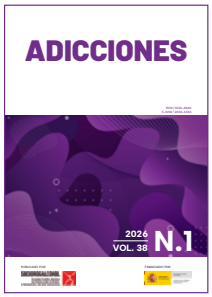
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ADICCIONES
2026 ■ VOL. 38 ■ N. 1 ■ PAGES 3–8
www.adicciones.es




EDITORIAL

# Language and social perception of cannabis: A debate on narrative constructions and their impact on Public Health

## *Lenguaje y percepción social del cannabis: Un debate sobre construcciones narrativas y su impacto en la Salud Pública*

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Words do not merely describe reality; they also shape attitudes and behaviors. In the case of cannabis, media and social debate has become framed within an apparently simple dichotomy between "recreational cannabis" and "medical cannabis." This terminological limitation can bias risk perception regarding the use of this substance. The adjective "recreational" suggests harmlessness and leisure, whereas the adjective "medical" suggests benefit and safety. From a public health perspective, the use of these terms is not trivial, because the way a substance and its uses are named can normalize them, shift the focus away from the determinants of harm (frequency, quantity, potency, age of initiation) toward people's subjective interpretations, and hinder clear preventive messages (Sanchez et al., 2023).

Moreover, in several countries where legal markets have opened, cannabis has become part of an economy with commercial interests capable of influencing messages, research, and policies. This phenomenon is better understood within the framework of the commercial determinants of health: marketing strategies, product design, lobbying, or the funding of evidence, all oriented toward industry profit and potentially increasing population exposure to cannabis and the harms associated with its use (Kickbusch et al., 2016). Experience with this type of industry suggests that, as the market grows, so do the incentives to normalize the product and expand the consumer base (Adams et al., 2021; Young-Wolff et al., 2022). In this context, rebranding strategies have been described that seek to present cannabis as a "natural" product associated with self-care or wellness, as well as influence dynamics that may shift the agenda from public health toward market expansion (Isorna & Villanueva-Blasco, 2022). In parallel, the circulation of ambiguous information (post-truths, oversimplifications, and "fake news") may erode health literacy and hinder informed social debate about risks, benefits, and regulation (Isorna-Folgar et al., 2023; López-Pelayo et al., 2018).

■ ISSN: 0214-4840 / E-ISSN: 2604-6334

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## Importance of language in the use of the concept of risk in cannabis use

The body of scientific evidence converges on one central idea: cannabis is not a harmless substance, and the risk associated with its use increases when the amounts of psychoactive substance consumed increase, use becomes more frequent, initiation occurs earlier, or products with higher THC potency are used (Campeny et al., 2020; Hoch et al., 2024). In adolescent populations, the evidence links cannabis use to poorer cognitive and educational performance, especially in intensive and sustained patterns of use (Lorenzetti et al., 2020). An association has also been described between the use of high-potency cannabis and a greater risk of psychotic disorders, particularly in vulnerable individuals (Di Forti et al., 2019; Volkow et al., 2016).

That said, it is important to clarify that there is no universally accepted "safe dose" of cannabis within the scientific community (Fischer et al., 2022; Oliveras et al., 2024; Solmi et al., 2023). In practice, accurately estimating how much THC is consumed is difficult because cannabis products are not homogeneous: potency (THC percentage), form of presentation (flower, resins, concentrates, edibles, extracts), route of administration (smoked, vaporized, oral), and, consequently, the amount actually absorbed and the effects all vary (Casajuana Kogel et al., 2018). This heterogeneity is compounded by the absence of a widely implemented standard unit that would allow THC exposure to be quantified comparably across product types and contexts of use (Casajuana et al., 2016; Freeman & Lorenzetti, 2020; López-Pelayo et al., 2021). Precisely for this reason, defining "risky cannabis use" remains a work in progress that requires consensus (Balcells-Oliveró & Oliveras, 2023).

In Spain, a Delphi consensus has proposed (while acknowledging that there is no risk-free pattern of cannabis use) an operational definition of "high-risk cannabis use" and underscores its necessarily provisional and revisable nature as evidence advances. In summary, risk indicators include the use of more than 28 mg of THC (around 4 joints) per week, the use of high-potency products (>10% THC), combined use with alcohol or other substances, and use in vulnerable situations or profiles, including initiation at early ages (before age 21) (Oliveras et al., 2024).

In this context, speaking of a "safe dose" may reinforce the idea that, below a supposed threshold, use would be harmless. This oversimplification is encouraged by rebranding narratives and misleading messages that present cannabis as a "natural" product, one that promotes well-being, or one that entails trivial risks, thereby contributing to reduced risk perception and shifting attention away from the real determinants of harm (potency, quantity, frequency, age of initiation, polysubstance use, and individual vulnerabilities) (Isorna-Folgar et al., 2023; Isorna & Villanueva-Blasco, 2022; López-Pelayo et al., 2018). Therefore, language should avoid being framed in terms of safety and should instead help identify higher-risk patterns and communicate clearly that "lower exposure" does not equal "zero risk," especially in adolescents and in people with vulnerability factors (Balcells-Oliveró & Oliveras, 2023; Casajuana et al., 2016).

In this regard, three terminological adjustments are proposed:

1. **Stop using the terminology "recreational cannabis" and use "non-medical use" instead.** Referring to non-therapeutic use as "recreational" introduces a leisure-related connotation that does not always reflect reality. Beyond leisure motives, many users report using cannabis to cope with negative emotions, to sleep, or as an established habit, and these motivations are associated with a higher likelihood of problematic use (Casajuana-Kögel et al., 2021). Likewise, the term "recreational" does not convey the determinants of risk (frequency, quantity, potency, age of initiation, polysubstance use, route of administration). For this reason, it is preferable to refer to "non-medical cannabis use" or "cannabis use for psychoactive purposes," which are more descriptive and neutral terms and allow the key element—the risk level of the pattern of use—to be incorporated into prevention and clinical approaches (Sanchez et al., 2023).
2. **Stop using the term "low risk" and use "lower risk" instead.** At present, when referring to cannabis use, we believe the most honest approach is to speak of "high risk" and "lower risk," the latter in a harm-reduction framework. In comparison with alcohol, for this legal substance there are consensuses on indicative low-risk thresholds, with the warning that zero risk does not exist (Córdoba-García et al., 2021; Ministerio de Sanidad, 2020). In cannabis, directly transferring that model is premature due to THC variability and the lack of dose standardization (Freeman & Lorenzetti, 2020; López-Pelayo et al., 2021), in addition to territorial variability in the legal and regulatory status of cannabis (Observatorio Español de las Drogas y las Adicciones (OEDA); Delegación del Gobierno para el Plan Nacional sobre Drogas (DGPNSD), 2026). As a precaution, it is more useful to prioritize the identification of high-risk patterns and, in parallel, offer harm-reduction recommendations—that is, "lower-risk" recommendations—eliminating the use of terms such as "low risk" or "safe use." In this line, Canada's Lower-Risk Cannabis Use Guidelines propose evidence-based recommendations to reduce harms in non-medical use (Fischer et al., 2022).
3. **From "medical cannabis" to "cannabis medicines" and "prescribed cannabinoids."** In colloquial language, the term "medical cannabis"

is used for very different realities, ranging from standardized pharmaceuticals to the use of flower or artisanal extracts with therapeutic intent. This ambiguity may increase the perception of safety and encourage self-medication. Evidence supports benefits in specific indications for certain cannabinoids or standardized preparations, whereas for many popular uses the evidence is insufficient or still preliminary (Hoch et al., 2024; Solmi et al., 2023). In addition, cannabis is not a homogeneous product; it contains multiple cannabinoids and other compounds, with potentially different effect profiles (Casajuana Kogel et al., 2018). Therefore, it is proposed to differentiate between: (a) "cannabis medicines" or "cannabinoid-based medicines," for standardized products evaluated for specific indications (Sordo & Gual, 2022); and (b) "prescribed cannabinoids," when there is an indication, dosage, follow-up, and pharmacovigilance, avoiding equating prescription with unregulated use (Bueno et al., 2024). This proposal is consistent with epidemiological surveillance, as conducted in drug surveys, in which prescribed and non-prescribed use of hypnotic-sedatives is distinguished, thereby facilitating risk interpretation and intervention planning (OEDA, 2025).

### A call for scientific, political, and social consensus

An effective change in the social perception of cannabis—and, by extension, in the way it is used and its different uses are regulated—depends on a collaborative and sustained approach involving public health, the education system, the media, researchers, addiction professionals, and policymakers. Scientific evidence should guide the direction of the debate, but the way that evidence is translated into the public sphere is equally decisive. When language is oversimplified, introduces connotations of safety, or shifts attention toward subjective intent, cognitive biases are reinforced and health literacy is weakened (Sanchez et al., 2023), health literacy being people's ability to access, understand, evaluate, and communicate information about their health (Higgins et al., 2009).

This consensus must explicitly include the media. Their role is not limited to merely 'informing,' as their actions also help shape the public's interpretive frameworks regarding social issues. Their involvement is therefore essential to prevent language from functioning as a shortcut that downplays risks ("recreational") (Campeny et al., 2020; Hoch et al., 2024), magnifies limited evidence ("medical") (Solmi et al., 2023), or facilitates the instrumental use of narratives by industry and political agendas not aligned with public health (Isorna & Villanueva-Blasco, 2022; Kickbusch et al., 2016; López-Pelayo et al., 2018).

Accordingly, if the goal is to improve health literacy and reduce the inappropriate use of cannabis-related terminology, four simple recommendations are proposed:

1. Replace "recreational" with "non-medical use" and describe, where appropriate, a "high-risk pattern of use."
2. Reserve "cannabis medicines" or "prescribed cannabinoids" for standardized products used under supervision and refer to other uses as "unregulated therapeutic use."
3. Incorporate risk-determining variables whenever possible, such as quantity of psychoactive substance, frequency, THC potency, and route of administration, while acknowledging that dose standardization remains an unresolved challenge (Casajuana et al., 2016; Freeman & Lorenzetti, 2020; López-Pelayo et al., 2021).
4. Maintain an approach sensitive to the regulatory context. Many measures (advertising, labeling, access) are specific to regulated markets. However, in settings without a legal market, as is the case in Spain (Observatorio Español de las Drogas y las Adicciones (OEDA); Delegación del Gobierno para el Plan Nacional sobre Drogas (DGPNSD, 2026), the priority is evidence-based prevention, harm reduction, and epidemiological surveillance.

In this way, terminological consensus is not a minor semantic debate: it is a public health tool. Precise language reduces misinformation, improves the detection of high-risk cannabis use, and enables the development of clearer and more effective preventive messages.

## Conflicts of interest

M.B.O. has received travel grants from Lundbeck and Camurus, and honoraria related to continuing medical education (CME) from Novo Nordisk, all outside the scope of this article. C.O. has received travel grants from Lundbeck, outside the scope of this text.

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