

Marijuana's Harms Are Hiding in Plain Sight

Legalization and commercialization have changed public perception faster than medicine and mental-health practice have adapted

During my years of clinical practice, I witnessed a substantial increase in marijuana use among patients seeking psychological assessment and treatment. The increase became so pronounced that I began routinely asking every patient whether they used marijuana, how often they used it, what products they consumed, how much they used, and how long they had been using it.

These questions should be standard in medical and mental-health evaluations. Too often, they are not.

Many physicians, psychologists, and other healthcare professionals appear uncertain about how to address marijuana use. Some assume that because marijuana is legal in many states, sold through licensed dispensaries, or described as “medical,” it is unlikely to be contributing to a patient’s symptoms. Others may avoid the subject because marijuana has become politically charged or because questioning its use can be interpreted as moralistic rather than clinical.

The result is a serious diagnostic blind spot.

Patients frequently seek treatment for anxiety, depression, attention problems, memory difficulties, irritability, emotional instability, sleep disturbance, reduced motivation, relationship conflict, paranoia, or unusual perceptual experiences. They may arrive convinced that they have ADHD, an anxiety disorder, a mood disorder, or another psychiatric condition. Clinicians may begin treating those symptoms without adequately investigating whether marijuana is causing, worsening, or complicating them.

In some cases, the diagnosis being treated is incomplete. In others, treatment may be directed at the wrong problem entirely.

Legal Does Not Mean Harmless

Legalization is a political and legal classification. It is not a medical determination of safety.

Alcohol and tobacco are legal, yet responsible clinicians routinely ask patients about both. We understand that legality does not eliminate the possibility of dependence, cognitive impairment, emotional disturbance, medical complications, poor judgment, or damage to relationships.

Marijuana should be treated with the same clinical seriousness.

Cannabis directly affects functions involved in memory, learning, attention, decision-making, coordination, emotion, and reaction time. Frequent or long-term use has also been associated with increased risk of psychosis or schizophrenia in some users, especially when use begins at a younger age or occurs frequently.

These concerns are not remnants of outdated drug policy. They reflect documented effects that have become easier to minimize as marijuana has been normalized, commercialized, and presented as a broadly therapeutic product.

The Perception Gap

One of the most important consequences of legalization has been a change in the way marijuana is perceived.

From an early age, children are taught that heroin, cocaine, methamphetamine, and similar drugs are dangerous. The message is direct and consistent: these substances can alter the brain, impair judgment, create dependence, destabilize behavior, and damage relationships and health.

Marijuana has increasingly been placed in a different category.

The public is exposed to messages describing it as natural, therapeutic, calming, nonaddictive, safer than alcohol, and useful for a wide range of psychological and physical complaints. Dispensaries often resemble wellness businesses rather than drug retailers. Edibles, vaping products, concentrates, colorful packaging, and the language of “self-care” further distance modern marijuana from the public image of drug use.

This messaging matters.

Research examining adolescents’ cannabis knowledge and risk perception has found that greater knowledge and greater perceived risk are often associated with lower current use and less intention to use. Studies tracking attitudes over time have frequently found increasing use alongside declining perceptions of danger. Research on medical-marijuana laws has also commonly identified decreases in perceived risk following legalization.

When perceived risk falls, experimentation becomes easier to justify. Regular use becomes easier to normalize. Parents become less likely to intervene, and clinicians become less likely to regard marijuana as a possible source of impairment.

The message many young people now receive is not simply that adults should be free from criminal prosecution for marijuana possession. It is that marijuana is relatively benign.

Those are not the same claim.

What Legalization Research Actually Shows

Advocates have frequently argued that legalizing marijuana for adults will not increase its use among adolescents or the broader population. The research is more complicated than that assurance suggests.

A 2024 systematic review and meta-analysis concluded that recreational cannabis legalization was associated with modest increases in past-month cannabis use among young people, with larger effects among young adults than among younger adolescents. Medical cannabis laws showed smaller or minimal average effects, although the authors emphasized that the findings were heterogeneous across studies and jurisdictions.

The most defensible conclusion is therefore not that legalization automatically produces a dramatic increase in every adolescent population. It is that legalization changes the legal, cultural, commercial, and perceptual environment in ways that can influence use.

What the State Comparisons Show

The state-level charts covering 2012–2016 illustrate a striking descriptive pattern. Among people aged 12 and older, marijuana use was generally lowest in states without legalization, higher in states permitting medical marijuana, and highest in states permitting both medical and recreational use.

In states without legalization, reported use generally ranged from approximately 9% to 13%. In medical-marijuana states, the range expanded to approximately 11% to 21.8%. In states permitting both medical and recreational marijuana, use ranged from approximately 13% to 25%.

Several states with more permissive laws also showed substantial increases across the reporting periods. Colorado increased from 18.92% in 2012–2013 to 23.12% in 2015–2016. The District of Columbia increased from 21.02% to 24.68%; Oregon from 19.03% to 22.70%; Alaska from 19.69% to 23.00%; California from 13.89% to 16.23%; and Massachusetts from 15.57% to 18.64%.

Medical-marijuana states demonstrated a similar, although less uniform, pattern. Maryland increased from 11.47% to 15.50%, Montana from 15.78% to 18.41%, New Hampshire from 15.39% to 17.58%, and Vermont from 19.10% to 21.79%.

Not every state followed the same trajectory. Nevada remained comparatively stable, Washington showed only a modest net increase, and some states without legalization also experienced changes. The charts therefore do not prove that legalization caused every difference or increase.

States with higher preexisting use may have been more likely to legalize marijuana. Demographic characteristics, enforcement practices, local culture, product availability, economic conditions, and survey differences may also influence the numbers.

Nevertheless, the overall pattern is difficult to reconcile with the categorical assertion that liberalization has no relationship to use. The charts show that states with more permissive laws often had considerably higher population-level rates, and several prominent legalization states experienced meaningful increases over time.

Legalization also operates through more than direct access. It can alter social acceptability, parental attitudes, perceived medical legitimacy, commercial advertising, product availability, exposure in homes and social settings, perceptions of danger, and clinicians' willingness to question use.

Even when prevalence does not rise immediately, legalization may influence how frequently people use, what products they consume, how potent those products are, and whether use is recognized as a possible health risk.

The Historical Warning Was Already There

Concern about adolescent marijuana use existed well before the recent expansion of recreational legalization.

The 2009 Monitoring the Future survey found that approximately 32.8% of 12th graders had used marijuana during the previous year. Daily or near-daily use was reported by 5.2% of high-school seniors, or approximately one in nineteen. The rate increased to 6.1% the following year.

These figures are important because they demonstrate that marijuana was already deeply established in adolescent culture before widespread recreational legalization. They also show why declining perceptions of harm deserve attention. Researchers associated with Monitoring the Future have repeatedly noted that changes in beliefs about risk and disapproval can precede changes in drug use.

The cultural groundwork for normalization was therefore laid over many years. Expanding claims of medical benefit, political advocacy, reduced legal penalties, and increasingly permissive attitudes all contributed to a changing message.

The message was not merely that marijuana use should be handled differently by the criminal-justice system. It increasingly became that marijuana was not especially dangerous.

The Sleep Paradox

Marijuana is frequently used as a self-selected treatment for insomnia. Because THC may initially produce sedation or help a person fall asleep, users often conclude that marijuana is improving sleep.

Falling asleep more quickly, however, is not necessarily the same as achieving healthy, restorative sleep.

In their 2009 review, Joanna Jacobus, Sunita Bava, Michal Cohen-Zion, Omar Mahmood, and Susan Tapert examined the functional consequences of adolescent marijuana use. They concluded that heavy adolescent users tended to show disadvantages in attention, learning, and processing speed, along with subtle brain abnormalities and compromised objective indicators of sleep quality. Some impairments appeared to continue beyond one month of abstinence, although certain findings improved with sustained cessation.

This creates a paradox. A person begins using marijuana because of insomnia. With repeated use, sleep may become increasingly dependent on the drug. When the individual attempts to stop, sleep temporarily worsens. The person then interprets this rebound disturbance as proof that marijuana is necessary for sleep and resumes using it.

What appears to be successful self-treatment may become a cycle of tolerance, withdrawal, and dependence.

This possibility is especially important in clinical evaluations because disrupted sleep can itself produce poor concentration, memory problems, irritability, anxiety, depressed mood, reduced motivation, and emotional instability. A patient may consequently receive multiple psychiatric diagnoses or medications without anyone recognizing that chronic marijuana use and marijuana-related sleep disruption are contributing to the presentation.

Today's Marijuana Is Not Yesterday's Marijuana

Public discussion often treats marijuana as though it were a single, stable substance. It is not.

A patient who says, "I use marijuana," may be describing occasional use of plant material, daily vaping of high-THC oil, ingestion of concentrated edibles, or repeated use of extracts and concentrates. These products differ substantially in potency, route of administration, onset, duration, and risk.

That distinction matters clinically.

Modern cannabis products can deliver high levels of THC rapidly. Concentrates, vaping oils, waxes, and similar products bear little resemblance to the comparatively lower-potency marijuana many adults associate with past decades.

The general term cannabis also encompasses numerous compounds and products. Marijuana refers more specifically to cannabis products containing substantial amounts of THC, the primary substance responsible for intoxication and alterations in mental state.

Asking merely whether a patient uses marijuana is therefore insufficient.

Cognitive Problems Can Be Mistaken for Psychiatric Disorders

Cannabis can affect attention, memory, learning, decision-making, processing, emotional functioning, coordination, and reaction time.

These are many of the same abilities patients complain about when seeking evaluations for ADHD, depression, anxiety, learning problems, or other psychological conditions.

A person may report poor concentration, forgetfulness, reduced productivity, procrastination, lack of motivation, slow thinking, disorganization, inconsistent performance, difficulty learning new information, or emotional reactivity.

These complaints are real. The mistake is assuming that they automatically establish a particular psychiatric diagnosis.

A patient who reports poor concentration, disorganization, low motivation, and forgetfulness may conclude that ADHD is the explanation. A clinician who relies heavily on symptom checklists may reach the same conclusion. Yet these symptoms are not unique to ADHD.

They may also emerge from chronic marijuana use, disrupted sleep, anxiety, depression, trauma, medication effects, other substance use, or interactions among several conditions.

Marijuana use does not rule out ADHD or another psychiatric disorder. Nor does every person who uses marijuana develop significant cognitive impairment. The clinically responsible position is that marijuana must be considered as a possible cause, contributing factor, aggravating condition, or barrier to accurate diagnosis.

Diagnosis requires differential evaluation, not merely confirmation of the patient's preferred explanation.

Emotional Instability and Relationship Damage

Marijuana is often used to manage stress, anxiety, anger, trauma, loneliness, or dissatisfaction. Some users report immediate relief. Immediate subjective relief, however, does not demonstrate that a substance is improving the underlying condition.

Avoidance often feels like relief in the moment.

A person may use marijuana to escape uncomfortable emotions while gradually becoming less capable of tolerating distress without it. Irritability, anxiety, sleep disturbance, restlessness, or mood changes may appear when the drug is unavailable or when the person attempts to reduce use.

The user may then resume marijuana and conclude that the substance is treating the symptoms. In some cases, repeated use or withdrawal may be helping sustain those same symptoms.

Family members often notice the changes before the user does. They may describe emotional detachment, irritability, defensiveness, diminished initiative, inconsistent follow-through, impaired

communication, financial strain, secrecy, reduced intimacy, conflict over use, or narrowing interests and activities.

These effects are easily minimized when the person remains employed, attends school, or does not fit a stereotyped image of addiction.

Functioning, however, is not all or nothing. A person can continue meeting some responsibilities while experiencing meaningful declines in memory, ambition, reliability, emotional regulation, judgment, and relationships.

Cannabis and Psychosis

The relationship between marijuana and psychosis is among the most serious clinical concerns.

Cannabis use has been associated with temporary psychosis involving paranoia, hallucinations, and impaired reality testing, as well as with longer-lasting psychotic disorders. The association with schizophrenia is stronger among people who begin using earlier and use more frequently.

This does not mean that marijuana alone causes every case of schizophrenia or psychotic illness. Genetic vulnerability, developmental factors, trauma, other substances, and preexisting symptoms can contribute. The relationship can also be complex and bidirectional.

Nevertheless, the association is strong enough that marijuana use should be directly evaluated whenever a patient reports paranoia, unusual beliefs, hallucinations, perceptual distortions, disorganized thinking, severe emotional instability, sudden deterioration in functioning, or abrupt personality or behavioral changes.

It is not sufficient to diagnose and medicate psychotic symptoms while ignoring continued exposure to high-potency THC.

In my own clinical experience, I have seen patients seeking treatment for what they believed to be independent psychiatric disorders, only for assessment to reveal that marijuana was likely causing or substantially worsening cognitive disturbance, emotional instability, relationship problems, paranoia, or psychotic symptoms.

The possibility is particularly important when symptoms emerge after use begins, intensify as use increases, or improve during sustained abstinence.

The Problem With “Medical” Marijuana

The term medical marijuana carries a degree of scientific authority that is not always warranted.

Certain cannabinoids, pharmaceutical preparations, or specific compounds may have evidence supporting limited uses. That does not mean smoked, vaped, or ingested high-THC marijuana is an established treatment for every condition listed by a dispensary, promoted online, or described in popular commentary.

Cannabis, THC, CBD, prescription cannabinoid medications, dispensary products, and recreational concentrates are not interchangeable. They differ in chemical composition, dose, quality control, purity, route of administration, evidence base, and risk.

The existence of a legitimate medical application for a particular cannabinoid does not establish that marijuana is generally therapeutic.

Opioids have legitimate medical uses. Benzodiazepines have legitimate medical uses. Stimulants have legitimate medical uses. Each can also be misused, overprescribed, poorly monitored, or harmful to particular patients.

Marijuana should not be exempt from the same reasoning. However, the use of opioids, benzodiazepines, and stimulants have much research on their medical uses and limitations. Marijuana is more difficult to evaluate than a conventional medication because it is not a single standardized drug. It is a chemically complex and highly variable plant whose products differ in THC concentration, cannabinoid composition, route of administration, potency, and dose. Consequently, research finding an effect from one cannabinoid, formulation, or product cannot automatically be generalized to marijuana as a whole. This complexity should make clinicians and policymakers more cautious—not less cautious—about broad claims of safety or therapeutic benefit.

A recommendation or authorization for marijuana also does not guarantee that the person has undergone a comprehensive psychiatric, cognitive, medical, and substance-use evaluation. A patient may be advised to use marijuana for sleep, anxiety, pain, trauma symptoms, or mood difficulties without adequate consideration of dependence, cognitive vulnerability, psychosis risk, medication interactions, or the possibility that marijuana will worsen the presenting complaint.

The fact that marijuana has been recommended does not remove the treating clinician's responsibility to assess its effects.

Clinicians Must Start Asking

Healthcare professionals do not need to become experts in cannabis policy before asking clinically necessary questions.

Every psychological and medical evaluation should include direct inquiry into whether the patient uses marijuana; age at first use; frequency and amount; typical product and potency; smoking, vaping, edibles, oils, or concentrates; reasons for using; medical or recreational source; changes in tolerance; withdrawal symptoms; attempts to reduce or stop; effects on sleep, memory, attention, mood, motivation, work, school, and relationships; episodes of panic, paranoia, hallucinations, or confusion; and whether symptoms improve during sustained abstinence.

Screening is not moral condemnation. It is competent healthcare.

Clinicians should also ask whether the patient is using marijuana to treat symptoms that may actually be worsened by continued use. The person using cannabis for anxiety may be experiencing rebound anxiety. The person using it for sleep may be developing dependence-related sleep disruption. The person using it to improve mood may be becoming less motivated and more emotionally unstable. The person using it to “focus” may be experiencing worsening memory and processing efficiency.

Without a careful timeline, these relationships are easily missed.

Public Policy Has Outpaced Public Education

The United States has moved rapidly toward legalization, commercialization, and normalization without developing an equally visible public-health campaign regarding marijuana-related risk.

That imbalance has consequences.

Commercial interests have incentives to emphasize wellness, consumer freedom, novelty, lifestyle, and potential benefit. Governments may focus on tax revenue, regulation, and criminal-justice reform. Advocacy organizations may emphasize autonomy and the harms of prohibition.

Some of these concerns may be legitimate. None eliminates the need for accurate health messaging.

The public should understand that adolescent use carries particular developmental risk; marijuana can affect attention, memory, learning, and judgment; dependence and withdrawal can occur; high-potency products differ from older forms of marijuana; marijuana can contribute to psychiatric destabilization; frequent use is associated with psychosis risk in vulnerable individuals; sleep may worsen with chronic use and withdrawal; marijuana-related symptoms can resemble independent psychiatric disorders; and “medical” labeling does not guarantee safety or effectiveness.

Warning people about these risks is not a return to exaggerated anti-drug propaganda. It is the same public-health principle applied to alcohol, tobacco, prescription opioids, benzodiazepines, and other psychoactive substances.

A Needed Correction

The marijuana debate is often framed as a choice between prohibitionist exaggeration and uncritical legalization.

That is a false choice. The central clinical question is not whether marijuana is politically popular, legally available, natural, profitable, or described as medicine.

The question is whether its use is affecting the individual sitting in the examination room.

For too many patients, that question is never seriously asked.

The consequences are predictable. Marijuana-related cognitive and emotional problems are interpreted as separate psychiatric disorders. Additional medications are prescribed. Relationships deteriorate. Academic and occupational performance decline. Sleep problems become chronic. Paranoia or psychosis is treated without confronting continuing THC exposure. Patients receive increasingly complicated diagnoses while one of the most important variables remains unexamined.

Marijuana should not automatically be blamed for every psychological complaint. Neither should it be granted automatic immunity from clinical scrutiny.

The prevailing cultural narrative has moved from exaggerating marijuana’s dangers to minimizing them. Good clinical practice requires rejecting both errors.

The evidence—not legality, commercial interest, political ideology, or public preference—should lead the conversation.

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