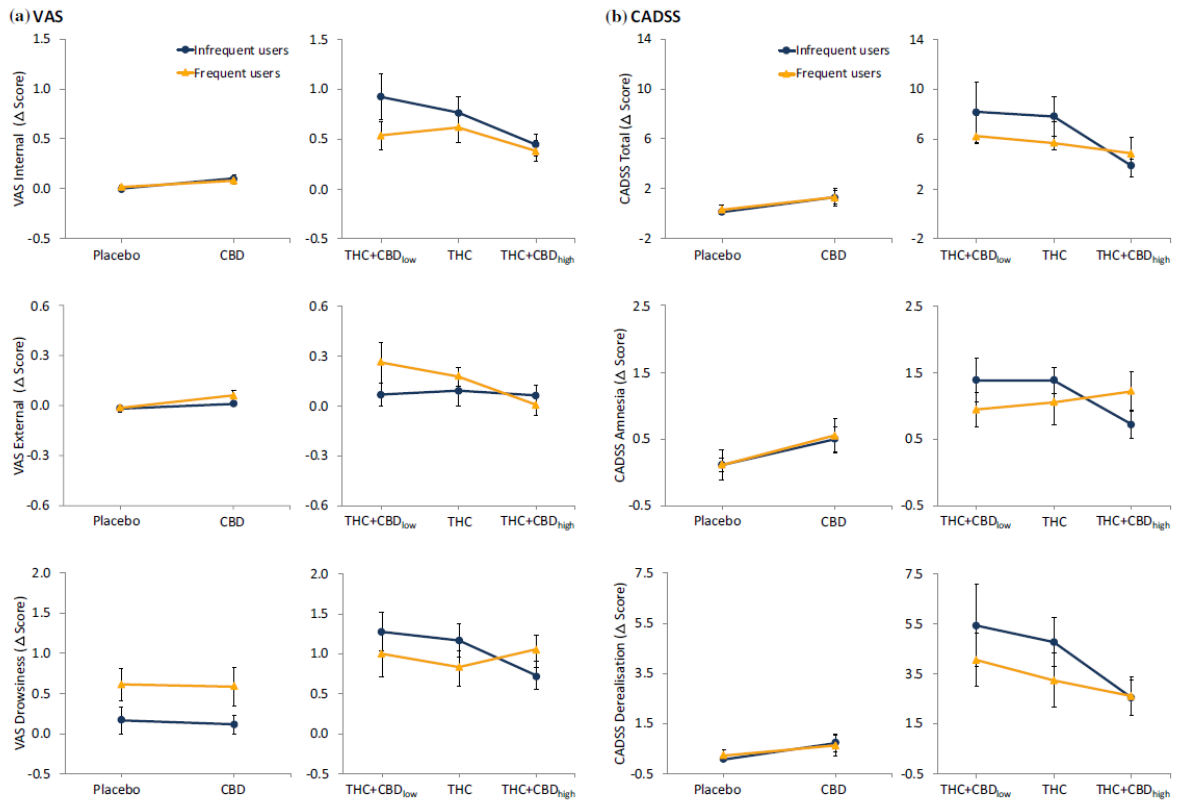


Figure 5