Perspectives of Prenatal Cannabis Use in Young Pregnant Individuals

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Alison E. Sanfacon*[1], Shinnyi Chou*[2], Samantha Saloom[3], Dahlia Lehman[4], Judy C. Chang[5], & Natacha M. De Genna[2]

[1]University of Pittsburgh Medical Center
[2]Department of Psychiatry, University of Pittsburgh School of Medicine
[3]Department of Psychiatry and Behavioral Health, The Ohio State University College of Medicine
[4]University of Pittsburgh School of Medicine
[5]Department of Obstetrics, Gynecology, & Reproductive Science, University of Pittsburgh School of Medicine
*Contributed equally

ABSTRACT

Objective: Adolescent pregnancy is associated with socioeconomic disadvantages and higher risks of adverse obstetric, fetal, and developmental outcomes. Pregnant adolescents and young adults also use cannabis at a higher rate than older individuals, which may compound these risks. In considering clinical interventions aimed at reducing prenatal cannabis exposure, it is critical to understand the perspectives of young pregnant individuals, including why some individuals in this age group abstain and why others use cannabis but stop for pregnancy. This qualitative study aimed to identify beliefs, attitudes, and perceptions of cannabis use in young pregnant patients. **Method:** We conducted qualitative semi-structured interviews of young pregnant individuals with and without prenatal cannabis use as part of the YoungMoms study. Interviews were transcribed, coded, and reviewed for patterns and themes. **Results:** Thirty-eight participants completed the interviews including 12 that continued to use cannabis during pregnancy, 15 that stopped upon pregnancy recognition, and 11 that had never used cannabis. The average age of the participants was 19 years (range: 17–21) and 68% identified as Black/African American. Participants voiced the following themes: 1) using prenatal cannabis to relieve physical symptoms and stress; 2) believing prenatal cannabis to be less harmful than other substances such as prescribed medications, while also voicing concern about potential risks; 3) relying on both non-professional and professional resources to shape their perspectives; and 4) recognizing and asserting autonomy regarding the rationales, decisions, and strategies to continue and/or reduce cannabis use during pregnancy. **Conclusions:** Young pregnant patients described mixed beliefs about the safety of prenatal cannabis use and felt that cannabis could be helpful to treat symptoms of nausea and stress. Participants highlighted a desire to make their own decisions and sought information from trusted sources. These findings suggest young pregnant patients may be receptive to patient-centered approaches when discussing prenatal cannabis use.

Key words: = cannabis; pregnancy; prenatal; young adult; adolescent

Corresponding Author: Natacha De Genna, PhD, University of Pittsburgh School of Medicine, 3811 O'Hara St. Pittsburgh, Pennsylvania, 15213. Email: degennan@pitt.edu

Younger pregnant people are more likely to use cannabis than older individuals (Alshaarawy & Vanderziel, 2022; Chapman et al., 2013; Volkow et al., 2017). In the 2002–2015 National Survey on Drug Use and Health (NSDUH), 14% of pregnant 12–17-year-olds reported cannabis use, compared to 6% of 18–25-year-olds and less than 2% of those ages 26–40 (Volkow et al., 2017). Similar patterns have emerged in other studies including the 2009-2017 Kaiser Permanente cohort (Young-Wolff et al., 2019), a 2012–2017 birth registry for Ontario (Corsi et al., 2019), and 2016–2018 data from the Pregnancy Risk Assessment Monitoring System (PRAMS; Sood et al., 2022). Co-use of tobacco cigarettes with cannabis is more common among younger pregnant individuals (Qato et al., 2020) and younger parents are more likely to continue using cannabis a decade or more after pregnancy (De Genna et al., 2009; Gillmore et al., 2006). However, there is considerable variation in cannabis use in this population, with many younger parents abstaining from cannabis before, during and after pregnancy (De Genna et al., 2015; Gillmore et al., 2006). Therefore, it is important to investigate different beliefs and behaviors related to prenatal cannabis use in pregnant adolescents and young adults.

Studies of prenatal cannabis use have mainly focused on adult pregnancies and noted associations with adverse child outcomes including preterm birth, low birth weight, neonatal intensive care unit (NICU) admission, attention deficit in toddlerhood, externalizing behaviors, and lower academic achievement (Corsi et al., 2025; De Genna et al., 2022; Gunn et al, 2015; Lo et al., 2025; Marchand et al., 2022). Socioeconomic hardship, which is more common among younger parents (Assini-Meytin & Green, 2015) and those who use cannabis during pregnancy (Alshaarawy & Vanderziel, 2022; Wolkow et al., 2017), may partially attenuate the associations between prenatal cannabis exposure and adverse child outcomes (Corsi et al., 2025). In qualitative studies, individuals have reported using cannabis to assist with pregnancy nausea and to improve their mood and stated beliefs that cannabis is safer compared to other recreational substances or medications, yet many have also voiced concerns about potential risks (Barbosa-Leiker et al., 2020; Chang et al., 2019; Denson et al., 2025; Foti et al., 2023). However, almost all these studies have been conducted in older individuals, who are less likely to use cannabis during pregnancy and whose beliefs and reasons may differ from younger patients. For example, Denson and colleagues (2025) conducted focus groups with adults (mean age 29.8) who were not pregnant but used cannabis at least once a week, in the state of Illinois, where recreational cannabis has been legal since 2020.

Although prenatal cannabis use and co-use of cannabis with tobacco is more common among adolescents and young adults (Alshaarawy & Vanderziel, 2022; Chapman et al., 2013; Volkow et al., 2017), little is known about their beliefs, practices, and reasons for abstaining or using cannabis during pregnancy. The only qualitative study focusing on younger people surveyed 14–24 years olds in the US about their prenatal cannabis beliefs via text message, finding that most considered it harmful and that it should be a topic of conversation with obstetric providers (Whitlock et al., 2024). However, these youth were not recruited during pregnancy, and it is not clear how many, if any, were pregnant when they responded to the survey, nor how many participants had ever used cannabis. Thus, there is a gap in the literature on beliefs about cannabis use during pregnancy and experiences of prenatal cannabis use, quitting and abstaining among younger pregnant individuals.

The aim of the current qualitative study is to explore young pregnant individuals' perceptions of and experiences with prenatal cannabis use. We included individuals who used cannabis during pregnancy, those who used before but quit for pregnancy, and those who had never used cannabis, to better understand why younger patients engage or do not engage in cannabis use. Such information may increase insight into whether this vulnerable population may have unique beliefs about cannabis use and behavior patterns that can help guide tailored interventions in this age group.

METHODS

Study Design

This qualitative study was part of a longitudinal, mixed-methods cohort study of prenatal tobacco and cannabis use in pregnant individuals aged 13–21. Through qualitative

interviews, the research team sought to learn about participants' experiences, thoughts, and beliefs about cannabis and tobacco and the use of them during pregnancy, how interactions with obstetric care providers impact substance use decisions, and how providers can make it easier for young, pregnant patients to talk to them about cannabis and tobacco use during pregnancy.

The study was approved by the University of Pittsburgh IRB. Participants aged 13–21 with confirmed pregnancies were recruited from UPMC Magee-Womens Hospital obstetric clinics, affiliated neighborhood OB-GYN offices, and the in-patient antepartum unit. Exclusion criteria included individuals not proficient in English and those currently using opioids or undergoing treatment for opioid use disorder. Once consented, all participants completed a baseline survey online, which collected details on demographics, substance use, and mental health.

Participants were eligible to participate in qualitative interviews if they had completed a baseline survey for the cohort study. Initially, no prenatal tobacco or cannabis use was required to enroll in the qualitative study. Near the end of the study, we only recruited participants who had reported prenatal tobacco use in their baseline survey or tested positive for cotinine on a urine screen, to ensure that we had adequate representation of patients with a history of prenatal tobacco use for the parent study. Qualitative study participants had the opportunity to complete up to 4 qualitative interviews: one in each trimester and one 6–18 months postpartum. Eligible participants were contacted by a member of the research team via phone, text, or email. A separate IRB-approved consent was used for the qualitative interviews and reviewed with participants before interviews were conducted.

One-on-one, semi-structured interviews were conducted between December 2020 and May 2024 and recorded through a HIPAA-compliant version of Zoom, or by telephone with a digital recorder. Audio-recorded interviews lasted approximately 45–60 minutes and were labeled with a participant ID number. Interviewers received intensive training in qualitative interviewing, including several practice interviews from an obstetrician-gynecologist with extensive expertise in conducting and teaching qualitative research. Interviewers included a medical student, research project specialists, and a research coordinator. Interview guides were modeled after a prior qualitative study of the beliefs and attitudes of adult pregnant women who used cannabis (Chang et al, 2019). The trimester-specific guides included questions relevant to that time period of pregnancy, cessation strategies and experiences, information sources, interactions with obstetric care providers, and recommendations from participants for future substance-use research and intervention (Table 1). Interviewees were paid $20 following completion of each interview. Given that prenatal cannabis beliefs, experiences, attitudes, and suggestions were asked and discussed in all prenatal interviews, and that we did not notice appreciable differences across trimesters in our analysis, we combined data addressing prenatal cannabis from all prenatal interviews. Postpartum interview data was not included in this analysis as these interviews focused primarily on postpartum experiences and differed from the prenatal interviews.

Table 1. *Interview Guide Topics*

Topic	Sample Questions
Pregnancy experience	• How is your pregnancy going so far? • How are you feeling? • Is your pregnancy going as you expected?
Substance use	• Has your pattern of use changed since you found out you were pregnant (or since your last interview)? • How old were you when you first tried cannabis/tobacco? Tell me about that experience. • Tell me about why you are currently using cannabis/tobacco. • Do you think your tobacco use is related to your cannabis use? If so, how are they related? If no, what separates them? • Are you trying to change your cannabis or tobacco use currently? If so, how, and what has that process been like?

	• Have you found other coping mechanisms besides cannabis/tobacco? • Since we last spoke, have there been any incidents or events that led you to use?
Beliefs and attitudes	• What do you think about the use of cannabis/tobacco during pregnancy? • Do you think one is safer than the other? • What are the good/bad things related to cannabis and tobacco use during pregnancy? • What are the effects of using cannabis/tobacco during pregnancy? • Where do young, pregnant people get information about cannabis and tobacco? • What do you think would help young, pregnant people get more information on these topics? • After your baby is born, what are your plans for cannabis and tobacco use?
Legal/CYF involvement, perceptions	• What have your health care providers or social workers told you about what will happen if your baby tests positive for cannabis at birth? • What impact do legal issues or CYF involvement have on your decision to use cannabis close to the time you are going to deliver? • How has the legalization of medical cannabis impacted your views on cannabis use?
Obstetric care experience	• Did your doctor or another provider talk to you about cannabis and/or tobacco use during your appointment? • How do you feel about that interaction? • What has influenced your decision to talk or not talk to your doctor about cannabis or tobacco use? • What can healthcare providers do to help young, pregnant people feel more comfortable talking to them about cannabis and tobacco use? • At your appointment, were you provided with information about the use of cannabis or tobacco during pregnancy?

Reflexivity

The authors recognize that aspects of their identities, personal experiences, relationships with each other, and interactions with participants can influence perceptions and choices throughout the design, data collection, and analysis processes. The team consisted of all cisgender females with existing interest in women's mental health. We received dedicated training on the conduct of qualitative interviews with a well-known expert in the field and completed mock interview sessions prior to interviewing participants. There were no previously established relationships between the participants and team members other than through participation in the prior quantitative study sessions of the larger parent study.

Data Analysis

Verbatim transcription of 13 interviews was initially completed by study personnel, using the Zoom or Word transcription feature and then manually editing the text to match the audio recordings. Landmark Associates, Inc., was contracted to complete transcriptions of the 30 remaining interviews, and all transcripts were reviewed by interviewers for accuracy. We used a qualitative description approach to perform thematic analysis as we sought to adhere closely to the words and narratives of our participants without any predetermined framework or theory (Vasimoradi et al., 2013; Vasimoradi et al., 2016; Sandelowski, 2000).

For participants who completed more than one prenatal interview, responses from all of their interviews were considered in the aggregated dataset. Interviews were designed to discuss changes in participant substance use and other life experiences since the previous interview, so topics relevant to this paper often repeated from one interview to the next. For example, a participant may have described their process for cutting down or quitting over the course of two trimesters or discussed their interactions with providers in more than one interview as prenatal care progressed.

To create the qualitative codebook, two researchers independently applied an open,

iterative coding process to transcripts using NVivo software (version 14) to store and organize the coding. They regularly met to review coding decisions using a constant-comparison method (Crabtree & Miller, 1999). Once transcripts stopped producing novel codes (i.e., an indication that saturation had been reached), the finalized codebook underwent team review before being applied to all transcripts.

Subsequent coding continued using this same process—two researchers coded transcripts independently and then met to review and compare decisions, ensuring consensus. All coded interviews were reviewed at regular full-investigative-team meetings, where the coding process and definitions were reviewed and emerging themes considered. After all transcripts were coded, coders reviewed high frequency codes, discussed patterns and categories, and together with the full investigative team, identified themes and subthemes.

RESULTS

Subject Characteristics

Fifty-six participants consented to the qualitative portion of the study, and 38 completed at least one prenatal interview (n = 13, 1st trimester, n = 18, 2nd trimester, n = 12, 3rd trimester). Five participants completed two interviews in different trimesters. As seen in Table 2, participants ranged in age from 17 to 21 years, with the largest percentage (27%) being 20 years old. Most identified as Black or African American (68%) and lived with their parents at the time they completed their baseline surveys (50%). Eight participants were students. Fourteen worked either part or full time. Most participants were expecting their first child (65%).

Table 2. *Characteristics of Study Participants*

Characteristic	*N* (%)
Age	
17	3 (8%)
18	8 (21%)
19	4 (11%)
20	10 (26%)
21	13 (34%)
Race	
Black	26 (68%)
White	9 (24%)
Biracial	3 (8%)
Self-Reported Cannabis Use in Baseline Survey	
Never used	11 (29%)
Stopped when learned of pregnancy	15 (39%)
Once a month	2 (5%)
Once a week	3 (8%)
2–3 days a week	3 (8%)
4 or more days a week	1 (3%)
Daily	3 (8%)
Self-Reported Tobacco Use in Baseline Survey	
Never used	21 (55%)
Stopped when learned of pregnancy	7 (18%)
One a month	1 (3%)
Once a week	0 (0%)
2–3 days a week	1 (3%)
4 or more days a week	3 (8%)
Daily	5 (13%)
Reproductive history	
First child	24 (63%)
Education and employment	
Enrolled in school	8 (21%)

Employed full time	7 (18%)
Employed part time	7 (18%)
Unemployed	24 (63%)
Living arrangement	
Living with parents	19 (50%)
Living alone (with children)	2 (5%)
Living with father of baby	12 (32%)
Living with another relative	3 (8%)
Other living arrangement	2 (5%)

In their baseline surveys, participants reported their frequency of cannabis and tobacco use, with responses ranging from never to every day. Although many participants stopped their cannabis use when they found out they were pregnant (39%), 26% reported ongoing cannabis use at a frequency of at least once a week (Table 2). Monthly use of cannabis at baseline was reported by 5% of participants. Twenty-seven percent reported prenatal tobacco use. There were no significant differences in baseline characteristics (age, race, employment, school enrollment, gravidity, or prenatal cannabis use status) between individuals who participated in a qualitative interview versus those who were not enrolled in this portion of the study.

Themes

We identified four major themes related to prenatal cannabis use in our analysis from the participants: 1) they described a key reason for using prenatal cannabis is to relieve physical symptoms and stress; 2) they described believing prenatal cannabis to be less harmful than other substances such as prescribed medications while at the same time voicing concern about potential developmental risks; 3) they relied on both non-professional and professional resources to shape their perspectives; and 4) they recognized and asserted autonomy regarding the rationales, decisions, and strategies to continue and/or reduce cannabis use.

Reasons for Prenatal Cannabis Use

Participants described the belief that cannabis is used to alleviate negative physical symptoms related to pregnancy. Participants who continued to use cannabis during their pregnancies stated that getting high or recreation was not a motivating factor; they argued that continued cannabis use during pregnancy was solely to manage physical or psychological reasons:

If I smoke [cannabis] enough to where I'm not nauseous… that's my limit… I just want to be able to eat… Before I got pregnant, I would smoke [cannabis] enough to where I would feel it. Now that I'm pregnant, I don't want to feel high. Like I said before, I just want to be able to make it through the day without puking. (Age 19, cannabis use during pregnancy)

For nausea of pregnancy, participants described feeling that cannabis use is an effective treatment and this then justifies its use. As one participant who used prenatal cannabis explained, "If I was fine during my pregnancy I'm pretty sure that I would have stopped" (Age 21, cannabis use during pregnancy). Some individuals shared that nausea made it difficult to eat, or sometimes they simply had no appetite. They emphasized their concern about lack of nutrition for the developing baby and importance of finding effective treatments to allow normal eating. As another individual who used cannabis reported, "When I smoke [cannabis] it just brings my appetite back like I need" (Age 21, cannabis use during pregnancy). They mentioned how obstetric clinicians often recommended or prescribed medication for nausea and voiced their perception that these medications were either not as effective to manage pregnancy nausea as cannabis or were more harmful than cannabis. One person who used cannabis to reduce nausea explained their experience with Zofran: "It doesn't really help very much. It will take the very edge off for five minutes, and then I'll start puking again" (Age 19, cannabis use during pregnancy). Those who did not use cannabis also endorsed their beliefs that pregnant patients who used cannabis were likely doing so to address a medical symptom.

Participants also voiced a belief that prenatal cannabis is used to treat mental health. Those who used cannabis described the stress relief or

sense of calm they felt after its use. One individual explained:

I feel like it made me much more calmer. It made me feel like everything doesn't have to be—I don't have to be so anxious about everything. I don't have to be so nervous about stuff, or overthink things. (Age 21, cannabis use during pregnancy)

Interestingly, for participants who did not use cannabis even prior to pregnancy, their reasons for not using were also related to physical and emotional symptoms – in their cases causing negative impacts. One participant explained:

It didn't help me at all. It just made me more hungry, more stressful, and more tired and I wasn't, I wasn't with it, so I stopped it. And with this one, I actually haven't smoked [cannabis] since. It's almost been four years. (Age 21, quit cannabis prior to pregnancy)

Other reasons shared by participants for never using or quitting cannabis prior to pregnancy included considering it a waste of money and safety concerns about its health effects.

Conflicting Beliefs Regarding Safety and Risks of Prenatal Cannabis Use

When asked about perceived risks of prenatal cannabis, participants listed a variety of potential risks including premature birth, low birth weight, and issues with lung and brain development. Many individuals were unclear on specific risks but described feeling that reducing frequency of use was generally a safer and important thing to do for a healthy pregnancy. One participant shared, "I want [my baby] to be healthy, so I wouldn't want any possible bad effects to happen to my baby" (Age 21, quit cannabis at pregnancy recognition).

Their perceptions about risk, however, became a bit more nuanced when explored in the context of other concerns such as nausea of pregnancy, lack of appetite, and mental health issues. Here, participants began to weigh their perceived risks of prenatal cannabis use with perceived risks of these conditions and often prioritized treatment of those conditions over avoidance of cannabis. In cases where cannabis was used for nausea and appetite, some participants believed the benefits of ensuring adequate nutrition for their developing babies outweighed the potential harm cannabis could cause infant development. Likewise, mental health was also often prioritized over potential risks of cannabis exposure. As one individual stated:

I don't know if it gives the baby comfort knowing that I'm relaxed enough for them to move around as much as they do, because I'll feel them moving during the day before I've smoked [cannabis], but it's not as much as I do after I'm relaxed and I'm calm and I'm not nauseous, I'm not puking. My stomach isn't all tight anymore or anything. That's when I feel the baby move the most. (Age 19, cannabis use during pregnancy)

Prescription medications were also considered in participants' benefit-risk analyses of prenatal cannabis use. Some preferred not to take medications due to concerns about safety, as one person expressed:

I can't take antidepressants to help with my… depression and my anxiety that goes on. I can't 'cause the baby could come out premature or… underweight so, you know, I don't want those things for my child. (Age 18, cannabis use during pregnancy)

Some also felt the prescription medication side effects they experienced to be worse than the symptoms compared to the relief they received from cannabis use. In addition, cannabis was often perceived as a natural, "chemical-free" alternative to prescription drugs: "I don't look at marijuana as a substance, as a drug. It's a leaf. It's an herb, so it's not bad" (Age 18, cannabis use during pregnancy).

In contrast, when comparing perceived risks of prenatal tobacco to cannabis, most participants believed tobacco to be more harmful:

I don't think people should smoke cigarettes while they are pregnant just because tobacco is more harsher and stronger than marijuana. And it's- it's- it's already bad for you, regardless, bad for your lungs, bad for your body period. So, while being pregnant, if it's bad for your lungs then it's bad for the baby's lungs. Like something like that. Marijuana, unless it's laced, there's nothing wrong with it. (Age 18, cannabis use during pregnancy)

This belief was shared among participants regardless of their cannabis use history:

My whole family has been smoking cigarettes and two of them actually have lung cancer because of the cigarettes. So it's like if I had to pick one or the other to be worse, definitely tobacco.

Because I still have yet to find out what's bad with marijuana. (Age 21, never used cannabis)

Reliance On Both Non-Professional and Professional Resources

Participants synthesized information regarding prenatal cannabis use from multiple sources. Most participants mentioned that they considered their healthcare providers generally helpful and knowledgeable. However, they described interactions that were brief, centered around the health of the developing baby, and lacked considerations important to the pregnant individual. Participants with prenatal tobacco use described similar interactions with health care providers. Commonly, participants described being asked if they used cannabis, followed by providers citing general risks to the pregnancy from cannabis and encouraging cessation. Many participants noted that their preferences or concerns regarding their mental health needs and/or medication use during pregnancy were not discussed before providers made these recommendations, which some participants perceived as unhelpful:

If they're going to sit there and give me that look and then ask me the question and then don't listen to the question and change the subject—what's the point of me wasting my breath to sit there and say so? (Age 21, quit cannabis at pregnancy recognition)

Conversations they had with providers were thus often perceived as not the most impactful on their decisions regarding cannabis use.

Participants described listening to health professional advice but then seeking additional information from their social circles and their own internet research to reach independent decisions regarding their beliefs, perceptions, and behaviors about prenatal cannabis use. Many participants shared stories about people they knew who smoked cannabis throughout their pregnancies and had babies born to term and without complications. These were sometimes close friends or relatives and other times acquaintances or strangers, like members of a social media parenting group. These experiences were weighed against the health provider's warnings as participants determined credibility. For example, a participant described their own mother's prenatal cannabis use as supporting evidence of its safety:

My mother, she said that she used to smoke [cannabis] before when she was pregnant with me and my siblings and I'm perfectly fine, healthy and, you know, we are living proof and example. (Age 21, never used cannabis)

Some participants also shared details of their own previous pregnancies that resulted in healthy babies despite smoking cannabis.

When participants' questions could be answered by familiar individuals' specific and personal experiences—whether in their own social circles or through social media—they tended to trust and value that information more than stand-alone facts stated by a provider. As one individual explained:

I feel like if it's genuine, and I know like this person has a baby, and I've seen them—I've seen their baby, and I've seen them like talking about it, and other people in the comments can agree or disagree, then I know it's real and I know like, 'Okay, this really happened.' (Age 18, cannabis use during pregnancy)

These known and lived experiences greatly shaped participants' decisions and weighed heavily in their benefit-risk analyses.

Like those who continued cannabis use, individuals who did not use cannabis during pregnancy learned about cannabis through an array of sources and then assessed the information's trustworthiness based on their own values. They referenced learning about drugs in school, personal anecdotes or opinions from their social circles, seeing information on social media, and speaking to their doctors. These participants, however, did not describe engaging in the same level of information-seeking as those who continued to use or were attempting to cut down. They received fewer mixed messages from trusted people around them, who were more clearly opposed to prenatal cannabis use, and they trusted the information they received from their providers:

Even if there is other forms of gettin' additional information, I personally don't wanna use them due to I would rather just speak to my provider 'cause they will know more than—they know more about the pregnancy than anything else. (Age 21, quit cannabis at pregnancy recognition)

Sense of Autonomy

While participants understood the role of their healthcare providers in the health of their pregnancies and developing babies, participants expressed desires to be treated as individuals who exist both within and outside the context of carrying a pregnancy. One participant described her preferred interaction: "I don't want to say concerned but interested. So, asking questions like, 'How are you? How are YOU? How are you while being pregnant?'" (Age 18, cannabis use during pregnancy). When participants sensed that providers were sincerely invested in their overall wellbeing, they were more likely to consider the provider trustworthy, to disclose their use, and to engage in more in-depth discussions with the provider. As one individual explained:

I would say that it's not just about showing them that they care… it's just the fact is like if you're going to sit there and ask me my medical records if I do that stuff, don't have a smirk or say something ignorant just be like 'okay, I understand,' or like even when you asked me a question like, 'do you think that's a good choice?' and if I say to be honest, I think it is because it helped me with my bipolar and stuff then you should be thankful, because obviously that's helped me way more than what your pills were doing for me… It's helping me calm down and be more relaxed and stress free… you know you're going to be okay, at the end of the day. And that's just how I feel about that. (Age 21, quit cannabis at pregnancy recognition)

Participants consistently declared that they would make their own decisions regarding their healthcare during pregnancy, including decisions regarding cannabis use, and they wanted this autonomy to be acknowledged by their providers. As one participant pointed out, "At the end of the day, the baby's going home with the mother, not the provider" (Age 21, never used cannabis). They expressed wanting to be listened to in a nonjudgmental and open-minded way, and to be empowered to make decisions that were in the best interests of themselves and their developing babies, "I just feel like it should be more be like 'Let's help the mother. Let's see what the mother's going through because she made it known that she's not doing it to harm her child" (Age 18, cannabis use during pregnancy).

This sense of autonomy appeared to be rooted in participants' expression of confidence that they knew their bodies and their needs. Participants followed self-prescribed rules of prenatal cannabis use. This often took the form of setting their own goals in harm reduction and designing their own cessation strategies, such as taking only a hit or two, just enough to relieve symptoms. One participant described their harm reduction method:

I'll try to go throughout the daytime without smoking [cannabis]. Sometimes, I don't have the appetite to eat nothing all day. I'll just like, 'Oh, well, I'll just, maybe, smoke just a little bit, just to get me to eat,' or something. Usually, I'll try to go days without smoking [cannabis]. It usually works. (Age 21, cannabis use during pregnancy)

Later in pregnancy, when morning sickness symptoms subsided, this confidence continued to appear in participants' decisions to leave or avoid environments that may have jeopardized their success in reducing or quitting cannabis use and choosing to take part in alternative activities instead. For one participant, avoiding stressful, triggering situations was key:

I feel like my best thing is, right now, I just ignore people. When they wanna argue and yell, I just block it and just—either I take myself out of the situation and just leave it at that, or I would just talk to somebody in my family about it, like just let it all out and just talk." (Age 19, cannabis use during pregnancy)

Participants also demonstrated autonomy through seeking information to inform their choices. Although most participants expressed comfort in asking their healthcare providers about medications and substance safety, and would generally trust the information they would receive, they did not initiate these conversations. Instead, participants described completing their own research with minimal guidance from their providers. They noted that this independent process resulted in their successful decision-making regarding cannabis use and suggested that the experiences reinforced their sense of capability of making critical healthcare and personal decisions. As one participant concluded, "I finally realized it's time to stop listening to everybody else and doing what everybody else wants me to do and believe in my own self" (Age 21, quit cannabis at pregnancy recognition).

Notably, for individuals who did not use cannabis during pregnancy this sense of autonomy was aligned with those of other participants. Although they believed it is safer not to smoke cannabis and that pregnant people risk their health and the health of the fetuses by continuing cannabis use during pregnancy, the participants who did not use cannabis during pregnancy considered prenatal cannabis use to be a personal choice. Many participants acknowledged that some people find cannabis helpful in relieving negative physical and emotional symptoms during and outside of pregnancy. Few of the participants who did not use cannabis were strongly against cannabis use in general.

DISCUSSION

The present study examined the perceptions and experiences of young pregnant individuals with and without prenatal cannabis use, most of them identifying as Black or African American. It is important to amplify the voices of young Black obstetric patients because they may be more likely to use cannabis while pregnant (Alshaarawy & Vanderziel, 2022; Volkow et al., 2017; Young-Wolff et al., 2019) and to be screened by obstetric providers for prenatal cannabis use (Olaniyan et al., 2023; Schoeneich et al., 2023). Importantly, this study included the perspectives of young pregnant people who had never used cannabis, those who stopped using cannabis at pregnancy detection or later in pregnancy, and those who continued using cannabis throughout. Other studies have only considered the beliefs of the two latter groups and thus lack information about how those who never used, or those who reduced or stopped their cannabis use at pregnancy recognition or during early pregnancy, arrived at their decisions. Four themes emerged from the individual anecdotes shared by the participants in this study: cannabis serves as a coping tool for physical and mental health symptoms; young women have conflicting beliefs regarding the safety and risks of prenatal cannabis use; individuals gather information to shape their decisions from multiple professional and non-professional sources; and upholding individual autonomy is central to shaping the rationales and behaviors regarding prenatal cannabis use.

Pregnancy associated symptoms were most often cited as the reason for prenatal cannabis use, despite many pregnant individuals having used cannabis prior to pregnancy, with some individuals using cannabis prior to pregnancy to treat mental health symptoms, similar to the literature with older participants (Barbosa-Leiker et al., 2020; Chang et al., 2019; Denson et al., 2025; Gunn et al., 2024; Skelton et al., 2026; Vanstone et al., 2021). For example, despite methodological differences (older sample who was not pregnant, all endorsed cannabis use, recreational marijuana state), Denson et al. (2025) reported that participants in their focus groups perceived that cannabis was effective for the relief of pregnancy-related symptoms and also helped them cope with mental health problems. Vanstone and colleagues (2021) described changes in reasons for cannabis use among pregnant and lactating individuals in Canada, who endorsed multiple reasons for use before pregnancy, including sensation seeking, symptom-management, and coping. During pregnancy, however, they used cannabis primarily for symptom-management, returning to other reasons for use in the postpartum period, during lactation.

Importantly, pregnancy was also most often cited as the motivation to reduce and discontinue cannabis use. This is notable as the implication is that many of these individuals who refrained or reduced cannabis use did not intend for their behavior pattern to be one of long-term abstinence, which has been found in previous studies (Mark et al., 2017) and is not seen with tobacco use. Indeed, in quantitative data from the parent study we observed that many individuals restarted cannabis use after delivery—half of the individuals seen in the postpartum period for an infant assessment in our offices tested positive for cannabis use (De Genna et al., 2024). This is consistent with prior data demonstrating that people who become parents at a younger age are more likely to continue using cannabis in the postpartum period compared to older parents (De Genna, et al., 2009; De Genna et al., 2015).

The self-contradiction between pregnancy as both the motivation to use and *not* use is reconciled by the beliefs that the benefit and safety of prenatal cannabis use outweigh the risks of poor nutrition, psychological stress, and prescription medication use during pregnancy for

pregnant people who decided to continue using cannabis during pregnancy, also stated in studies with older participants (Barbosa-Leiker et al., 2020; Chang et al., 2019; Denson et al., 2025; Gunn et al., 2024). Most participants agreed that prenatal tobacco use was more harmful than prenatal cannabis use. Few individuals in this study discussed the risks of prenatal cannabis exposure on offspring outcomes past infancy such as toddlerhood executive function impairments or externalizing behavior problems during childhood and adolescence (De Genna et al., 2022). Prior work indicates that obstetric providers are not providing this information to patients (Chang et al., 2019; Holland et al., 2016) although some patients who use cannabis may be interested in learning about these long-term effects (Denson et al., 2025).

In contrast to the varying levels of concern about the risk of addiction described in some studies focused on adult pregnant individuals (Chang et al., 2019), none of the young pregnant participants in the current study expressed concerns about cannabis as a potentially addictive substance. Rather they focused on the ease with which they were able to reduce or stop use based on their self-imposed rules and strategies, and many reported successful reduction and cessation during pregnancy that was corroborated by the quantitative data from the larger study. It is possible that, as younger individuals who may be using to treat symptoms as needed rather than on a daily basis, cessation was easier for them compared to individuals who used cannabis more frequently (Robinson et al., 2022).

Another notable difference between themes identified from the current participants compared to older pregnant individuals in other studies is the minimal discussion surrounding fear of legal ramifications (Chang et al., 2019, English & Greyson, 2022; Mark et al., 2017). Recreational cannabis use is illegal in this state, and few participants endorsed medical cannabis use purchases from a dispensary. Of note, the hospital system does not have universal drug screening but mandates reporting of any patients testing positive for cannabis at delivery. Prior work demonstrates higher rates of testing among Black patients who disclose cannabis use to providers in this hospital (Olaniyan et al., 2023). Black patients are also more likely to experience obstetric racism (Davis, 2019) which shapes interactions with the health care system including assumptions about substance use (Hill et al., 2023). Nonetheless, few participants discussed concerns about mandated reporting of their prenatal cannabis use as a main consideration for their cannabis use behavior. It is uncertain whether this is indicative of the changing landscape in how providers communicate these concerns or shifting social attitudes toward the risks of prenatal cannabis use (Brown et al., 2017; Jarlenski & Spencer, 2022).

In comparing what young pregnant individuals shared as their experiences discussing cannabis use with their obstetrics healthcare providers, similar to the adult literature (Cernat et al., 2024; McCoy et al., 2023; Olaniyan et al., 2025), they desired open, nonjudgmental communication. They often noted believing their providers were good sources of information, but also found interactions surrounding the topic of cannabis use to be brief, superficial, and unhelpful. These limited interactions around cannabis use with obstetrics providers have been reported in other qualitative and mixed-method studies (Barbosa-Leiker et al., 2020; Holland et al., 2016; Jarlenski et al., 2016; McCoy et al., 2023), and is indicative of a missed opportunity for bidirectional dialogue that may lead to meaningful support for not only cannabis use, but also for mental health and other concerns that the young pregnant individual may be facing. Of note, participants with tobacco use described their interactions with providers around prenatal tobacco use similarly. Patients who use substances during pregnancy need to feel as though clinicians care about them, not just the baby, and take the time to establish good rapport with attentive listening (Olaniyan et al., 2025).

Perhaps what is most notable in the anecdotes gathered from these young pregnant individuals is the absence of language suggestive of indecision, passivity or coercion from adult caretakers. These young people made definitive and intentional decisions regarding changes in their cannabis use pattern during pregnancy, voiced concrete rationale for their use patterns based upon an informed decision-making process, and adhered to their own rules for when and how to use cannabis during pregnancy. These findings suggest that clinical conversations with younger pregnant people should acknowledge their autonomy and decision-making skills, consistent

with a reproductive justice model that supports healthy pregnancy and bodily autonomy for birthing people of all ages (Ross & Solinger, 2017). Clinicians should also consider and address not just infant but also maternal health.

Several limitations should be considered for the current study. First, our participant demographic may not be generalizable to the overall population of young pregnant people in the US and in particular lacks representation from rural communities and those who identify as Latine. However, it was important to hear from young patients who identify as Black or African American, given higher rates of younger age at first birth (Brown et al., 2025) and prenatal cannabis use (Alshaarawy & Vanderziel, 2022; Volkow et al., 2017, Young-Wolff et al., 2019). There may also be social desirability bias in individuals who consented to participate in this qualitative arm from the larger parent study, especially considering that most participants reported use reduction or cessation to be easily achieved and preferred. Nonetheless, this is consistent with our quantitative data. Moreover, others have demonstrated that many people who use cannabis prior to pregnancy stop upon pregnancy recognition or by the second trimester of pregnancy (Chang et al., 2019; Ko et al., 2015; Volkow et al., 2017).

Overall, the present study increased our understanding of young pregnant individuals' perceptions and experiences surrounding prenatal cannabis use, many of whom identified as Black or African American and some of whom also used tobacco. We identified individuals with clear rationale, motivation, intention, and strategies for tailoring their behaviors during the prenatal period. Most participants described pregnancy and associated conditions as the reason to use and *not* use, and all individuals delineated these reasons based upon information they gathered from multiple sources, including family, friends, media, and healthcare professionals. Given the demonstrated intentionality of these young individuals, healthcare providers may empower them to seek out information from reliable sources, so that their informed decision-making process can be built upon a more robust knowledge base.

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