Cannabis Use and Stigma

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INTRODUCTION

Over the span of their lifetime, approximately 21.6% of Canadians may report having a substance use disorder and approximately 6.8% of Canadians will experience a Cannabis Use Disorder (Pearson et al., 2013). Substance use disorders tend to be more prevalent within youth populations. According to Pearson et al. (2013), youth aged 15 to 24 had the highest rate of substance use disorder (11.9%) while the lowest rate (1.9%) was observed among those aged 45 and older. With regards to Cannabis Use Disorder (CUD), 9% of cannabis users overall will meet the criteria for a cannabis use disorder in their lifetime, however, 17% (1 in 6) who begin using during adolescence will meet the criteria for a CUD (Volkow, N. D. et al, 2014).

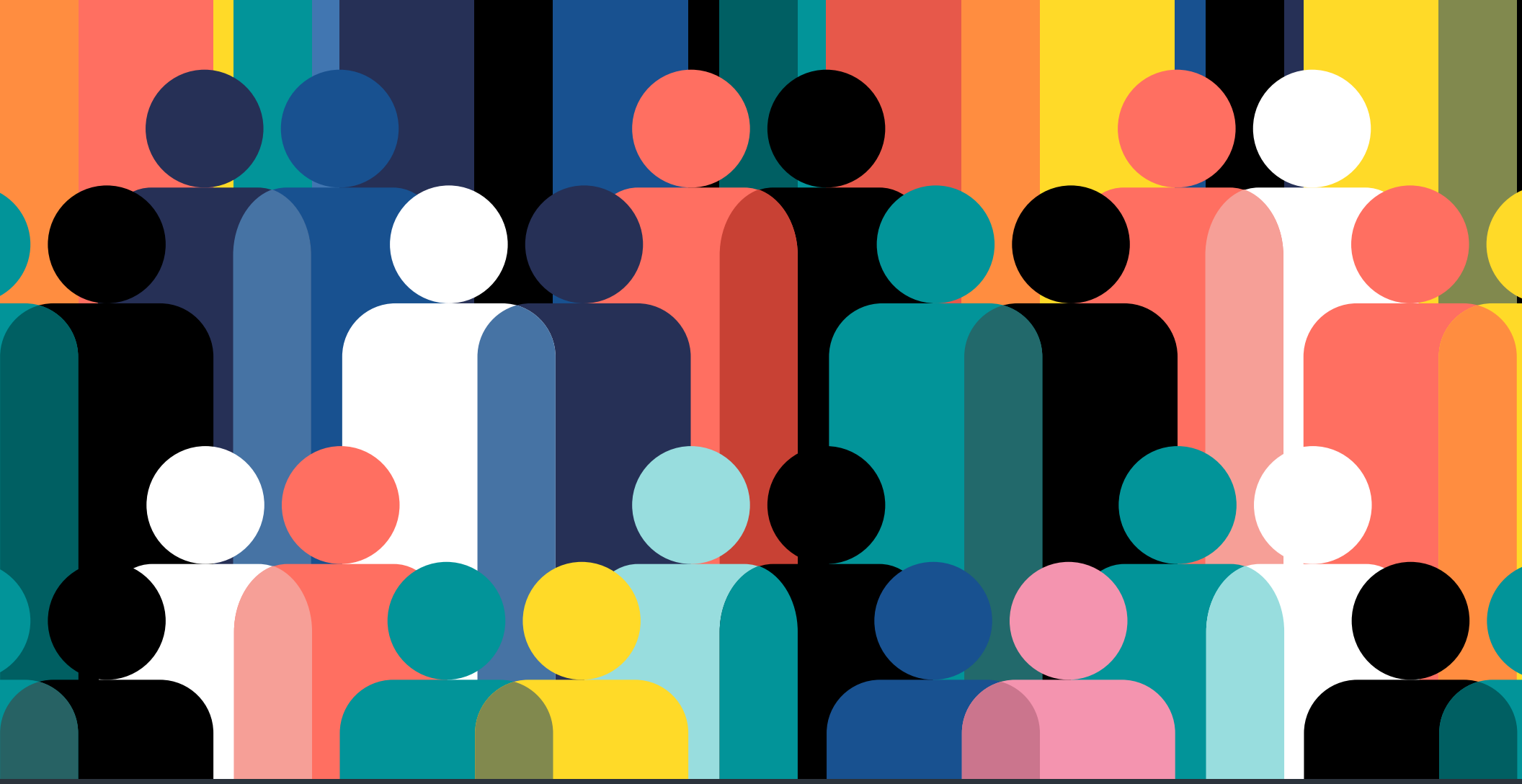
Stigma creates barriers, prevents people from seeking help, isolates individuals and affects families and communities (Buttazzoni et al., 2021). Around 40% of people report that stigma prevents them from seeking medical help (CAMH, 2021). As substance use disorders have a higher prevalence within youth populations, it's important to discuss the effects of stigma on substance use (including cannabis use) as it pertains to youth specifically, as less than 20% of youth with mental illness/ substance use disorders get the help that they need (CMHA, 2021). This low percentage can be attributed to stigma's effect on policy-makers and wellness providers and their willingness to allocate resources and quality care to those who need it (Yang, L. H., et al, 2017).

This review intends to provide guidance on dismantling stigma related to cannabis use and support the development of content which informs a youth-focused intervention on cannabis use and stigma.

WHAT IS STIGMA?

Stigma is an ancient Greek word. In its origins, the word stigma represented a type of marking or tattoo that was cut or burned into the skin of what society deemed morally polluted persons such as traitors, criminals, or slaves to visually identify them as blemished. This marking meant these individuals were to be avoided, especially in public places. Stigma was meant to serve as an outward indication that there was something shameful about the bearer. The word stigma was later adapted and applied to more personal attributes considered discrediting or even shameful. To this day, the term signifies some disgrace or failing (Encyclopedia, 2018).

Today, stigma can be associated with physical attributes (including disability), group membership (including ethnicity or religious affiliation), or other personal traits that are viewed negatively in society, including mental illness or addiction (Hing, et al., 2016). Stigma is a major cause of discrimination, exclusion, and abuse of human rights. It is also a public health issue that contributes to increased risk of death, incarceration, and mental health concerns among dependent populations. Stigma negatively affects a person's self-esteem, damages relationships with loved ones, and prevents those experiencing substance use disorders from accessing treatment.



Types of Stigma

There are five main types of stigma currently defined. People may experience stigma at many different levels in their lives ranging from internalized stigma to systems in place which stigmatize groups and individuals.

Exploring the five main types of stigma can improve understanding about the barriers people may face when opening up about their substance use or seeking support from loved ones and professionals.

- Social Stigma
- Self Stigma
- Structural Stigma
- Anticipated Stigma
- Secondary Stigma

TYPES OF STIGMA

Self Stigma

Encompasses internalized stigma and perceived stigma. Internalized stigma pertains to how members of stigmatized groups view themselves. Closely related, perceived stigma relates to how members of these groups believe others in society see them (Canadian Nurses Association, 2021). People with substance use disorders may be viewed as more responsible for their conditions than people with other mental health concerns. As a result, someone who uses cannabis may feel that their use is due to personal deficiencies or behaviours (Committee, 2016).

Social Stigma

Refers to how different majority groups in society view minority groups. This can also be referred to as minority stigma (Canadian Nurses Association, 2021). People who use cannabis may experience social exclusion or even segregation as a result of social stigma (Committee, 2016).

Structural Stigma

Refers to how professionals who work with stigmatized groups, including counsellors, doctors, and police, view members of stigmatized groups (Livingston, Milne, Fang, & Amari, 2011). Structural stigma towards people who use cannabis may appear as lower quality treatment in health care settings for people who have substance use or mental health concerns (Committee, 2016).

Anticipated Stigma

Refers to situations when individuals may not disclose certain characteristics about themselves out of fear of experiencing stigma for said characteristics (Canadian Nurses Association, 2021). People who use cannabis may experience fears related to the consequences of disclosing their substance use, creating an additional barrier to help- seeking (Committee, 2016).

Social Stigma

Experienced by those in society who are supporters or caregivers to stigmatized individuals (Canadian Nurses Association, 2021). In other words, it is stigma by association. A person who has a parent or a sibling with a substance use disorder may feel aspects of stigma because they are associated with this specific family member.

Stigma has further been investigated according to its constituent dimensions. The six dimensions of stigma are concealability, course, disruptiveness, aesthetic qualities, origin, and peril (Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984). Concealability refers to the extent to which the stigmatizing behaviour is visible to others, and/or can be hidden or minimized. Course refers to the pattern, outcome, or life course of a behaviour – particularly the extent to which a behaviour is inevitable or permanent. Disruptiveness describes the behaviour's impact on an individual's daily social functioning. The aesthetic dimension examines the extent to which the behaviour makes an individual attractive or repellent. The origin dimension analyses the circumstances of the onset of the behaviour, as well as attributions of responsibility for it. Finally, the dimension of peril describes the extent to which the behaviour is perceived as dangerous to others (Donaldson, et al., 2015).

PROCESS OF STIGMA CREATION

There is a gap between effective evidence-based treatments and those who access these treatments when examining people with substance use disorders (SUDs). Stigma persists in many layers of substance use treatment. The impact of stigma on people who use cannabis/experience cannabis use disorder is formed through a process involving the co-occurrence of labelling, stereotyping, social distancing (referred to as emotional reactions) and status loss and discrimination. This cycle of stigma affects many areas of treatment availability from policies created, resources allocated, and limited screening for SUD which may make individuals with SUDs less inclined to seek treatment
(Yang, et. Al, 2017).

Labelling:
Emphasizes differences and defines a person by their condition or problem and triggers stereotypes (E.g. “Stoner”).

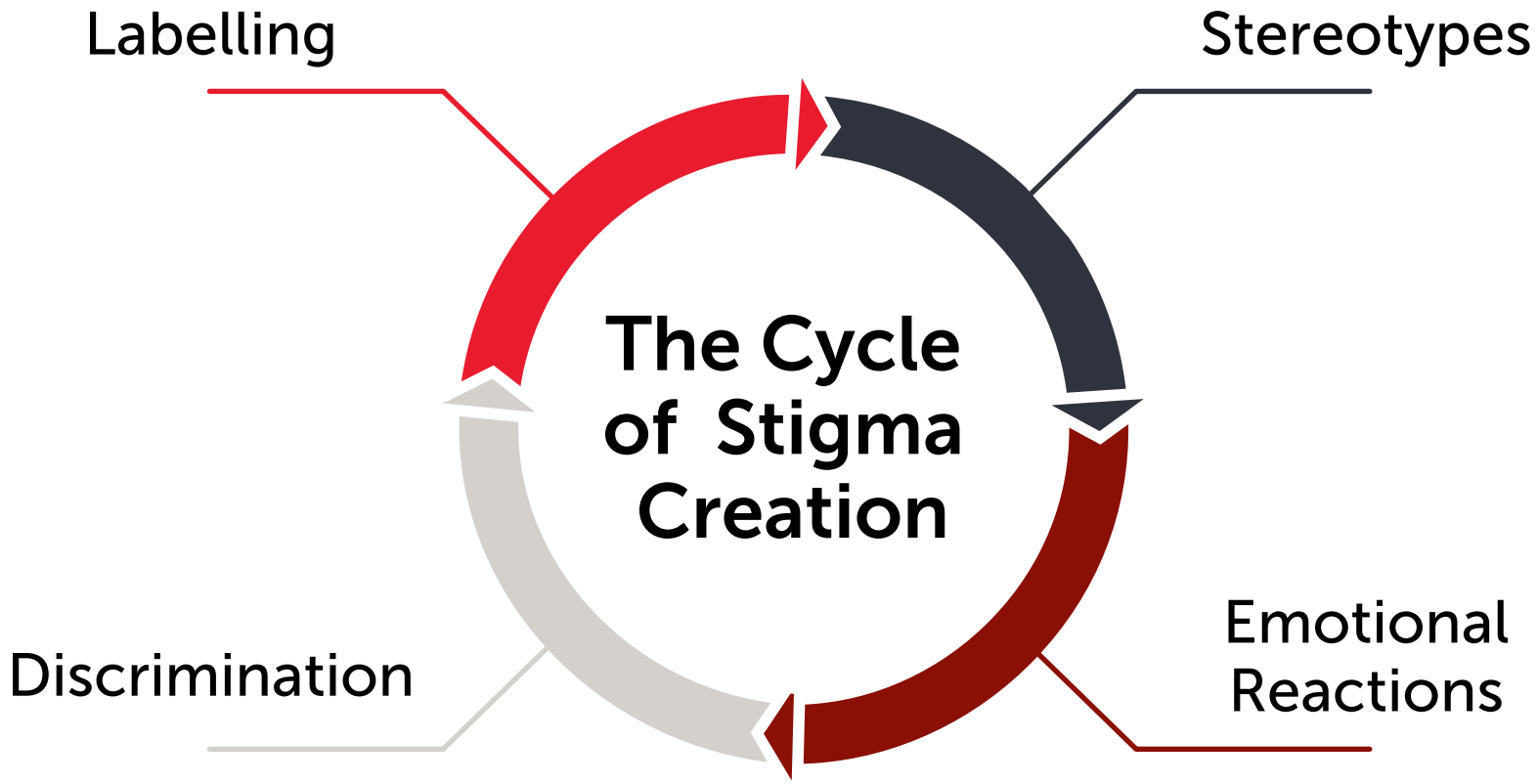
Stereotyping:
Placing people or groups in categories based on generalizations (or labels) assuming they are all alike rather than individuals. Negative stereotypes include a characterization with unjustified disapproval (Matthews, et al., 2017).
Common stereotypes associated to people with SUDs include being considered dangerous, unpredictable, uncontrollable, unable to make decisions and immoral (Yang, et. Al, 2017).

Emotional Reactions:

The way people feel towards those who use substances impacts the way they interact with these individuals. This further impacts their environment, resulting in a social distancing and an "us versus them" mindset. Emotional reactions towards people with SUDs typically include feelings of fear, anger and pity. When hypothetical characters who used cannabis were presented in a study, respondents felt negative feelings towards these individuals (Yang, et. Al, 2017).

Discrimination and Status Loss:

Exclusion of people who use substances from opportunities and society in general contribute to the stigmatization of those with SUDs. Studies show that common societal behaviours towards people with SUDs include imposing treatment or limiting opportunities to seek treatment, as well as placing restrictions on people who use substances in terms of holding positions of responsibility in society. Discrimination also can be seen in the form of a reluctance to interact with people who use substances or diminishing intention to support and help those with SUDs (Yang, et. Al, 2017).



FACTORS CONTRIBUTING TO CANNABIS STIGMA

Is Cannabis Use Normalized?

Dimensions taken into consideration in the context of cannabis normalization include (Parker, 2005):

- Availability and accessibility of cannabis
- Rates of cannabis use and future intentions among nonusers to try cannabis
- Recent and regular cannabis use
- Social accommodation of cannabis use: nonusers respect the right of others to use cannabis
- Cultural acceptance of cannabis where it is presented and understood as uncontroversial
- Government response and actions to cannabis use

It is hard to measure social and cultural dimensions and how different social groups perceive cannabis. Claims of normalization are over-simplified as group-specific findings are generalized to the whole of society. It may be a normalized youth phenomenon but perceptions about cannabis and the support for cannabis legalization differ between generations and are dependent on age. Although there is some degree of social acceptance, society still needs to move past existing stereotypes, stigmas, and structural penalties (Reid, et al. 2020).

While excessive and dependent cannabis use is stigmatized, the act of using cannabis itself is also stigmatized regardless of context. As an example,
in a study completed by Satterlund et al. (2015), medical users of cannabis were aware that their status as a user would be viewed negatively by society and would result in judgment from others. Participants in this study mentioned that they feared the repercussions that could come from others learning about their medical cannabis use. This idea greatly impacted participants' decisions on disclosing their use to those around them.

Transformations in a country's policy including medicalization and legalization remove some structural sources of stigma and support reduction of cannabis stigmas, but they don't entirely shift social perceptions on their own. Structural stigma manifests itself when rights and life opportunities of stigmatized people are restricted. Restrictions around ownership of firearms, parental rights and ineligibility for organ transplants are examples of manifestation of the stigma in the United States for people with mental illnesses as well as cannabis users in certain areas.

Cultural norms affect policy decisions. Stigmatizing beliefs and actions within groups and individuals are developed on a structural level through policies that ban cannabis use of all forms in the workplace and/or public housing. For school-aged youth, programs that portray cannabis solely as an extremely dangerous drug, as well as perspectives of some professionals working in health care and child protection services create a similar context. Society may stigmatize drugs because there is a belief that pleasure should only be achieved through hard work and that drug use is linked with immorality, irresponsible decision making, poor choices, and having a weak mind. For example, parents, students and workers who use cannabis are believed to be less proficient compared to their non-using peers. Any minor mistake they make may be linked with their cannabis use. Parents may be shunned; students may be forced to complete a rehabilitation program and workers may be fired. Cannabis use can be associated with the young adult phase of life, and therefore individuals who continue cannabis use beyond this age range may be stereotyped as being immature, inexperienced or irresponsible. There is also stigma towards people who do not use cannabis themselves but have friends or family whose cannabis use is publicly known or toward individuals who own a legal cannabis business (secondary stigma). As such, parents may hide their use from their child's friends or workers in the cannabis industry may use "cover stories" for their employment (Reid, et al. 2020).

Mainstream medicine may view cannabis as a competition especially due to the fact that it was medicalized in the United States following a patient-led movement and did not undergo the clinical trials required for every other medicine. Friends and family of medical cannabis users may undermine the severity of the patient's illness. If the method of administering cannabis mirrors the methods of recreational use such as joints and water pipes, it can also impact the stigma towards medical use. This stigma can force patients to hide their use from their social networks, leave them or even relocate to another area. Patients who cultivate their own medicine report repeated harassment by police, landlords, and housing authorities for those in state-subsidized housing. Cannabis patients sometimes suffer from other illnesses, may have low socio-economic status, or belong to equity-deserving communities. A person's background and identity can carry it's own stigmas which further contributes, and compounds cannabis stigma (Reid, et al. 2020).

Those with social privileges, musicians, athletes, and celebrities could be immune from the stigmatizing labels becoming their primary status. In contrast, cannabis use by women and racialized people in a cumulative way (i.e., Black athletes) are more stigmatized compared to White men with the same status. Cannabis users may apply devalued cultural stereotypes to themselves resulting in self stigma, impacting their self-esteem and self-efficacy. This can cause the individual to adjust their behaviour or appearance (i.e., concealing use, substituting smoking with edibles or other forms of cannabis products, changing clothing after smoking, etc.) (Reid, et al. 2020).

Stigma around cannabis can be attributed to many different factors throughout history in Canada. Understanding the history, laws, approaches, attitudes and legalization of cannabis is a critical piece in de-stigmatization of the substance. Beliefs individuals hold towards cannabis influence how society interacts with people who use cannabis, the concept of cannabis, and cannabis laws and policies.

History of Cannabis in Canada

The history of cannabis in Canada is complex, ambiguous and likely had influence from the neighbouring United States of America. In 1922, cannabis was prohibited in 10 American states, looped in with other drugs like opioids and described in books as a "new menace." In 1923, although cannabis was not a popular drug of choice in Canada, cannabis was added to the Act to Prohibit the Improper Use of Opium and other Drugs as the substance grew more popular in international drug conferences. The first cannabis seizure was not reported until 1932 and the first possession offence was not reported until 1937. In 1972, the Le Dain Commission released a report claiming prohibition of cannabis was "costly to both individuals and the state" and although they were overlooked, the report provided recommendations to decriminalize cannabis in Canada.

Decades later, the Ontario Court of Appeal in 2000 brought forth the legalization of medical cannabis in Canada and paved the way for the legalization of recreational cannabis in 2018 (Canadian Encyclopedia, 2021). The almost century-long history of cannabis prohibition in Canada likely played a role in how laws, policies and public views around cannabis evolved and continue to evolve today.

Cannabis Representation in the Media

Social or self-stigma to varying degrees may occur from a lack of comfort with cannabis. Examples of social stigma can be still seen in Canadian media, especially in provincial public service announcements where cannabis use can be associated with criminality, low intelligence, and danger (Crabb, 2018). When messaging about cannabis is framed in this manner, negative stereotypes regarding those who use cannabis recreationally are further perpetuated, and can strengthen barriers that are already in place that limit individuals from accessing programs and services that they may need.

Although negative cannabis stereotypes are apparent in some public service announcements, Canada has a handful of public figures that have come to be strongly associated with cannabis culture in a more positive sense in some cases. Actors & comedians such as Seth Rogen (Pineapple Express) and Tommy Chong (Cheech and Chong, That 70s Show) take a comedic spin on cannabis culture through the media that they appear in. They are typically cast as stereotypical 'stoner' characters which are shown as free-spirited, and unmotivated. Outside of these roles, both have expressed their support towards cannabis legalization and decriminalization. Seth Rogen specifically has used his large social media following to advocate towards cannabis amnesty in Canada (Smith, 2019). In addition, both of these individuals successfully combat negative cannabis stereotypes through their successful careers in both cinema and in the cannabis industry. Careers of this type require high motivation in order to gain high levels of success, thus contrasting the 'lazy stoner' stereotype that these individuals portray in the media that they appear in.

In the United States, there are very few depictions of ordinary, 'normal' people in the media that are also cannabis users. Although some cannabis users may embrace or find humour in certain stereotypes, other stereotypes can be harmful to these individuals (Mortensen, et. al., 2020). According to Mortensen, et al., media reinforces and reproduces stereotypical images based on religion, gender and race, even recently. Entertainment media tends to portray drug use as distorted or exaggerated, and tends to focus only on the most extreme cases in society. Cannabis users are typically portrayed in the media negatively as marginalized people, or positively as those with privilege, like men, celebrities or athletes (Mortensen, et al., 2020). Individuals that belong to stigmatized groups are more likely to be portrayed in a negative fashion in the media, and this further perpetuates negative stereotypes that are already rampant in society.

Common images that are used to display cannabis incorporate 'pot culture' stereotypes or criminal behaviour as key themes (Mortensen, et. al., 2020). In terms of 'pot culture,' stereotypes such as tie-dye prints, long hair, dreadlocks and Rastafarian colours (red, green, and gold) are used to represent cannabis in the media. In addition

to these 'pot culture' stereotypes, images of criminal behaviours that often correlate with racial stereotypes are used to represent cannabis as well (Mortensen, et. al., 2020). Media stories that aim to normalize the use of cannabis in society tend to feature images of White middle-aged men and women more than other demographics (Mortensen, et. al., 2020). With this being said, Mortensen, et al. suggest that individuals who face more stigma in society are less likely to be the face of the normalization and acceptance of cannabis use and are instead used to represent cannabis culture stereotypes and criminality (2020).

The representation of cannabis in the media impacts how people who use cannabis and cannabis products are viewed. New studies of social media suggest that initiatives aiming for anti-stigma messaging may be effective in reducing stigma (Committee, 2016). Experimental studies have found that using stories of people in recovery actually decreased people's prejudice towards people that experience substance use disorders (Committee, 2016). Campaigns for stigma looking to reduce public misinformation from other media campaigns could be effective for youth-targeted anti-stigma efforts (Committee, 2016). Educating youth on how to critically observe media messaging and media literacy techniques could foster destigmatizing attitudes and equip youth with skills to identify stigmatizing messaging. Working with youth and people involved in youths' lives to reduce misinformation and stigma around cannabis use could counteract negative perceptions around cannabis and lead to an increase in help-seeking behaviours.

Intersections of Cannabis and Other Stigmatized Groups

Socio-economic status, education, race, ability, gender and sexual orientation are some of many markers of stigma. Despite legalization, the use of cannabis is still stigmatized in Canada, and this stigma can often intersect with other aspects a person faces marginalization from within society. Research has discovered that certain marginalized populations such as Black, Indigenous and racialized peoples tend to have higher odds of using cannabis relative to White individuals. In addition, cannabis may be used as a coping mechanism for youth who face racial discrimination along with other stressors related to marginalization. Racialized youth are portrayed as "more deviant" relative to White youth if they choose to use cannabis. This can similarly create stigma-induced mental health concerns that are related to cannabis use (Buttazoni, et al., 2020). As a result, youth that are both racialized and also using cannabis have additional barriers related to accessing physical and mental health care services that stem from the stigmatization of their intersecting identities.

Rural living is a stigma marker that is also associated with cannabis use in youth. Youth who live in isolated rural areas and have weak social bonds with peers are found to be more likely to misuse cannabis (Buttazzoni, et. al, 2020). This is important to consider as individuals that reside in rural areas have significantly less access to mental health care services relative to individuals that live in large urban centers. Similarly, rural parents report that they are less likely to seek mental health services for their children and themselves due to stigma by association or secondary stigma (Buttazzoni, et. al, 2020). As a result, youth living in rural settings face additional barriers that may reduce the ability to access critical services that they may need.

There is a strong association between maternal education level and cannabis use in youth. Many youths who have mothers with limited education, may face socioeconomic inequalities in health. Youth who have both mothers with lower education/low socio-economic status and are cannabis users will face additional stigma, and this will allow inequalities in various areas of life to be continuously perpetuated (Buttazzoni, et. al, 2020).

Individuals in 2SLGBTQIA+ communities are noted to be more likely to use cannabis relative to individuals that identify as heterosexual and cisgender (Buttazzoni, et. al, 2021). According to Buttazzoni et al., aspects of Minority Stress Theory such as expectations of stress, environmental/external events (discrimination), and internalization processes, along with internalizing disorders can reduce an individual's resiliency and can be indicative of higher cannabis use within this demographic (2021). 2SLGBTQIA+ youth are known to experience higher rates of physical and emotional violence, depression, perceived lack of safety and suicidal ideation which can increase engagement in risky coping behaviours such as cannabis misuse. Findings in Buttazzoni et al.'s study also suggest that non-binary youth who live in unsupportive households, as well as limited access to gender-affirming health care, can similarly drive 2SLGBTQIA+ youth cannabis use (2021).

CANNABIS LAWS AROUND THE WORLD: PROHIBITION VS LEGALIZATION

International cannabis laws can help explain how liberal versus punitive laws may influence how a society feels about cannabis. These laws may affect the degree of stigma seen based on the policies and the level of enforcement that countries adopt. The comparison of seven European nations with different levels of cannabis criminalization (i.e. facing between 0 to 12 years in prison depending on the country) has shown that punitive cannabis policy is associated with stigma and liberal cannabis policy is associated with de-stigmatization and that stigma is more prevalent where cannabis laws are more punitive. Some countries have chosen to decriminalize cannabis, while others like Canada, Uruguay and numerous U.S. states have gone a step further to legalize the substance (Kostas, 2020).

Legalization of cannabis in Canada brought promise to improve several areas of cannabis prohibition. One of those hopes was to decrease the stigmatization of cannabis and people who use cannabis. Almost half of daily cannabis users in seven European countries felt others perceive them as unreliable. Similarly, one in four believed people felt someone who uses cannabis is dangerous. This suggests that negative stereotypes are still associated with people who use cannabis; these people may be labelled as unmotivated and lazy individuals and may also begin to experience self-stigma (Kostas, 2020). While Canada is taking steps towards reducing stigma with cannabis, negative stereotypes that remain in public opinion feed into cycles of stigma, and all levels of stigma are a barrier to accessing and/or seeking support. When looking into the future of de-stigmatization, it is important to reflect on past and current approaches to legalization, and look at how they are taken into consideration when evaluating public policy, health programs, and community supports.

Social Acceptability of Cannabis Post Legalization in Canada

According to a 2017 survey from Dalhousie (Charlebois, 2021), 27% of Canadian respondents suggested that they would not want their coworkers to know if they used cannabis, and 17% mentioned that they would be concerned about being seen buying cannabis in a legal market.

In 2020, 51% of respondents suggested that they would be comfortable to publicly disclose if they used cannabis or not (CCS, 2020). Two years later, 46.2% of respondents reported smoking cannabis for non-medical purposes regularly as either somewhat unacceptable (24.6%) or completely unacceptable (21.6%).

Vaping cannabis regularly for non-medical purposes was also reported by 48.4% of respondents as either somewhat unacceptable (25.3%) or completely unacceptable (23.1%) and eating cannabis for non-medical purposes was reported by 44.2% of respondents as either somewhat unacceptable (23.9%) or completely unacceptable (20.3%) (CCS, 2022). In pre- and post-legalization settings, stigmatizing ideologies toward cannabis and those who use it continue to be apparent in Canadian society.

Acceptability of Medicinal Cannabis Post Legalization in Canada

There are people with health issues who use cannabis therapeutically to manage symptoms such as anxiety, insomnia, trauma, chronic pain, and appetite suppression. The 2020 Canadian Cannabis Survey reported that approximately half out of the 27% of Canadians who used cannabis in the last year used it for medical purposes, with rates of use being high among people reporting poor or fair mental health.

Stereotypes about people who use medicinal cannabis can also lead to discrimination and exclusion. This idea is clearly presented in a study completed by Bottorff, J.L (2013) in British Columbia, which found that individuals using cannabis for therapeutic purposes were labelled as potheads, drug addicts, problem patients, irresponsible, non-contributing, and on the margins of society.

Youth Cannabis Use Post Legalization in Canada

Legalization came with the intent to keep cannabis out of the hands of youth and to combat the illegal market. This intent is written into the federal Cannabis Act and almost all Provincial Cannabis Acts. There appears to be a public perception that youth are using cannabis at a much higher rate post-legalization than pre-legalization (Cannabis Council of Canada, 2020). According to Canadian Student Tobacco, Alcohol and Drug Survey (2019), past-12-month use of cannabis by students in grades 7 to 12 was 18%, unchanged from the 2016-17 report from before legalization. This means that the majority of youth do not report using cannabis (CSTADS 2018-2019). Youth cannabis use, in reality, is at a much lower rate than some adults perceive. This highlights the need for ongoing education for adults towards youth cannabis use rates, as this may help reduce the spread of misconceptions and misinformation that contribute to increased stigma towards youth who do or do not use cannabis.

Cannabis Amnesty

Legalization of cannabis aimed to achieve additional goals and outcomes identified through evidence-based approaches to policies. Legalization looked to reduce harms created from criminal records, social attitudes and concerning consumption patterns, all resulting in varying degrees of stigma. Legalization allowed millions of dollars of funding for public education (Government of Canada, 2021), research, treatment and harm reduction services, that may have been previously underfunded or nonexistent. Although legalization led to progress toward many of these goals, there still remains issues with cannabis legalization found through the limited success of cannabis amnesty and limits to cannabis record suspensions (Canada, 2020). These limitations still impact individuals, families and communities and may further perpetuate social and structural stigma for people who use cannabis.

This highlights the importance of ongoing work in the stigma field to develop resources, educational programs, and campaigns that advocate towards stigma reduction in Canadian society.

The Cannabis Use Spectrum

Figure 2

Image created by Nicole Rita (Placement student, Humber College, December 2022)

DIFFERENTIATING RECREATIONAL USE FROM PROBLEMATIC USE

Cannabis use exists on a spectrum that goes from non-use on one end of the spectrum to a potential Cannabis Use Disorder diagnosis on the opposite end (see Figure 2). This spectrum analysis identifies that individuals may use cannabis to varying degrees and that each degree of use has a corresponding level of associated risk. Although an individual may be using cannabis, they may not be experiencing problems resulting from their cannabis use. Furthermore, an individual's degree of risk can move either way on the spectrum depending on a variety of factors. These include whether the person is increasing or decreasing their cannabis use, or if they are using cannabis in more or less risky ways. Examples of risky cannabis use may also act as criteria for Cannabis Use Disorder, and can be found in the list on the right side of this page.

It's important to highlight that, regardless of where one sits on the spectrum, it is never too early or too late to seek help for concerns related to one's cannabis use.

There are eleven criteria on the DSM-5 for cannabis use disorder. Use of cannabis for a one-year period, with at least two of the following symptoms, may result in a CUD diagnosis:

- Cannabis is used in larger amounts and over a longer period than intended.
- Repeated failed efforts to reduce or quit use.
- Spending more time than intended acquiring, using, or recovering from the effects of cannabis.
- Cravings or desires to use cannabis.
- Continued use despite experiencing negative consequences from using.
- Continued use despite persistent or recurrent social or interpersonal problems caused or worsened by the effects of cannabis.
- Other important activities in life, such as work, school, hygiene, and responsibility to family and friends are put off in favour of using cannabis.
- Cannabis is being used in dangerous contexts (eg. driving while intoxicated).
- Use of cannabis continues despite awareness of the risks associated with it.
- Developing a tolerance to cannabis.
- Experiencing withdrawal symptoms when trying to cease cannabis use.

What is a Cannabis Use Disorder?

A Cannabis Use Disorder (CUD) is a medical term which describes a variety of behaviours that result from risky/problematic cannabis use. Individuals who experience a Cannabis Use Disorder may experience difficulties such as distress, increased health risks, struggles in work/school, and rifts in interpersonal relationships. Diagnostic criteria for a Cannabis Use Disorder are outlined in the DSM-5 (a manual developed by American Psychiatric Association containing diagnostic criteria for various mental disorders). In order for an individual to be diagnosed with a Cannabis Use Disorder, the individual must show at least two out of eleven criteria from the DSM-5 over the span of 12 months (Canada, 2018). Cannabis Use Disorder can be classified as either mild (2-3 criteria), moderate (4-5 criteria) or severe (6+ criteria) (Patel, J. & Marwaha, R., 2021). Cannabis Use Disorder may be treated with a variety of interventions including urgent care or hospitalization, in-patient treatment centres, out-patient treatment centres, motivational enhancement therapy, cognitive behavioural therapy, and some pharmacological interventions.

Motivational enhancement therapy and cognitive behavioural therapy have shown effective results in aiding individuals experiencing cannabis use disorder. Multiple sessions and follow-up from initial sessions have been shown to be the most successful for patient treatment progression and relapse prevention (Jutras-Aswad, et al., 2019). Reducing stigma is essential to encouraging help seeking behaviours as evidence shows treatment is more effective with ongoing intervention beyond initial treatment. The more inclusive environments that are created for people with CUD, the better the overall outcomes for the patients and society.

Risk Factors

According to the Centre for Addiction and Mental Health, there is a multitude of reasons that an individual may develop a Cannabis Use Disorder. Some individuals have a genetic predisposition towards the addictive properties of a substance and as a result, they are at a higher risk of developing a Cannabis Use Disorder. Others may grow up in environments where substance use is normalized and encouraged, and this could put them at increased risk as well. Adverse childhood experiences/trauma stemming from neglect, and physical, emotional and sexual abuse is another major factor. According to the Center for Addiction and Mental Health, more than 50% of individuals with substance use disorders have a coexisting mental health disorder (2010). As a result, having a pre-existing mental health disorder can put an individual at a higher risk of developing a CUD.

Another risk factor can be the way an individual copes with thoughts or feelings. When an individual uses cannabis as their 'go to' strategy to cope with the stresses of life or even boredom, they may put themselves at a higher risk of developing a CUD (CAMH, 2010). Behaviours surrounding the motive for using cannabis may also contribute to cannabis use frequency and the risk of dependency in young adults (Bravo et al, 2017). All of these specific factors on their own have the potential to put an individual at risk, and when these factors are combined the amount of risk can be amplified.

Protective Factors

As there are risk factors, there may also be protective factors. Although these factors do not guarantee that an individual will or will not develop a Cannabis Use Disorder, having protective factors can balance out risk factors that one may experience that could otherwise lead to harmful use. Protective factors can also play an integral role in recovery if an individual already has an occurring substance use disorder (CAMH, 2010). According to Rothenberg et al., protective factors such as active coping, achieving higher grades and positive activity involvement can predict lower cannabis use during late adolescence at marginal or high levels (2020).

When speaking of protective factors, research by CMHA (2021) and the World Drug Report (2018) suggest that the protective factors towards Cannabis Use Disorder include:

- Positive adult role models
- Parental or other caregiver supervision
- Having a strong attachment to family, school and community
- Having goals and dreams
- Being involved in meaningful, well-supervised activities (e.g., sports, volunteer work)
- Physical safety and social inclusion
- Caregiver monitoring and involvement
- Health and neurological development
- Emotional regulation
- Developing coping skills
- Quality school environments
- Safe neighbourhoods

INTERVENING AND ADDRESSING STIGMA

Education is often the first line of intervention in combatting stigma surrounding mental health (Davidson, 2002). However, research has shown that education efforts, in the form of providing facts and emphasizing the unacceptability of stigmatization, are not very effective, and any effects tend to be short-lived (Davidson, 2002). However, it is possible that education that includes more personal stories and interactions with members of stigmatized groups can be more effective in reducing stigma than traditional educational approaches (e.g., Ladouceur et al., 2005).

Research investigating stigma associated with other mental health and addictions issues reveals promising trends. A systematic review looking at evaluations of substance use disorder-related stigma interventions suggests that self-stigma and shame can be reduced through interventions such as group-based acceptance and commitment therapy (Livingston et al., 2011). This review also revealed that social stigma towards those dependent on drugs or alcohol can be somewhat reduced using educational campaigns (e.g., leaflets) and brief motivational interviews (Livingston et al.n et al., 2011). Furthermore, the review suggests that structural stigma can be reduced and clinician comfort can be raised through clinicians interacting with individuals who experience substance use disorders (Livingston et al., 2011). Limited research has investigated interventions to reduce stigma associated with Cannabis Use Disorder specifically.

When addressing social stigma, research suggests that changing the public's perception of substance users from attitudes leading to fear, segregation, abuse or neglect to those of support, providing opportunities and quality treatment may be effective ways to reduce stigma. Strategies proposed as effective interventions may include the use of media to change perceptions of myths and misconceptions around health concerns and treatment options. Other mentionable strategies are to increase the knowledge of disorders, display people who use substances, and challenge discriminatory practices (Committee, 2016).
In terms of addressing self-stigma, reviews of research encourage interventions that promote self-efficacy and self-esteem. Evidence-based interventions reducing self-stigma may be further effective alongside peer support networks, fact-based education, mentorship, and opportunities to learn coping and social skills. Education on treatment options and engagement is critical. Treatment options that are evidence based allow individuals to promote positive behaviours like monitoring symptoms, accessing supported employment programs, involving support networks like family and friends in treatment progression, enhancing skills required to manage disorders, and encouraging combined treatment options. Finally, encouraging substance use disclosure may be the first step in removing the sense of burden from the individual around this self-stigma when the timing is safe and appropriate on the treatment journey (Committee, 2016).

Cannabis Use Disorder: A Choice or an Illness?

In promoting recovery and supporting individuals experiencing Cannabis Use Disorder to heal, there is a need to enhance the understanding of substance use disorders and how they work. A substance use disorder is labelled as a disorder because it changes the way that one's brain responds in various situations that revolve around stress, and can persist even after one ceases to use a substance (American Addiction Centers, 2021).
One of the reasons that individuals may develop a substance use disorder is that substances cause feelings of euphoria which trigger the pleasure-reward system. When individuals take these substances, the brain will release dopamine (a neurotransmitter which is released during pleasurable and rewarding experiences) which will encourage repeated use. As a person continues to use a substance, the brain will rewire itself so that other forms of pleasure and reward may become less appealing (American Addictions Centers, 2021). Because the brain becomes less sensitive to other forms of reward, a person with a substance use disorder values the substance more than other rewards and may feel depressed during times when they are not using their substance of choice (American Addiction Centers, 2021). With this being said, Cannabis Use Disorder can happen to anyone. Although there are multiple risk and protective factors which contribute to one's susceptibility to developing a Cannabis Use Disorder, the road is complex and can be different for each individual depending on things out of their control such as genetic and environmental circumstances (American Addiction Centers, 2021).

Tools to Use in Discussions About Cannabis Use

> Empathy: Research shows that using more empathy with people who use substances like cannabis can be beneficial to reducing stigma and helping individuals overcome some of the challenges associated with substance dependency (Massey, et al., 2018).

> Come prepared with fact-based knowledge: When talking to people with cannabis use disorder, it is most beneficial if the people close to them in their lives like loved ones, friends and family use evidence-informed information from science and factual information (NIH, 2021).

Myths and Misconceptions

Myths, misconceptions and stereotypes about groups and their features are significant influencers of stigma in society. Below are common myths and misconceptions that individuals in society hold about those who experience substance use disorders and ways that these myths can be dispelled.

"Once an addict, always an addict."

This is a large misconception. Although there currently is no cure-all for substance use disorders, recovery is always possible. An individual in recovery is different than one who experiences an active substance use disorder. Substance use disorders can be overcome when an individual can implement recovery habits and seek treatment. (Canadian Centre for Addictions, n.d.).

"A person with a substance use disorder should hit 'rock bottom' before seeking treatment."

"Rock bottom" is a term that describes a point in a person's life in which they feel as if things cannot get any worse. Everyone's perception of "rock bottom" however is different. For some, "rock bottom" is losing their job. For others, "rock bottom" is a near-death experience or a health scare. One does not have to wait until they are at their worst or "rock bottom" to seek help. Waiting to seek help may actually put an individual at higher risk of serious harm (Canadian Centre for Addictions, n.d.).

"People that can't beat addiction just aren't strong enough."

Overcoming a substance use disorder is a lot more complex than just saying "no." As regular substance use can affect one's body and brain, physical or psychological dependency and withdrawal can make overcoming a substance use disorder extremely challenging (Canadian Centre for Addictions, n.d.).

"Addicts are unemployed and lazy."

There are many individuals who have active substance use disorders and still have a job and pay bills (Canadian Centre for Addictions, n.d.).

"Having a substance use disorder comes from having bad morals."

Substance use disorders are complex. As seen through risks and protective factors there are many reasons as to why an individual develops a substance use disorder. Some factors can be things that are out of an individual's control such as genetics and their upbringing (Canadian Centre for Addictions, n.d.).

Language Matters

In the Cycle of Stigma, "labelling" is listed as the first step in stigma creation. Being aware of language is one of the easiest ways to combat stigmatizing practices. Table 1 reflects this idea by contrasting stigmatizing vocabulary with recommended language. The Canadian Centre on Substance Use and Addiction (CCSA) suggests that using person-first language, as well as speaking in a way that is medically accurate can encourage individuals to seek the help they need. It can also positively affect the quality of health services and can positively influence policies surrounding treatment options and accessibility (n.d.). Person-first language is a way of speaking in which acknowledges an individual as a whole person before acknowledging their condition or personal attributes (CCSA, 2017). Moving away from terms like addict and addiction helps avoid dehumanizing individuals who may use substances (CPHA, 2019). Replacing 'Cannabis Addiction' with 'Cannabis Use Disorder' moves away from language that may leave a person feeling blame or the idea that by using substances they are failing in willpower, personally or morally. Saying "Cannabis Use Disorder" allows us to view the person as a whole and to acknowledge the physiological, psychological, genetic and sociocultural factors that make substance use so complex (CPHA, 2019).

Medically accurate language acknowledges that substance use disorders should be treated as medical conditions and addresses them as such (CCSA, n.d.). The Canadian government chose to adopt the scientific term cannabis as opposed to the term marijuana as cannabis refers to the whole plant as opposed to marijuana referring to only parts of the plant (Alberta, 2021). The term marijuana is considered stigmatizing as it has historically racialized contexts stemming from the United States and was used to negatively associate Mexican or Black immigrants to "illegal activities" (Canadian Encyclopedia, 2021). When individuals with substance use disorders are labelled through stigmatizing language (eg. substance abuser) they are perceived to be a greater social threat and to be more deserving of punishment (Kelly et al., 2010).

Table 1

Stigmatizing Language	Preferred Language
Addict	Person with a substance use disorder
Stoner	Person who consumes cannabis
Marijuana	Cannabis
Dirty/Clean	Actively using/Not actively using

Normalize Conversations About Mental Health

Through normalizing conversations about mental health and substance use, individuals who experience mental illness can have more visibility which can challenge negative stereotypes such as assuming that all individuals with mental illnesses carry the same negative qualities. Some ways to normalize these conversations are to become involved in anti-stigma campaigns or even sharing or listening to the stories of those who experience mental illness or substance use disorders. Research suggests that these techniques can help students specifically become more empathetic and accepting towards others (Alberta Health Services, n.d.).

RECOMMENDATIONS

Stigma creates barriers towards services, and can deter help-seeking behaviours. It is therefore important that Canadians are given a chance to become educated on this topic and are given resources that allow them to check their biases and learn how they can address stigmatizing practices as they encounter them in society.

Some effective stigma reduction strategies could include changing societal beliefs and attitudes (Herek et Tal. 2009), and addressing the consequences of cannabis criminalization (Bottorf et al. 2013), and the legacy of prohibition.

As there are many reasons why individuals choose to use cannabis, and a multitude of risks that contribute to one's susceptibility for developing a Cannabis Use Disorder, it's important that cannabis stereotypes are challenged and dismantled. In order to do this, there must be an emphasis on correct language surrounding CUDs, less stigmatizing media messaging regarding cannabis use, and policy changes surrounding access to services, amnesty, and the criminal justice system (i.e. less charges for racialized people).

While acknowledging the complexity of stigma around cannabis use, recommendations for immediate action around addressing and reducing stigma related to cannabis include:

- Encouraging the use of "people first" language when discussing cannabis use in all settings. Use accurate and neutral terms about cannabis in everyday life, especially when working in health care settings, as service providers, and working with youth. Create a comfortable space with less barriers that allows for open conversations and informed decision making around cannabis (Ng et al., 2018).
- Promoting resources, services and programs from accredited sources that allow individuals access to factual information around cannabis, substance use and mental health, and encourage those accessing this information to pass on the facts when speaking with others, especially youth (CAMH, 2021)

Newhart and Dolphin (2019) propose the following ways to address cannabis stigmas:

- Public identification of cannabis users so that their diversity becomes visible to others. This will challenge stereotypes which assume all users have similar negative qualities.
- Nonusers can be found within everyone's social network. Nonusers may learn that they have respected friends, family and associates who use cannabis.
- Identifying and challenging the source of stereotypes and misconceptions. Dispelling misconceptions and facilitating contact between the public and the stigmatized can change negative attitudes.

With Canada's deep history of prohibition, it will take time for stigma towards individuals who use cannabis to decrease.

Cannabis users in general have been positioned apart from respectable society (i.e. the poor, the marginal, chronically ill, seekers after the meaning of life, social and religious nonconformists, etc.) (Chasteen, 2016) and that exploring the history of cannabis in addressing its stigma is also important.

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