



Original Article

Mistrust Limits Possibilities for Patient-Provider Discussions Regarding Cannabis Use During Pregnancy

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A B S T R A C T

Background: Recent changes in cannabis policy and use among pregnant people have prompted recommendations that health care providers discuss cannabis use with pregnant patients. We explored pregnant people's perceptions of their interactions with health care providers regarding cannabis use during pregnancy.

Methods: We conducted in-depth interviews with 34 individuals who were either pregnant or had been pregnant within the past 2 years and who used cannabis before or during their pregnancy. The interviews explored people's experiences with and perspectives on communication with health care providers about cannabis use during pregnancy. **Results:** Most participants reported an absence of provider-initiated inquiries about cannabis use and few disclosed their cannabis use to a provider. Participants expressed distrust in providers as sources of accurate cannabis information, as they understood providers as grouping cannabis with alcohol and other drugs, which they saw as conflicting with their perception of a lack of conclusive scientific evidence about health effects of cannabis use during pregnancy. They worried about providers judging and reporting them to child welfare if providers learned about their cannabis use. Participants described using cannabis for medical reasons, but only rarely recalled experiencing providers talking with them about risks and benefits of cannabis versus other treatments.

Conclusions: Although many pregnant people use cannabis as a medicine to manage pregnancy symptoms or health conditions, they perceive providers as viewing and treating cannabis as a harmful recreational drug. This disconnect, along with their fears of provider judgment and of providers reporting them to child welfare, appears to be limiting effective, person-focused discussions regarding risks and benefits of different approaches to treating the symptoms and health conditions for which pregnant people use cannabis.

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Recent changes in cannabis policy that have legalized recreational cannabis in many states and increases in cannabis use during pregnancy in the United States (Brown et al., 2023; Hayes et al., 2023; NIAAA, 2025; Singh et al., 2020; Young-Wolff et al.,

2019) have prompted new efforts to inform pregnant people about potential health effects of using cannabis during pregnancy. The literature on health effects of using cannabis during pregnancy is evolving rapidly. There were six new systematic reviews on the effects of cannabis use during pregnancy published between January and August 2025 (Bailey et al., 2025; Lo et al., 2025; Portillo et al., 2025; Przy et al., 2025; Reck et al., 2025; Sainz et al., 2025). Although there are methodological limitations to this literature (e.g., challenges with adequate controlling for other substance use during pregnancy and for nausea and vomiting during pregnancy, a common reason people use cannabis during pregnancy) the literature to date indicates that there are increased risks of adverse birth outcomes

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and there may be some adverse neuropsychiatric outcomes for children associated with using cannabis during pregnancy (Bassalov et al., 2024; Lo et al., 2025; Sainz et al., 2025).

One approach to informing pregnant people about potential health effects of using cannabis during pregnancy is posting warning signs in places where cannabis is sold (NIAAA, 2022). Research suggests, however, that pregnant people who use cannabis tend to not trust information on signs and that signs may be more harmful than helpful (Gould et al., 2025; Roberts et al., 2023). Instead, research indicates pregnant people turn to online sources or social networks for information (Bhatia et al., 2023; Jarlenski et al., 2016; Lebron et al., 2022). Yet, information from these sources may not be up-to-date or evidence-based (Lagan et al., 2011). Further, people may perceive a lack of conclusive research and infer that cannabis is not unsafe to use during pregnancy (Jarlenski et al., 2016).

Another approach to informing people is via health care providers. Pregnant people have expressed wanting more evidence-based information on effects of using cannabis during pregnancy and report they would welcome having honest, unbiased, nonjudgmental conversations with health care providers (Foti et al., 2023; Jarlenski et al., 2016). Professional association guidance recommends providers ask all pregnant people about use of alcohol and drugs, including cannabis (ACOG, 2017). Additionally, recognizing that many pregnant people who use cannabis report using cannabis to manage medical concerns (Chang et al., 2019; Daniels et al., 2023; Foti et al., 2023; Vanstone et al., 2021; Westfall et al., 2006), professional associations recommend providers work with pregnant people who use cannabis for medical reasons to identify alternative therapies for which there are more pregnancy-specific data (ACOG, 2017).

Prior research suggests a few reasons pregnant people rarely discuss cannabis with providers (Jarlenski et al., 2016; Skelton et al., 2023). First, providers express feeling unprepared to have conversations about cannabis with pregnant patients and fear disrupting the patient-provider relationship (Ceasar et al., 2023; Kitsantas & Pursell, 2024). Second, pregnant people express concern that discussing cannabis with providers may lead to them being reported to child welfare and possibly having their children removed (Cernat et al., 2024; Skelton et al., 2024; Woodruff et al., 2021). Yet, much of this research was conducted before the wave of recreational cannabis legalization at the state level in the United States (NIAAA, 2025), dramatic increase in research (more than 2,000 new scientific articles on cannabis and health each year since 2021 in PubMed), and increasing recognition that pregnant people often use cannabis for medical purposes (ACOG, 2017). The rapidly changing context could affect how patients and/or providers approach the topic in health care settings. The goal of this study was not to consider the rapidly evolving literature on the potential effects of cannabis use during pregnancy that informs providers' counseling, but to examine pregnant people's perspectives on interactions with providers regarding cannabis use during pregnancy.

Methods

We used interpretive phenomenology methodology in meaning-making of people's experiences of and perspectives on communicating with their providers about cannabis use during pregnancy. We recruited participants from a population of U.S. residents in varying cannabis policy climates who completed a survey, fielded by Ipsos (a market research firm) in May–June

2022, and who agreed to be contacted for an interview. Ipsos fielded the survey among their probability-based online panel (KnowledgePanel) and members of opt-in panels. Eligible survey participants included English- or Spanish-speaking adults (18–49 years) currently pregnant or pregnant in the past 2 years and residing in one of 37 study states at survey recruitment. Participants first completed the survey, which included questions about sociodemographic characteristics, cannabis use, and reasons for cannabis use during pregnancy. We asked KnowledgePanel participants who reported using cannabis in the year before their pregnancy and/or during their pregnancy about interest in participating in an interview and reached out to those who expressed interest via e-mail. We purposively selected interview participants to ensure a balance of demographic characteristics, experiences using cannabis, and state cannabis policies. We reached out to 77 people and completed 35 interviews; one participant was dropped from analysis because, during the interview, they reported not using cannabis before or during pregnancy. Participants completing interviews received 50,000 survey points in their Ipsos account (equivalent to \$50USD). The University of California, San Francisco Institutional Review Board approved this study. Recruitment, survey, and interview methods have been detailed elsewhere (Gould et al., 2025; Roberts et al., 2023).

Three interviewers (two public health researchers, one with a master's and another with a doctoral degree and a doctorally trained social psychologist), all of whom identify as cisgender women and are mothers, conducted interviews. Each interviewer had previous experience conducting qualitative interviews about stigmatized topics and behaviors during pregnancy, although only one had previously conducted interviews specifically about substance use among pregnant people. Interviewers explained the study purpose as seeking to learn more about pregnant people's experiences with and beliefs about marijuana use during pregnancy. Interviewers obtained verbal consent and conducted semi-structured, in-depth interviews (averaging 50 minutes) by phone between June and September 2022. Interviewers made field notes about each interview. Interviews were audio-recorded and professionally transcribed. Each participant was interviewed once; other than related to scheduling, interviewers had not previously interacted with participants before the interviews. The primary purpose of the interviews was to understand experiences, views, and preferences among people who had used cannabis before or during a recent pregnancy related to laws mandating the posting of signs warning about the harms of cannabis use during pregnancy (Gould et al., 2025). After establishing rapport, interviewers used narrative engagement (Miller-Day & Hecht, 2013) to elicit participants' descriptions of specific moments of cannabis use before and/or during pregnancy, and reflections about conversations they may have had with family, friends, or clinicians about cannabis use during pregnancy. As part of this section, the interview guide included specific questions related to interactions with providers: *“Can you think of any time a doctor, nurse, or other health care provider has talked to you about using cannabis during pregnancy? If so, who was it? Can you describe for me how that conversation went? How did you feel about what they said? How, if at all, did that conversation affect you?”* The interview guide also included sections where we used directed interviewing (DiCicco-Bloom & Crabtree, 2006; Rubin & Rubin, 2011) to encourage participants to reflect on things they may have heard about how using cannabis might be helpful or harmful. The final sections focused

specifically on their views about and experiences with the mandatory warning signs.

We coded the data using a multi-stage thematic analysis process (Braun & Clarke, 2006). As part of our overall analysis of these data, H.G. and C.Z. read transcripts and applied deductive codes based on research questions and interview domains. In the initial reading of transcripts, it appeared that participants' descriptions of the interactions with providers regarding cannabis use during pregnancy seemed to suggest a disconnect between professional association recommendations regarding provider-initiated discussions of cannabis use during pregnancy and pregnant people's descriptions of their perceptions of their interactions with their providers related to this topic. We then decided to focus additional analysis on these patient-provider interactions regarding cannabis and pregnancy and perceptions of these interactions. H.G. then reviewed interview sections deductively tagged as indicating a conversation/lack of conversation about cannabis with a provider (33 transcripts) or another interaction with a provider (six transcripts) and, after noting initial ideas on patterns in the data, inductively developed an initial codebook. H.G. and C.Z. then double coded five randomly selected transcripts, identifying and reconciling additional codes through discussion and revising the codebook. H.G. and C.Z. discussed codes with S.C.M.R. and K.A.S. and repeated the process until no new codes emerged. The final codebook included 12 codes, which H.G. applied to all transcripts in Dedoose. We reviewed frequency of codes across transcripts and then reviewed excerpts associated with each code to identify key themes and subthemes. We identified representative quotes reflecting key subthemes. Additionally, we reviewed each participant's description of their interactions with providers to classify whether the participant reported disclosing cannabis use during pregnancy to a provider. For demographic characteristics and reasons for using cannabis, we relied on quantitative survey responses. Because we know Black patients are more frequently subjected to toxicology testing, child welfare reporting, and family separation (Chasnoff et al., 1990; Jarlenski et al., 2023; Perlman et al., 2022; Roberts & Nuru-Jeter, 2011; 2012; Roberts et al., 2015; Soos et al., 2024), we explored whether experiences varied by race; based on the sample that included more than five times more white than Black participants, we did not find evidence that they did.

Results

Participant Characteristics

Participants included 34 individuals, all of whom identified as women; 67% identified as non-Hispanic white, 12% as non-Hispanic Black, 12% as Hispanic, and 6% as multiracial (see Table 1). Most (53%) had a bachelor's or master's degree or higher. Participants resided in 16 states across the Midwest (41%), West (38%), Northeast (15%), and South (6%). Sixty-five percent lived in states with legal recreational cannabis and half lived in states with child welfare reporting laws for drug use during pregnancy. Two-thirds ($n = 22$) reported using cannabis during pregnancy and one-third ($n = 12$) using cannabis in the year before pregnancy but not during pregnancy. Of those who used cannabis during pregnancy, most ($n = 14$) reported their use as only medical, for example, to manage pregnancy symptoms, such as nausea or migraines, or health conditions, such as anxiety or depression; six reported their use as both medical and recreational, and two as recreational only.

Table 1
Sample Characteristics

Participant characteristics	Number (%)
Total	34
Age	
18–25	7 (21)
26–35	16 (47)
36–49	11 (32)
Education	
No high school	2 (6)
High school graduate/GED	5 (15)
Some college or associate's degree	9 (26)
Bachelor's degree	10 (29)
Master's or higher	8 (24)
Race/ethnicity	
White, non-Hispanic	23 (67)
Black, non-Hispanic	4 (12)
Asian, non-Hispanic	1 (3)
Hispanic	4 (12)
2+ races	2 (6)
Region ^a	
Midwest	14 (41)
West	13 (38)
Northeast	5 (15)
South	2 (6)
Cannabis use	
Use in the year before, but not during, pregnancy	12 (35)
Use during pregnancy	22 (65)
Cannabis policy in state of residence	
Legalized recreational cannabis	22 (65)
No legalized recreational cannabis	12 (35)

^a Participants resided in one of the following states: Arizona, California, Colorado, Illinois, Iowa, Maine, Michigan, Missouri, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Virginia, Washington, Wisconsin.

We identified three main themes. First, pregnant and recently pregnant people do not recall providers routinely bringing up cannabis use during pregnancy and report rarely disclosing cannabis use to providers. Second, when interactions with providers related to cannabis use during pregnancy take place, they do so in the context of mistrust. Third, in a few cases, pregnant people perceive benefits in discussing cannabis with providers. Although pregnant people describe using cannabis as a medicine for pregnancy-related symptoms and other health conditions, they perceive providers as classifying and responding to cannabis like a harmful recreational substance. Specifically, they describe experiencing providers grouping cannabis with their screening, testing, and messaging for alcohol and other drugs. They also fear and describe experiencing providers taking actions that will result in them being reported to child welfare. These experiences contribute to people who use cannabis mistrusting providers in general and as sources of information on cannabis use during pregnancy in particular. This mistrust impedes patient-provider discussions regarding cannabis use during pregnancy and discussions of underlying pregnancy symptoms or health conditions patients use cannabis to self-treat.

Pregnant and Recently Pregnant People Do Not Recall Providers Routinely Bringing Up Cannabis Use During Pregnancy and Report Rarely Disclosing Cannabis Use to Providers

Few ($n = 6$) participants reported that providers had initiated conversations about cannabis during pregnancy-related visits. In some cases, participants said providers gave them pamphlets, but did not have a conversation, about using drugs, including cannabis. One participant explained, "I think there was a

pamphlet in the waiting room, but they never even asked.” (Participant #12, age 38, white).

Participants recalled that, when providers did broach the topic of cannabis, they usually did so during initial medical history intakes or verbal drug screening. They described the conversations that followed as typically brief and focused on risks of alcohol and drug use during pregnancy, without exploring why participants used cannabis. One participant remembered “*they kind of give you your usual spiel when you actually verify your pregnancy, of the things that you're supposed to sort of refrain from.*” (Participant #5, age 42, white).

A few participants recounted that their provider brought up cannabis in response to a positive drug test. Some said they had been surprised to learn the provider had ordered a test:

“There's only one time [cannabis] was mentioned. When I was getting those genetic tests and things and they ran a whole ton of tests, they were going over results, and she was just, like, and I see you tested positive for marijuana here... I was, like, mildly embarrassed—a little bit, kind of, caught off guard by them. I didn't realize that drugs were going to be in that test... I was also kind of surprised that it was, like, the first and only time it was ever mentioned to me.” (Participant #9, age 36, white)

In these cases, the providers learned about patients' use without them disclosing it. Overall, disclosure was uncommon, as were patient-initiated conversations with providers about cannabis use in pregnancy.

When Interactions With Health Care Providers Regarding Cannabis During Pregnancy Occur, They Occur in a Context of Mistrust

Participants described the interactions related to cannabis use during pregnancy that they had with providers as often occurring in a context of mistrust, which limited pregnant peoples' interest in and willingness to discuss cannabis with providers. When participants recalled either providers broaching the topic or broaching the topic themselves, conversations did not seem to work well for patients. Participants reported not trusting the information providers gave them related to cannabis use during pregnancy; anticipating their prenatal providers judging them for using cannabis; and fearing providers would report them to child welfare, which would lead to family separation.

Although some participants said they agreed with providers' recommendations to avoid cannabis during pregnancy, many did not regard providers as sources of accurate, unbiased information about cannabis. Some questioned the strength of scientific evidence about cannabis use in pregnancy and discounted providers' warnings or viewed them skeptically. Without having what they believed was conclusive evidence, many (though not all) participants decided to continue using cannabis during their pregnancy. “*My doctor did tell me something about that it would affect her brain. I don't find that to necessarily be credible data, either. I feel like that's old because I couldn't find anything to actually back that up.*” (Participant #4, age 40, white) In several cases, participants interpreted provider warnings about cannabis to be less based on evidence and more on opinion. This sentiment was reinforced when providers made blanket statements about risks of cannabis or “lumped” cannabis with alcohol, tobacco, and other drugs, including substances participants considered more harmful and addictive:

“I do remember seeing something in the doctor's office once. It said, ‘If you have substance abuse problems,’ some hotline number. And I'm like, okay, I just don't like that marijuana's lumped into cocaine and heroin. I feel like those drugs are so much more severe and cause so many more problems than weed ever would.” (Participant #14, age 33, white)

Many participants shared anecdotes from conversations they had with providers about cannabis; these varied from recommending complete abstinence to focusing on strategies to reduce possible harm. For example, some recounted that providers had encouraged them to cut back if they did not plan to stop, told them about variable risks during different gestations of pregnancy, or made reassuring statements about impacts of their use on their pregnancies. Participants sometimes interpreted this variation in what providers said about risks of cannabis use during pregnancy as confirmation that research is unsettled and that provider opinion, rather than evidence, guides their actions.

“When I was pregnant, and I was going to my appointments, they never really said anything to me about having the marijuana in my system. But you do have other providers and other gynecologists that feel like you shouldn't be doing anything like that. And sometimes they will put you through drug counseling for marijuana, but that's only in certain instances, certain doctors' offices you go to, certain providers that you see. Because certain providers have different opinions on marijuana.” (Participant #15, age 22, Black)

Some participants who did not seek guidance on cannabis from providers described a fundamental difference between their beliefs and what they saw as providers' beliefs about perceived risks and benefits of cannabis use in pregnancy. Whereas participants perceived providers as approaching cannabis as a risky recreational drug, participants often used it as a medicine to manage pregnancy symptoms or health conditions. For some, using cannabis was the only thing they felt worked to treat their symptoms and stopping use would mean giving up an approach that worked. Participants expressed frustration when providers proposed alternatives that did not address their needs.

“They just told me the one time that I did try to talk to them about [cannabis] and tell them that, you know, I was having really bad morning sickness, they told me there was alternative methods, like if I can't stop throwing up, I can go to the hospital and get an IV full of fluids and that should help. I mean, they were very, very against smoking [cannabis] while pregnant... I didn't feel like I was being heard. I understand that they were trying to come up with alternative methods but ... I cannot spend my whole pregnancy in a hospital being shot up with fluids, basically. So, I was just really annoyed.” (Participant #6, age 29, white)

Participants mentioned worrying providers would judge them if they knew about their cannabis use. This concern was based partly on past experiences of feeling judged or treated disrespectfully by providers. Participants were not necessarily passive related to this fear; some described strategies they used to avoid judgment. Non-disclosure was the most common. Asked whether she could think of a time where she might have talked to a provider about using cannabis during pregnancy, one participant said, matter of factly, “*No, because people tend to look at people differently when they know that they're doing drugs...*”

They would judge me.” (Participant #17, age 34, Hispanic) Another named specific things about provider offices that lead them to worry about judgment, “No. No. I was too petrified. Because we see the materials that are on the wall at the doctor's office. I knew I couldn't say anything. I was too scared to.... I would get in trouble. Judgment. I'd be judged.” (Participant #19, age 33, white) Not everyone used the same strategy. One participant disclosed her use but set a boundary: “I told him, you know, I was being open about it, but I didn't want to converse about it any further than that just because... I really don't feel comfortable talking to you about it just because of the fact, I don't want you guys thinking that, ‘Hey, she's smoking, she's a bad mom.’” (Participant #8, age 24, Hispanic).

Pregnant patients' mistrust was compounded by fears that providers who learn about their cannabis use would report them to child welfare, which could result in family separations. This concern emerged in 20 interviews even though the interview guide did not include any direct questions about fears or experiences with child welfare. One participant expressed a common mindset:

“I don't know how serious it is, but there's also this threat that if you test positive for THC, even if you have a prescription in the State of [state], you automatically get red-flagged by Child Protective Services, and that's just not something that I want to endure ever.” (Participant #4, age 40, white)

Although this particular fear surfaced when discussing patient-provider interactions related to cannabis use during pregnancy generally, participants often described it as closely connected to provider drug testing practices. As described earlier, participants sometimes experienced providers testing them for drugs without informed consent. Although a few described feeling embarrassed when providers mentioned positive tests, their overwhelming emotion was fear that a positive test would lead providers reporting them to child welfare.

These concerns about child welfare reporting were informed by people's own experiences, and by having heard about or witnessed other people's experiences, including friends, relatives, or people in online cannabis forums (e.g., Facebook). Five participants described previous personal experiences being reported; three said they had friends or family who had been reported to or investigated by child welfare. One participant described disclosing cannabis use to a provider and the provider informing her a child welfare report was warranted, which instigated her to seek care elsewhere.

“During my first pregnancy, the first doctor that I was going to, when we sat down at our 7-week meeting... I was telling her just how sick I was. I shared with her that I had been using [cannabis] to help myself not throw up all the time, and she told me that she was going to tell child support or child protective services and have my baby taken away from me, so I didn't go back to that place.” (Participant #3, age 32, white)

This fear of being reported influenced pregnant people's willingness to discuss symptoms they were experiencing and possible approaches to treating them with providers. One participant who was experiencing severe nausea and vomiting was interested in research evidence about effects of using cannabis during pregnancy and other possible treatments. Due to concern about child welfare reporting, she looked into the research herself and decided to self-treat with cannabis rather than ask a provider.

“I was scared to tell the doctor anything, not only for the judgment—because I'm pretty sure that the doctor would have never let me live it down, they would have kept bringing it up—and my fear was CPS [child protective services] getting involved. So, at that point, I didn't even say anything. You know, I was just too uncomfortable.” (Participant #1, age 39, Hispanic)

In a Few Cases, Pregnant People Perceive Benefits in Discussing Cannabis With Providers

Examining experiences and perceptions of the few participants who disclosed cannabis use with providers revealed that, in some cases, participants perceived benefits from doing so. One perceived benefit to disclosing was medical. A participant who works as a paraprofessional in a prenatal care setting disclosed so her doctor could provide appropriate care in case of an emergency and to avoid potential adverse medication reactions:

“[Y]our doctor needs to know that you're using because if an emergency happened during the pregnancy or during birth, then they can make adjustments to the meds they need to give you.... After working in the medical field for a few years and seeing what can happen when people don't say what they're on, and they're given other meds—bad reactions can happen very quickly, so I think it's always better to be honest than hide things like that.” (Participant #7, age 37, white)

Another perceived benefit to disclosing was determining the providers' child welfare reporting practices. Describing what seems like an atypical provider response, one explained,

“I actually brought [child welfare reporting] up to the OB... And what was said was just pretty much, ‘Calm down.’ I was never told to stop. What I was told, because my concern was, ‘Hey, I don't want my child to be in jeopardy when it's time for me to give birth.’ And what I was told was, ‘Ma'am, we deliver children that have tested positive for methamphetamine, crack, and X, Y, and Z as far as other drugs. There will be counseling given.’ And it was.” (Participant #21, age 31, Black)

Another participant, who was using cannabis to manage intense nausea and vomiting, felt she was not being effectively treated with Zofran (anti-nausea medication) and disclosed her use despite strong concerns about a child welfare report. In this case, her disclosure to her provider, who she described as “not condoning” her use but also not telling her to stop, led to a reassuring conversation about reporting practices:

“It made me relieved because I was afraid that I was going to have to stop [cannabis use], especially in those end months when I needed it the most. And it made me very relieved because she said they don't test the babies in [state]. They don't test the mother for drugs in [state] unless there is probable cause. So, that made me feel really better, that what I was doing was okay and I wasn't putting myself and my family at risk.” (Participant #16, age 38, white)

Discussion

In this study, we conducted an interpretive phenomenological analysis of perceptions of interactions with health care providers regarding cannabis and pregnancy among pregnant and recently pregnant people who used cannabis. The themes that emerged from meaning-making support the

conceptualization of a phenomenon that we identified as clinical dissonance during care provision, whereby pregnant people experience providers as classifying and responding to cannabis like a harmful recreational substance in their screening, testing, messaging, and child welfare reporting practices, despite pregnant people describing their use of cannabis as a medicine for pregnancy-related symptoms and other health conditions. This phenomenon of clinical dissonance whereby patients experience providers as grouping cannabis with recreational substances and not with medicines contributes to mistrust. This mistrust, in turn, impedes patient-provider discussions regarding cannabis use during pregnancy and the health conditions patients are using cannabis to self-treat.

Many of our study findings about challenges in communication between providers and pregnant people who use cannabis are consistent with previous research. Previous research has found that pregnant patients rarely disclose cannabis use to prenatal providers and some providers avoid talking about cannabis with patients (Cernat et al., 2024; Daniels et al., 2023; Gerardin et al., 2011; Kitsantas & Pursell, 2024; Panday et al., 2022; Taneja et al., 2023; Woodruff et al., 2021). Consistent with previous research, this study indicates that pregnant people who use cannabis, even when legal, continue to fear drug testing, provider judgment, and provider-initiated child welfare involvement as system-driven risks to patients communicating with providers about their use, and they do not trust providers to protect them from these consequences (Cernat et al., 2024; Gould et al., 2024; Skelton et al., 2024; Woodruff et al., 2021), although a few may disclose when they perceive a medical benefit to doing so (Cernat et al., 2024). Although previous research has found that people often look to sources other than providers for information about cannabis during pregnancy and make their decisions independently from their providers (Cernat et al., 2024), this study extends previous research by defining a new phenomenon of clinical dissonance during patient-provider communication about cannabis and pregnancy and identifying a new aspect of mistrust as a byproduct of this clinical dissonance (i.e., that some pregnant people appear to not trust providers as sources of accurate information about effects of using cannabis during pregnancy). This clinical dissonance, along with patients' fears that providers will judge them and may report them to child welfare, may be limiting potential effectiveness of recommendations that providers discuss cannabis use with their pregnant patients. Our findings also suggest some provider practices regarding child welfare reporting may not align with ACOG recommendations that "seeking obstetric-gynecologic care should not expose a woman to...penalties for marijuana use, such as...loss of custody of her children" (ACOG, 2017; American Society of Addiction Medicine, 2020; National Academies of Sciences, Engineering, and Medicine, 2024). Patients who are interested in receiving accurate information about cannabis use during pregnancy who decide not to discuss or disclose cannabis use in this context are balancing their interest in information from health care providers against the risk of judgment and being reported to child welfare.

Consistent with recent research (Chang et al., 2019; Vanstone et al., 2021; Zaugg et al., 2024), most participants described using cannabis for medical reasons and considered cannabis to be safe and effective treatment. Yet, consistent with findings about provider practices from a systematic review (Panday et al., 2022), the pregnant and recently pregnant people in our study

perceived providers as viewing, talking about, and responding to cannabis as a harmful substance that should be avoided. These clashing perspectives of participants and providers appeared to impede discussions of the symptoms and conditions patients were experiencing and risks and benefits of alternative approaches to symptom relief during pregnancy.

Implications for Policy and Practice

Current professional association guidance recommends screening for and providing information about cannabis use during pregnancy alongside screening and education for other substances (ACOG, 2017; American Society of Addiction Medicine, 2020; National Academies of Sciences, Engineering, and Medicine, 2024). This study suggests that screening for and providing information about cannabis alongside screening and information for other substances, particularly in the context of the potential for child welfare reporting, may not be resonating with some people who use cannabis during their pregnancies, particularly those who are using cannabis for medical reasons. Although participants did not use this language themselves, what they described wanting is individualized, consented, person-focused care (Scott & Davis, 2022; Starfield, 2011) and counseling that allows patients to weigh risks, benefits, and alternatives of cannabis use for medical reasons, effectively treats underlying symptoms and conditions, and supports their efforts to promote the health of their pregnancies. Given the phenomenon of clinical dissonance and medical mistrust, our study justifies a need to explore and test alternative approaches for patient-provider conversations, such as person-focused approaches (Scott & Davis, 2022; Starfield, 2011) that deliver accurate, evidence-based information respectfully and without judgment or surprises; acknowledge that people using cannabis during pregnancy might be doing so to manage pregnancy symptoms and health conditions; and do not expose patients to child welfare involvement. In such approaches, providers also should be aware that people who are using cannabis during pregnancy may be anticipating judgment from them related to cannabis and thus tailor their counseling approaches and clinic environment to communicate a nonjudgmental atmosphere.

Strengths and Limitations

A strength of this study is inclusion of individuals from a large multi-state sample who had reported using cannabis before and/or during pregnancy. Interpretive phenomenology does not aim for statistical generalizability, but rather reflects the researchers' interpretations of the unique lived experiences of a specific population within a certain context. Thus, our rich descriptions, transparent methodology, and attention to power dynamics and positionality between pregnant people and providers facilitates transferability to other contexts, populations, or situations by the reader. Although most participants spoke about interactions with prenatal providers, including obstetrician/gynecologists and midwives, it was sometimes unclear what kind of provider they were speaking about. In some cases, they reported on interactions they had with neonatal care providers, primary care providers, or others. However, interactions with any provider can impact people's perceptions of health care and influence their behavior with other providers. Further, participants' reports were based on recall and those

who used cannabis only in the year before but not during their pregnancy may have had differential recall or experiences. Also, the participants in this study were reporting on stigmatized behaviors that, in some cases, were illegal in their state, which could have led them to underreport cannabis use or provide inaccurate or incomplete responses to the study questions, whether due to social desirability bias or to legal concerns. Last, we collected these data in 2022, at which point there were far fewer published studies about the health effects of cannabis use during pregnancy than there are today. At that point, there was limited research, and it was far less conclusive than it is today (e. g., Lo et al., 2025; NAS, 2017). Thus, it is possible that provider descriptions of existing evidence regarding the health effects of using cannabis during pregnancy and the information about cannabis and pregnancy that pregnant people encounter when they search for it themselves have changed since we collected these data.

Conclusion

Pregnant people describe using cannabis as medicine for pregnancy symptoms and other health conditions, yet they experience providers as viewing and treating cannabis like a harmful recreational substance. This phenomenon we identified as clinical dissonance, along with patient fears of provider judgment and of providers reporting them to child welfare, appears to contribute to mistrust that may be limiting effective person-focused discussions regarding risks and benefits of different approaches to treating symptoms and health conditions for which patients are using cannabis.

CRedit authorship contribution statement

Heather Gould: Writing – review & editing, Writing – original draft, Investigation, Formal analysis. **Claudia Zaugg:** Writing – review & editing, Writing – original draft, Project administration, Formal analysis. **Karen A. Scott:** Writing – review & editing. **Sarah C.M. Roberts:** Writing – review & editing, Writing – original draft, Supervision, Funding acquisition, Conceptualization.

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References

- ACOG. (2017). Committee opinion no. 722: Marijuana use during pregnancy and lactation. *Obstetrics and Gynecology*, 130(4), e205–e209. <https://doi.org/10.1097/AOG.0000000000002354>
- American Society of Addiction Medicine. (2020). *Public policy statement on cannabis*. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/2020-public-policy-statement-on-cannabis-reaffirmed-thru-12-12-30.pdf?sfvrsn=6e63f8ca_2
- Bailey, A., Kerr, W., Alhay, Z., Rom, M., Hamilton, S., Campbell, J., & Reese, J. A. (2025). Fetal cannabis exposure and neonatal outcomes: A systematic review and meta-analysis. *Maternal and Child Health Journal*, 29(5), 703–713. <https://doi.org/10.1007/s10995-025-04096-5>
- Bassalov, H., Yakirevich-Amir, N., Reuveni, I., Monk, C., Florentin, S., Bonne, O., & Matok, I. (2024). Prenatal cannabis exposure and the risk for neuropsychiatric anomalies in the offspring: A systematic review and meta-analysis. *American Journal of Obstetrics & Gynecology*, 231(6), 574–588.e8. <https://doi.org/10.1016/j.ajog.2024.06.014>
- Bhatia, D., Rosenberg, S., Rees, R., & Brooks-Russell, A. (2023). Perinatal cannabis use and cannabis use during breastfeeding: The role of health care workers. *American Journal of Perinatology*, 41(S 01), e2686–e2695. <https://doi.org/10.1055/a-2145-7775>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Brown, Q. L., Shmulewitz, D., Sarvet, A. L., Young-Wolff, K. C., Howard, T., & Hasin, D. S. (2023). Cannabis use, cannabis use disorder and mental health disorders among pregnant and postpartum women in the US: A nationally representative study. *Drug and Alcohol Dependence*, 248: Article 109940. <https://doi.org/10.1016/j.drugalcdep.2023.109940>
- Cesar, R. C., Gould, E., Stal, J., Laughter, J., Tran, M., Wang, S. D., & Santos, J. J. (2023). Legislation has changed but issues remain: Provider perceptions of caring for people who use cannabis during pregnancy in safety net health settings, a qualitative pilot study. *Women's Health Reports (New Rochelle, N. Y.)*, 4(1), 400–408. <https://doi.org/10.1089/whr.2023.0057>
- Cernat, A., Carruthers, A., Taneja, S., Popoola, A., Greyson, D., Panday, J., & Vanstone, M. (2024). Counseling about cannabis use during pregnancy and lactation: A qualitative study of patient and clinician perspectives. *Birth*, 51(4), 867–877. <https://doi.org/10.1111/birt.12873>
- Chang, J. C., Tarr, J. A., Holland, C. L., De Genna, N. M., Richardson, G. A., Rodriguez, K. L., & Arnold, R. M. (2019). Beliefs and attitudes regarding prenatal marijuana use: Perspectives of pregnant women who report use. *Drug and Alcohol Dependence*, 196, 14–20. <https://doi.org/10.1016/j.drugalcdep.2018.11.028>
- Chasnoff, I. J., Landress, H. J., & Barrett, M. E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *New England Journal of Medicine*, 322(17), 1202–1206. <https://doi.org/10.1056/NEJM199004263221706>
- Daniels, S., St Pierre, M., Sanchez, T., & Walsh, Z. (2023). Physician communication and perceived stigma in prenatal cannabis use. *Journal of Psychoactive Drugs*, 55(3), 290–298. <https://doi.org/10.1080/02791072.2022.2076179>
- DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, 40(4), 314–321. <https://doi.org/10.1111/j.1365-2929.2006.02418.x>
- Foti, T. R., Green, A., Altschuler, A., Iturralde, E., Does, M. B., Jackson-Morris, M., & Young-Wolff, K. C. (2023). Patient perceptions of prenatal cannabis use and implications for clinicians. *Obstetrics and Gynecology*, 142(5), 1153–1161. <https://doi.org/10.1097/aog.0000000000005295>
- Gerardin, M., Victorri-Vigneau, C., Louvigne, C., Rivoal, M., & Jolliet, P. (2011). Management of cannabis use during pregnancy: An assessment of health-care professionals' practices. *Pharmacoepidemiology and Drug Safety*, 20(5), 464–473. <https://doi.org/10.1002/pds.2095>
- Gould, E. E., Ganesh, S. S., Nguyen, R. M., Breton, C. V., Bastain, T. M., Dunton, G. F., & Ceasar, R. C. (2024). The unseen patient: Competing priorities between patients and providers when cannabis is used in pregnancy, a qualitative study. *Frontiers in Global Women's Health*, 5: Article 1355375. <https://doi.org/10.3389/fgwh.2024.1355375>
- Gould, H., Zaugg, C., Biggs, M. A., Woodruff, K., Long, W., Mailman, K., & Roberts, S. C. M. (2025). Mandatory warning signs for cannabis: Perspectives and preferences of pregnant and recently pregnant people who use cannabis. *Journal of Studies on Alcohol and Drugs*, 86(1), 75–84. <https://doi.org/10.15288/jsad.23-00214>
- Hayes, S., Delker, E., & Bandoli, G. (2023). The prevalence of cannabis use reported among pregnant individuals in the United States is increasing, 2002–2020. *Journal of Perinatology*, 43(3), 387–389. <https://doi.org/10.1038/s41372-022-01550-y>
- Jarlenski, M., Shroff, J., Terplan, M., Roberts, S. C. M., Brown-Podgorski, B., & Krans, E. E. (2023). Association of race with urine toxicology testing among pregnant patients during labor and delivery. *JAMA Health Forum*, 4(4): Article e230441. <https://doi.org/10.1001/jamahealthforum.2023.0441>
- Jarlenski, M., Tarr, J. A., Holland, C. L., Farrell, D., & Chang, J. C. (2016). Pregnant women's access to information about perinatal marijuana use: A qualitative study. *Women's Health Issues*, 26(4), 452–459. <https://doi.org/10.1016/j.whi.2016.03.010>
- Kitsantas, P., & Pursell, S. R. (2024). Are health care providers caring for pregnant and postpartum women ready to confront the perinatal cannabis use challenge? *American Journal of Perinatology*, 41(S 01), e3249–e3254. <https://doi.org/10.1055/s-0043-1777669>
- Lagan, B. M., Sinclair, M., & Kernohan, W. G. (2011). What is the impact of the internet on decision-making in pregnancy? A global study. *Birth*, 38(4), 336–345. <https://doi.org/10.1111/j.1523-536X.2011.00488.x>
- Lebron, C. N., Morales, V., Saenz, S., & Vidot, D. C. (2022). "Ganja Mamas": Online discussions about cannabis use in pregnancy. *Drug and Alcohol Dependence*, 241: Article 109689. <https://doi.org/10.1016/j.drugalcdep.2022.109689>
- Lo, J. O., Ayers, C. K., Yeddala, S., Shaw, B., Robalino, S., Ward, R., & Kansagara, D. (2025). Prenatal cannabis use and neonatal outcomes: A systematic review and meta-analysis. *JAMA Pediatrics*, 179(7), 738–746. <https://doi.org/10.1001/jamapediatrics.2025.0689>
- Miller-Day, M., & Hecht, M. L. (2013). Narrative means to preventative ends: A narrative engagement framework for designing prevention interventions. *Health Communication*, 28(7), 657–670. <https://doi.org/10.1080/10410236.2012.762861>

- NAS. (2017). *The health effects of cannabis and cannabinoids: The current state of evidence and recommendations for research*. National Academies Press.
- National Academies of Sciences, Engineering, and Medicine. (2024). Cannabis policy impacts public health and health equity. <https://www.nationalacademies.org/our-work/public-health-consequences-of-changes-in-the-cannabis-landscape#sectionCommittee>.
- NIAAA. (2025). Alcohol Policy Information System. Recreational use of cannabis: Volume 1. <https://alcoholpolicy.niaaa.nih.gov/cannabis-policy-topics/recreational-use-of-cannabis-volume-1/104>.
- NIAAA. (2022). Warning signs: Drugs during pregnancy. <https://alcoholpolicy.niaaa.nih.gov/apis-policy-topics/warning-signs-drugs-during-pregnancy/164#page-content>.
- Panday, J., Taneja, S., Popoola, A., Pack, R., Greyson, D., McDonald, S. D., & Vanstone, M. (2022). Clinician responses to cannabis use during pregnancy and lactation: A systematic review and integrative mixed-methods research synthesis. *Family Practice*, 39(3), 504–514. <https://doi.org/10.1093/fampra/cmab146>
- Perlman, N. C., Cantonwine, D. E., & Smith, N. A. (2022). Racial differences in indications for obstetrical toxicology testing and relationship of indications to test results. *American Journal of Obstetrics & Gynecology MFM*, 4(1): Article 100453. <https://doi.org/10.1016/j.ajogmf.2021.100453>
- Portillo, R., Synova, T., & Staud, F. (2025). Effects of prenatal cannabinoid use on the monoamine system in the fetoplacental unit: A systematic review of animal and human studies. *Drug and Alcohol Dependence*, 268: Article 112579. <https://doi.org/10.1016/j.drugalcdep.2025.112579>
- Przy, R., Jacoby, B., & Christie, B. R. (2025). Synaptic signatures of perinatal cannabinoids: A systematic review of rodent hippocampal synaptic plasticity, learning, and memory. *Drug and Alcohol Dependence Reports*, 16: Article 100353. <https://doi.org/10.1016/j.dadr.2025.100353>
- Reck, A. M., Reilly, T., Vanegas, S. O., Shook, N. J., Kinsey, S. G., & Casavant, S. G. (2025). Risks of cannabinoid exposure on birth outcomes: A systematic review. *Cannabis and Cannabinoid Research*. <https://doi.org/10.1089/can.2025.0027>
- Roberts, S. C., & Nuru-Jeter, A. (2011). Universal alcohol/drug screening in prenatal care: A strategy for reducing racial disparities? Questioning the assumptions. *Maternal and Child Health Journal*, 15(8), 1127–1134. <https://doi.org/10.1007/s10995-010-0720-6>
- Roberts, S. C. M., & Nuru-Jeter, A. (2012). Universal screening for alcohol and drug use and racial disparities in child protective services reporting. *The Journal of Behavioral Health Services & Research*, 39(1), 3–16. <https://doi.org/10.1007/s11414-011-9247-x>
- Roberts, S. C. M., Zahnd, E., Sufrin, C., & Armstrong, M. A. (2015). Does adopting a prenatal substance use protocol reduce racial disparities in CPS reporting related to maternal drug use? A California case study. *Journal of Perinatology*, 35(2), 146–150. <https://doi.org/10.1038/jp.2014.168>
- Roberts, S. C. M., Zaugg, C., & Biggs, M. A. (2023). Association of mandatory warning signs for cannabis use during pregnancy with cannabis use beliefs and behaviors. *JAMA Network Open*, 6(6): Article e2317138. <https://doi.org/10.1001/jamanetworkopen.2023.17138>
- Rubin, H. J., & Rubin, I. S. (2011). *Qualitative interviewing: The art of hearing data*. SAGE Publications.
- Sainz, K., Ulibarri, H., Arroyo, A., Herrera, D. G., Hamilton, B., Ruffley, K., & Marchand, G. J. (2025). Meta-analysis of maternal and neonatal outcomes of cannabis use in pregnancy current to March 2024. *Maternal Health, Neonatology and Perinatology*, 11(1), 20. <https://doi.org/10.1186/s40748-025-00216-9>
- Scott, K. A., & Davis, D. A. (2022). Destigmatizing and democratizing postpartum care: A "Black woman-person first" approach. *Clinical Obstetrics and Gynecology*, 65(3), 663–675. <https://doi.org/10.1097/GRF.0000000000000729>
- Singh, S., Filion, K. B., Abenhaim, H. A., & Eisenberg, M. J. (2020). Prevalence and outcomes of prenatal recreational cannabis use in high-income countries: A scoping review. *BJOG*, 127(1), 8–16. <https://doi.org/10.1111/1471-0528.15946>
- Skelton, K., Nyarko, S., & Iobst, S. (2024). Perceptions, barriers, and facilitators of cannabis screening during pregnancy and labor: A qualitative study. *Drug and Alcohol Dependence Reports*, 12: Article 100274. <https://doi.org/10.1016/j.dadr.2024.100274>
- Skelton, K. R., Nyarko, S., & Benjamin-Neelon, S. E. (2023). Maternal report of cannabis screening and recommendations during prenatal care visits in the United States. *American Journal of Obstetrics & Gynecology*, 229(4), 464–466. e2. <https://doi.org/10.1016/j.ajog.2023.07.010>
- Soos, A., Plegue, M., Darwiche, A., Oshman, L., & Frank, C. J. (2024). Racial disparities in newborn drug testing after implementation of question-based screening for prenatal substance use. *Obstetrics and Gynecology*, 144(2), 233–240. <https://doi.org/10.1097/AOG.00000000000005631>
- Starfield, B. (2011). Is patient-centered care the same as person-focused care? *The Permanente Journal*, 15(2), 63–69. <https://doi.org/10.7812/TPP/10-148>
- Taneja, S., Panday, J., Popoola, A., Greyson, D., McDonald, S. D., Patel, T., & Vanstone, M. (2023). Making informed choices about cannabis use during pregnancy and lactation: A qualitative study of information use. *Birth*, 50(3), 504–512. <https://doi.org/10.1111/birt.12668>
- Vanstone, M., Taneja, S., Popoola, A., Panday, J., Greyson, D., Lennox, R., & McDonald, S. D. (2021). Reasons for cannabis use during pregnancy and lactation: A qualitative study. *CMAJ: Canadian Medical Association Journal*, 193(50), E1906–E1914. <https://doi.org/10.1503/cmaj.211236>
- Westfall, R. E., Janssen, P. A., Lucas, P., & Capler, R. (2006). Survey of medicinal cannabis use among childbearing women: Patterns of its use in pregnancy and retroactive self-assessment of its efficacy against 'morning sickness'. *Complementary Therapies in Clinical Practice*, 12(1), 27–33. <https://doi.org/10.1016/j.ctcp.2005.09.006>
- Woodruff, K., Scott, K. A., & Roberts, S. C. M. (2021). Pregnant people's experiences discussing their cannabis use with prenatal care providers in a state with legalized cannabis. *Drug and Alcohol Dependence*, 227: Article 108998. <https://doi.org/10.1016/j.drugalcdep.2021.108998>
- Young-Wolff, K. C., Sarovar, V., Tucker, L. Y., Conway, A., Alexeeff, S., Weisner, C., & Goler, N. (2019). Self-reported daily, weekly, and monthly cannabis use among women before and during pregnancy. *JAMA Network Open*, 2(7): Article e196471. <https://doi.org/10.1001/jamanetworkopen.2019.6471>
- Zaugg, C., Terplan, M., Mailman, K., & Roberts, S. C. M. (2024). Reasons pregnant people use cannabis to self-treat health conditions during pregnancy: Results from a US population-based survey. *Drug and Alcohol Review*, 43(7), 1742–1752. <https://doi.org/10.1111/dar.13934>

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