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The Battle Off the Battlefield: Exploring Medical Cannabis Use Among U.S. Veterans Looking for Relief

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THE BATTLE OFF THE BATTLEFIELD: EXPLORING MEDICAL CANNABIS
USE AMONG U.S. VETERANS LOOKING FOR RELIEF

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Master’s Program in Sociology

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Viridiana Edwards

2019
Dedication

I would like to dedicate this thesis to several significant individuals in my life. First and foremost, I dedicate this thesis to my husband Jairemy Q. Edwards, and to our daughter Sariah L. Edwards. Jairemy thank you for your constant love, support, and encouragement, especially throughout this entire process. Thank you for always inspiring and pushing me to be the best version of me. Sariah, thank you for your sheer ability to make my heart warm with love and joy even in the most stressful moments of this thesis just with your smile and presence. I would also like to especially thank my parents Rita T. Molina and Isidro Monreal. Without them, their love and their guidance I would not be the woman I am today. Thank you for always supporting and encouraging me. Additionally, I would like to dedicate this thesis to my sisters Teresa Briceño, and Kassandra Monreal thank you for always being supportive and encouraging me throughout my life. Lastly, I would like to dedicate this to all veterans that are currently fighting for the right to legally consume medical cannabis. No veteran should have to depend on an undependable black market in order to obtain medication that will help them find relief. Keep fighting!
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by

VIRIDIANA EDWARDS B.S. in Social Psychology

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Abstract

This study analyzed the reasons U.S. veterans use cannabis, focusing on what ways cannabis is socially acceptable, what ways it is viewed as deviant, and to what extent veterans are using cannabis for pain and/or mental relief. To answer these questions, an open and closed ended questionnaire was created and was available online. My results showed that U.S. veterans were using medical cannabis due to the negative side effects from the pharmaceutical medication that they were prescribed, physicians not listening to them during their appointments, and for social integration.
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Introduction

It is a dark night in September; the only thing illuminating the sky are flashes of light caused by explosions of rockets. I can feel my heart racing; the rain falls around me as I listen for enemy presence within our guard radius. Our Forward Operating Base (FOB) is under attack and the enemy is launching rockets to random coordinates within the FOB. With every launch my heart is racing wondering where it will land. Then I hear it, the whistle of the rocket as it flies above my head. As it lands, my heart races, time stands still, I take one last breath, and then all I see is a flash of white light and what seems like red dust.

I have reoccurring nightmares of this event and other similar events I witnessed. That was one of the first rocket attacks we had while I was deployed with the U.S. Army in Kandahar, Afghanistan and the first time I had seen a body turn to red dust. As my time overseas continued, the intensity of the events I witnessed only increased, and consequently, I now suffer from service-connected Post-Traumatic Stress Disorder (PTSD), similar to other U.S. Veterans. In addition to PTSD, I also suffer from paralysis, anxiety, and chronic pain. Each of these conditions require physicians that specialize in treating them, as well as medication. The pharmaceutical medications that I was prescribed by the providers, at my local Veterans Affairs Clinic, did little to improve my medical conditions. Fortunately, like many other veterans, I have found relief from medical cannabis.

Cannabis can be grown at home and can be administered in different forms. It can be baked or cooked with food, smoked, vaporized, and turned into a concentrate that also comes in various forms like wax and oil. Cannabis can be defined and used in many ways. According to the Textbook of Forensic Medicine and Toxicology (Vij, 2011), cannabis, also known as marijuana, is a psychoactive plant intended for medical or recreational use. Cannabis has other uses as well. In fact, the Neolithic people from Central Asia knew cannabis as a source of food and fiber (Duval,
2015). For individuals like myself, cannabis is a form of alternative medicine that can treat a variety of symptoms that vary from pain to depression and even cancer (Behere, Behere & Sathyanarayana, 2017).

Despite the positive attributes, cannabis use has a negative social stigma within some segments of society. This is partially due to the federal government considering the use and sale of cannabis illegal. In 2016, the former United States Attorney General, Jeff Sessions, stated at a senate Caucus for International Narcotics control that “this drug is dangerous, you cannot play with it, it is not funny, it is not something to laugh about and to send that message with clarity that good people don’t smoke marijuana” (Ingraham, 2016). These words expressed by the former attorney general are a testament to how the federal government places negative stigmas on cannabis users.
Research Questions

The purpose of this research is to increase our knowledge of the reasons for and perceptions of cannabis use among U.S. veterans. Based on an online survey of open- and closed-ended questions, I seek to explore the questions below. Specific research questions include:

RQ1: What are the reasons U.S. veterans use cannabis?
RQ2: In what ways is cannabis socially acceptable?
RQ3: In what ways is it viewed as deviant?
RQ4: Are veterans using cannabis for pain and/or mental relief?
   If so, how do veterans view cannabis in comparison to prescription medications?
RQ5: In what ways does the healthcare system shape cannabis use among veterans?

Thus far, most of the research related to veterans and cannabis is focused on using it to cope with PTSD (Bennett, Golub, Guarino, & Luther, 2015; Babson, Boden, Bonn-Miller, Short, & Vujanovic, 2013; Betthauser, Pilz, & Vollmer, 2015). I build on this literature by exploring in what ways medical cannabis is used informally to treat pain and other forms of mental conditions, how cannabis is viewed in relation to pharmaceutical medication prescribed by a doctor, and if veterans experience social stigmas associated with its use. Looking at the health uses of cannabis more specifically, with my research I would like to explore the medical reasons U.S. veterans are using cannabis. Are the reasons combat injury related? Or non-combat injury related? How are veterans acting on their choice to use cannabis instead of pharmaceutical medications? To what degree are they open about their use?
Statement of Personal History

The Department of Veterans Affairs treats veteran’s medical conditions and disabilities which were caused by service in the military. Service-connected is defined as an injury or illness that occurred or was aggravated by military service (Office of Public and Intergovernmental Affairs, 2010). Pharmaceutical medication is just one of the medical treatment options that is afforded to the veteran seeking treatment. Unfortunately, the medications are not always effective, and in some cases, can lead to addiction and/or health problems. A 2013 study showed that for the 11th year in a row, overdose deaths were rising in the U.S. (Jones, Mack, & Paulozzi, 2013). Ringland and colleagues (2008) found that some of the overdose cases among veterans can likely be attributed to life-threatening combinations of prescribed medications.

In my case, I have been prescribed pharmaceutical medications since the day of my injuries (October 2009). I fortunately did not become addicted to them. However, I developed health problems attributed to the pharmaceutical medications I was prescribed. My health problems began with the weight gain, a common side effect listed on most of the medications I was prescribed. Because of the added weight, I began to develop high blood pressure and was nearing high cholesterol levels. Having been relatively healthy all my life, the extra weight had an effect on my mental health because I was always worried about how my weight affected my appearance.

As previously mentioned, similar to many other U.S. veterans, I suffer from service-connected PTSD. According to the Department of Veterans Affairs, 11-20% of Veterans that served in Operation Iraqi Freedom (OIF) and/or Operation Enduring Freedom (OEF) have been diagnosed with PTSD compared to 12% for veterans that served in Desert Storm and 15% for veterans that served in the Vietnam War (National Center for PTSD, 2018). The pharmaceutical medications that I was prescribed by the providers at my local Veterans Affairs clinic did little to improve my conditions. At first, I was started on low dosages of pain killers, muscle relaxers,
nerve medication, and anxiety medication. As time went by, my medical conditions did not improve. As a result, the pharmaceutical medications would change, or the dosage would be raised. Due to the ineffectiveness and the negative side effects of the pharmaceutical medication, I turned to Cannabidiol (CBD) to treat my maladies after Texas legalized the use of CBD.

I was introduced to CBD by my husband who had extensive knowledge of it. Unfortunately, due to the legality of it in Texas, I had to delay the use of it because it was not legal to ship CBD to Texas from other states where it was legal. Now with CBD being legal, a part of me continues to feel deviant about using it due to the responses I received in the past. Initially when I began using CBD, I wanted to enlighten everyone I knew about this healing supplement. However, I was quickly judged and labeled as deviant by individuals outside of the cannabis community. I began to notice that my veteran status was overlooked by these individuals as soon as I mentioned that I used CBD.

One occasion that comes to mind took place during one of my undergraduate classes. An individual to whom I was recommending CBD expressed to me that my service to this country was dishonorable because honorable veterans do not use illegal substances. To this individual it did not matter that cannabis relieved my pain. Unfortunately, I have not completely discontinued use of all my prescribed medication from the Department of Veterans Affairs, because although CBD helps me significantly, my symptoms would find complete relief with THC. However, the state of Texas does not allow cannabis to have more than .05% of THC (Texas, SB339).

When I made the change to CBD, the change in my body was immediate. I did not experience the drowsiness that comes with certain medications that are used to treat chronic pain. On the contrary, I felt alert and energized. I especially felt the change in my mental health. Because of my medical conditions, I am in pain about 95% of my day. Feeling pain 24 hours a day 7 days a week began to take a heavy toll on my mind. I wanted all the pain and discomfort to stop. Every
day I found myself longing for the female I used to be, before my injuries. I was headed in the direction that many of my fellow veterans know too well, and that was very dangerous. It has been reported that since the War on Terrorism was launched, 20 veterans a day commit suicide (Mental Health, 2018). I truly believe cannabis saved my life.

Then one day while talking to another veteran, we both realized that we had both been using CBD instead of pharmaceutical medications. I turned to Facebook in search to find more veterans like myself. Indeed, I realized that there were a lot of veterans using cannabis instead of pharmaceutical medication, but they all had different reasons other than PTSD for using it. I continued to research cannabis and its healing properties. However, talking about my cannabis use outside of my home and the veteran community was not simple since there is still a great deal of negative stigma surrounding the use of cannabis, regardless if the form of cannabis I was using had zero THC.

My mother, for instance, was one whom did not understand at first. She was born and raised in Chihuahua, Mexico and arrived in the United States in 1983, after spending her entire life in Mexico. She did not have the greatest impression of cannabis, because she knew it as “marijuana”, and she frequently demonized it by saying it was a dangerous drug no different from meth or cocaine. When I made the change to cannabis, I mentioned it to my mom, except I did not refer to it as marijuana. I referred to it by its botanical name, cannabis. My mother could not believe how much cannabis had helped me and she was elated with the results. However, when my mother found out that cannabis was marijuana, she freaked out. With a simple name change, her entire opinion on cannabis transformed. She no longer saw cannabis as a healing plant; she saw marijuana, the gateway drug that in Mexico was often associated with criminals and the depraved (Campos, 2012).
Later, my mother understood that I had found relief, and that’s all that mattered to her. Perceptions about cannabis have evolved from either negative or positive, to now being contingent on the milieu of its use. Attentiveness to the context in which cannabis is being administered is preferable to stigmatizing into a “type of user” (Hathaway, 2004). In my case, my mother accepted my use of cannabis despite the way she felt about marijuana because she understood that I was using it medicinally to treat my maladies.

The rhetoric that we use when discussing cannabis is essential. I believe that when cannabis is referred to as “weed” it is associated with something unwanted, akin to weeds in a beautiful green lawn. Additionally, when cannabis is referred to as marijuana, the negative connotation of that word comes to mind. This is why it is imperative that we begin changing the negative stigma surrounding cannabis by simply beginning to refer to it by its botanical name, cannabis. As veterans, although we are no longer active service members, we are viewed in a positive light. We have federal holidays that celebrate and commemorate our service to this country. Electing to treat our maladies with a non-traditional medical option that involves a substance with a negative connotation should not be a negative judgement on our character or service.

While most of the research on veterans using cannabis links its use to PTSD (Bennett, Golub, Guarino, & Luther, 2015; Babson, Boden, Bonn-Miller, Short, & Vujanovic, 2013; Betthauser, Pilz, & Vollmer, 2015), not all veterans have PTSD. This is where I come in. With my study, I contribute literature that will help develop an understanding of the reasons why veterans are electing to use cannabis and how that change has affected their health. Additionally, I would like to bring attention to how their choice to use medical cannabis has affected their social identity with family, friends, and other social networks.
Theoretical Frameworks

For my theoretical frameworks, I will be using Emile Durkheim’s conception of deviance to explain what deviance is and how being deviant can affect one’s position within society. Additionally, I will be using Ervin Goffman’s stigma theory to show how the label of deviant leads to a negative stigma within our society. Lastly, I will be using work on social and personal identity to understand an individual’s construction of identity in relation to the choices they make and the groups they socialize with.

Deviance

Emile Durkheim argued that crime was inevitable and that a society cannot exist without it (Durkheim, 1958). Crime reminds us of what is considered normal behavior and what is considered deviant. Additionally, Durkheim postulated that a society without crime is impossible because crime upholds the collective social opinions that form what constitutes a crime (Durkheim, 1958). So, what is deviance? According to Durkheim, an individual is considered deviant when they violate the norms, beliefs, and values that society has established (Durkheim, 1958), what may or may not be a crime. Crime and deviance become the manner in which society establishes social norms, laws, and policies. Cannabis users do not know the kind of judgement, if any, they will receive from non-cannabis users, therefore the use of cannabis is usually kept secret in order to avoid the label of criminal of deviant (Becker, 2018). In the U.S., there are several activities that people partake in that violate the legal norms of society. However, these illegal activities occasionally have support from U.S. citizens. Cannabis is one example because cannabis use is supported by large numbers of individuals, yet at the same time, it is still punishable by federal law (Akers & Meneses, 2011).

According to Durkheim (1958), having the label of deviant is not necessarily bad. He believed that crime enables social change, and that the encroachment of the collective conscience
provides possibilities for advancement. Durkheim believed that when someone questions the norms set by society it creates the possibility for change. The label of deviant can temporarily harm a person’s social identity, and/or permanently destroy it, and any achieved status can be pushed to the side as they are expected to assume their new ascribed status of deviant (Gibbs & Thompson, 2017).

The use of cannabis is limited to the individual and whether they find it suitable or not for personal use. This suitableness, whether it is actual or assumed, comes as a result of a belief that if non-cannabis users determine that an individual uses cannabis, sanctions will be applied (Becker, 2018). The deviance from social norms can lead to stigma from society. A technique that individuals labeled as deviant employ is information control, in which the deviant suppresses the potentially stigmatizing characteristic in order to avoid being identified as a deviant individual (Gibbs & Thompson, 2017). These techniques can enable an individual to avoid being labeled as deviant and the negative stigma associated with this deviance.

**Military Deviance**

Similar to the establishment of norms set by U.S. society, subcultures like the military have also established sets of norms (National Research Council, 2014). Individuals that enlist in the various branches of the military are expected to follow these established norms or face punitive actions by their immediate chain of command or from the Uniform Code of Military Justice (UCMJ) (National Research Council, 2014). Beginning with keeping physically and mentally fit, service members are expected to keep their body in combat-ready shape at all times, unless they have a medical reason that has been documented by a military medical facility (National Research Council, 2014).

These norms are expected to be followed at all times, even when the service member is off duty. Any deviance from the established norms will lead to low level forms of behavior
modification, like physical activity. Because the majority of the military society will follow the norms, being labeled as someone who does not follow the norms can be career-crushing. Everything from food, medical care, clothing, and even authorized sexual positions have been established by the military for service members to follow (National Research Council, 2014). This extent of self-control that is developed, shapes an individual’s social identity to that of one that adheres the policies that have been set in place.

Stigma

Stigma results from a socially discrediting attribute that causes individuals to be classified by others in a negative way instead of being viewed as an equal. When an individual is introduced to the presence of others, others generally begin to assess them. Others notice their attire and behavior and begin to form assumptions of who a person is. These assumptions can range from personality type to socioeconomic status (Goffman, 1963). But why do people do this? According to Erving Goffman (1963), the answer is simple; individuals are gathering information about others in order to predict their behavior. This allows a person to correctly assess how they should react to the behavior of the individual that is being introduced (Goffman, 1963). As for the individual that is being introduced to the group, they strive to make the best impression possible. They begin to practice what Erving Goffman refers to as impression management in which they may conceal information about themselves when it is incompatible with the image they are trying to portray to a social group (Goffman, 1963).

According to Goffman’s theoretical framework on stigma, cannabis users may engage in impression management and omit their cannabis use due to the fear of being stigmatized. They expect that their relationships with non-cannabis users will be strained if their cannabis use is revealed (Becker, 2018). In practicing impression management, people censor what they say and how they behave. It is possible that for cannabis users, impression management is a tool to avoid
the stigma of being seen as deviant, especially considering that cannabis continues to be
criminalized in some parts of the country.

**Social and Personal Identity**

Social identity theory posits that a person’s sense of self is dependent on the social groups
to which they belong. A part of an individual’s concept of self develops from the groups they are
affiliated with (Tajfel, Turner 1979). Additionally, individuals possess multiple selfhoods that are
associated with the groups they belong to; depending on the social situation and environment, that
same individual will behave differently in varying social contexts. As individuals age, the groups
they are affiliated with will change and their multiple selfhoods evolve as the groups change
(Hogg, Terry & White, 1995). Personal identity is the conceptualization that we as individuals
develop about ourselves; this evolves throughout the course of our lives (Locke, 1689). Personal
identity includes ascribed aspects in which the individual has no control over, such as skin color
or place of birth, as well as achieved statuses such as joining the military or personal beliefs (Hogg,
Terry & White, 1995). As a veteran, individuals develop an identity tied to patriotism, combat,
comradery, and integrity, among other attributes that are not necessarily associated with an
individual that uses cannabis.

**Normalization of Cannabis among Cannabis Users**

Although some individuals outside of the cannabis community view cannabis use as a
crime given the federal legality and a display of deviant behavior, individuals within the cannabis
community believe that cannabis laws are too harsh and that cannabis should follow the same legal
regulations as alcohol (Hammersley, Jenkins & Reid, 2001). Cannabis users do not believe that
cannabis is addictive, nor a gateway drug that will lead to more addicting drugs like heroin.
Moreover, cannabis users have reported feeling more cautious about legal substances like alcohol
and tobacco than cannabis (Hathway, 2004). The background information on why an individual is
using cannabis has evolved to be more important than the traits of cannabis users (Hathaway, 2004). The normalization of cannabis use has led to increasingly permissive attitudes towards cannabis for personal use (Asbridge, Brochu, Cousineau, Duff, Erickson, Hathaway, & Marsh, 2012). Regardless of the illegality of cannabis, after cannabis users have been participating in long term use, they tend to no longer be as concerned about negative judgement from society (Becker, 2018). Normalization of cannabis use both inside and outside of the veteran community allows individuals to once again feel like they are part of society as opposed to an individual that has been labeled a deviant of society.
Literature Review

This research draws on the prevalence of medical cannabis use among U.S. veterans. In this section, I present previous research on cannabis use. I initiate with the taxonomy and etymology of cannabis as well as an explanation of what cannabis is. I then continue by discussing the evolution of cannabis into its deviant status. I conclude this section by discussing the use of cannabis among U.S. veterans.

Taxonomy and Etymology of Cannabis

In 1753, the father of modern taxonomy, Carolus Linnaeus, formally described the cannabis plant (Duval, 2015). Taxonomists saw an affinity between cannabis and genus humulus (flowering plants under the Cannabaceae family), because they both have a floral structure, and both contain achenes and laticifers. Achenes produce food, medicine, and feed. While laticifers produce a sticky resin that produces a psychoactive phytochemical (Duval, 2015). Later in 1969, a British taxonomist categorized cannabis under the cannabaceae family and assigned it to the hackberry species. The hackberry species was once considered an important source of nutrition in the pre-historic old world (Duval, 2015) and it is commonly used for medical and recreational purposes (Booth, 2003). Almost 24 years later, Dr. Allyn Howlett discovered how THC causes its well-known effects and identified the cannabinoid receptor. Cannabinoid receptors are located throughout our bodies as part of the endocannabinoid system and involve several physiological processes involved in pain, memory, and appetite (Goldstein, 2016).

The effects that cannabis has on an individual vary based on the administration of it. When cannabis is administered orally, trans dermally, or is inhaled, the cannabinoids in the cannabis activate the neurotransmitters in the body. In turn, this activates endogenous cannabinoid receptors that modulate a neurotransmitter release that produces a wide range of effects on the central nervous system, including increased pleasure and modification of memory processes. These
outcomes contribute to the pharmacologic method of reasoning for the utilization of cannabinoids in managing the three core PTSD symptom groups: hyperarousal, numbing, and avoidance (Betthauser, Pilz & Vollmer, 2015). High levels of cannabinoid receptors are located in the amygdala of the brain that control the emotional responses to stress, memory and anxiety. When these receptors are activated by THC, the individual begins to experience a reduction in PTSD symptoms and anxiety (Goldstein, 2016).

The terminology used to describe cannabis is important because it signals to the social stigma associated with it. The language used to describe cannabis has evolved over time depending on the culture and period of its existence (Duvall, 2015). The evolution of the word is accompanied by the evolution of its use. In 1753, cannabis was viewed botanically for its benefits and uses (Duval, 2015). The origins of the word marijuana come from the Central American Spanish term marihuana, although it is a mispronunciation of mariamba, which is the plural of riamba, meaning cannabis, in several Central African languages (Duvall, 2015). Riamba originates from Old Arabic Bhang meaning psychoactive cannabis (Duvall, 2015). It seems that as cultures evolved and enculturated with one another, the languages that each culture brought with them combined over time to form new words.

**Cannabis and Deviance in the U.S.**

Cannabis was not always demonized by the United States Federal Government. On the contrary, during the 17th century the government saw the benefit in producing hemp (Schlosser, 2004). The production of hemp was encouraged by the U.S. government, as it was used for clothing, sails, and rope (Schlosser, 2004). Hemp is also in the cannabaceae family and may contain small amounts of THC. Although hemp contains THC, the amounts are too small to have any kind of psychoactive effect (Britannica, 2018).
The Virginia Assembly passed legislation requiring farmers to cultivate hemp in 1619. That same year, the U.S. government also acknowledged hemp as a form of legal tender in Maryland, Pennsylvania, and Virginia (Schlosser, 2004). Domestic production of hemp thrived, until hemp was replaced by imports and other domestic materials after the Civil War. During the 19th century, cannabis evolved into a well-known ingredient used in medicinal products and was sold in public pharmacies (Schlosser, 2004).

After the Mexican Revolution of 1910, Mexican immigrants introduced the recreational use of cannabis to U.S. citizens upon their arrival (Schlosser, 2004). Fueled by fear and prejudice that was ignited by the anti-drug campaigners, whom cautioned against the intruding immigrants referring to them as the “marijuana menace,” U.S. citizens began associating cannabis use with the newly arrived Spanish-speaking immigrants (Schlosser, 2004). It is possible that U.S. citizens let their fear of the unknown and the prejudice of the anti-drug campaigners dictate what to make of the immigrants, instead of getting to know the Mexican immigrants and forming their own opinion. Years later, the controversy around marijuana continued.

Pharmaceutical Companies’ Role in Cannabis Prohibition

Before cannabis was made illegal in 1937, pharmaceutical companies had discovered its healing properties and had launched a campaign to include it in the banned opiates list (Gieringer, 1999). By launching anti-cannabis campaigns, pharmaceutical companies made sure that there were limited and effective alternative treatments to pharmaceutical medication. Pharmaceutical medications soon became the norm when it came to medical treatments (Gieringer, 1999). However, this change would later contribute to opiate addiction and unprecedented overdose deaths in the United States (Jones, Mack & Paulozzi, 2010). A 2010 study stipulated that pharmaceutical overdose deaths were up for the 11th year in a row (Jones, Mack & Paulozzi, 2010).
As unemployment increased during the Great Depression, U.S. citizens continued to fear the Mexican immigrants and began to resent them and support deportation campaigns. This resentment escalated the cannabis use concern among the public and the government. Biased research began to associate the use of cannabis with racial inferiority and lower income communities, crime, and socially deviant behaviors. As a result, 29 states in the U.S. had prohibited the production, use, sale, and cultivation of cannabis by 1931 (Schlosser, 2004). Consequently, during the Great Depression, Harry Anslinger from the Federal Narcotics Bureau pushed U.S. Congress to pass a federal law against the possession, use, and cultivation of cannabis. Anslinger claimed that cannabis was a “killer weed” that induced violence in everyone, provided “super human strength” and stimulated a “lust for blood.” His cannabis crusade was responsible for the federal scheduling of cannabis as a dangerous narcotic in 1937. Anslinger’s unverified claims created a fear in individuals across the U.S. that set the perfect climate to pass laws to criminalize cannabis in the U.S. Speculations that Mexican immigrants were providing this killer weed to American schoolchildren began to spread (Adler & Adler, 2016).

The association between cannabis use and crime was no longer limited to Mexican immigrants; soon African Americans were also associated with these stigmas (Schlosser, 2004). The resulting racial discrimination within the legal system for drug-related offenses has not faded. Currently, African Americans and Latinos represent three-fourths of the state prison population serving time for drug offenses including cannabis offenses, even though according to Sentencing Project data, whites represent a large part of dealers and illegal drug users in the United States (Lassiter, 2015).
On August 7, 1937, President Franklin Roosevelt signed federal legislation that banned the use, production, and sale of cannabis, including industrial hemp in the United States (Armentano, 2017). However, this did not prevent U.S. troops from using cannabis while serving overseas. In the summer of 1967, while living in Vietnam, Martin Booth, a Booker prize novelist and writer, witnessed U.S. troops using cannabis for medicinal purposes (Booth, 2003). Booth recalls that almost every American soldier, including non-commissioned officers and commissioned officers, had their own personal supply in a draw bag, cigarette box, pouch, or polished brass cartridge case (Booth, 2003). This recollection by the late Mr. Booth signals that at one point, cannabis use was normalized among U.S. troops.

Today, despite having 38 states in the U.S. that have established policies to allow the use of cannabis for medical or recreational purposes in the last two decades, the federal government still considers cannabis an illegal substance (Robinson, 2018). In addition to the federal ban of
cannabis, the federal government also established The National Commission on Marihuana and Drug Abuse as a part of the Comprehensive Drug Abuse Prevention and Control Act of 1970, to conduct a two-year study on the multifaceted misgivings in cannabis use and social responses (Blaine & Bozetti, 1975). This set the grounds for the policies that established the Controlled Substance Act, that was enacted into law by the Nixon Administration in 1971 (Title 21 United States Code (USC) Controlled Substances Act, 1971).

More recently, in 2005, in an effort to diminish curiosity in the medicalization of cannabis treatments, the U.S. Supreme Court passed a law making the medical use of cannabis federally illegal. However, as of 2013, cannabis has been legalized in 18 states for medical use (Clarke & Merlin, 2013). The attempt by the federal government to impede the widespread use of medical cannabis in 2005 was unsuccessful. In 2006, Rhode Island legalized the medical use of cannabis followed by New Mexico in 2007 (Procon, 2017). However, regardless of the number of states that have legalized cannabis for medical use, it is still illegal at the federal level.

The Controlled Substance Act is regulated by the federal government. It is made up of five schedules that categorize all substances into a specific schedule depending on the substance’s medical use, safety or dependence liability, or potential for abuse (Drug Enforcement Agency). However, the Controlled Substance Act does not apply to intrastate cultivation and possession because the commerce clause only grants Congressional authority over interstate commerce (Gonzalez v. Raich, 2005). The regulation of intrastate cultivation and possession by Congress exceeds the power of the Controlled Substance Act and the power granted to Congress within the commerce clause. For this reason, state laws pertaining to medical cannabis access, cultivation, and possession can sometimes override federal laws (Gonzalez v. Raich, 2005).
Legalization of Cannabis in North America

In October 2018, two countries in North America decriminalized the recreational and medical use of cannabis. Cannabis was legalized nationwide in Canada on October 17, 2018 (Bilefsky, 2018). Fourteen days later, México’s Supreme Court legalized cannabis for all forms of non-commercial adult use. The Mexican Supreme Court acknowledged that cannabis can be used for research, rituals, medical use, and recreational use (Timmons, 2018). These international legalizations have surrounded the U.S. borders with medical and recreational access to cannabis.

In the United States, the District of Columbia and the states of Michigan, Massachusetts, Arizona, New Jersey, California, Delaware, Connecticut, Illinois, New Hampshire, Colorado, Washington, Minnesota, Maryland, New York, Utah, Iowa, Missouri, Mississippi, Alabama, South Carolina, Tennessee, Kentucky, Alaska, Oregon, Louisiana, West Virginia, Texas, Ohio, Florida, North Dakota, Arkansas, Pennsylvania, Nevada, and Maine have all legalized cannabis, with or without THC, for medical use, recreational use, or both (Bascome, 2018).

Image retrieved from Katusa Research Commodities
A significant, although unknown number of U.S. citizens use cannabis, in spite of the fact that it is illegal (Becker, 2018). Regardless of the increasing state legalization, cannabis is still negatively stigmatized by the federal government since it is listed as a schedule one substance, despite being legalized at state levels for medical and or recreational use in 32 states (Staff, 2018). As of 2018, six in ten Americans support the legalization of cannabis (Geiger & Hartig, 2018). Unfortunately, cannabis continues to be negatively stigmatized by a part of society that shares the same belief as the federal government in that cannabis is a dangerous drug that has no medical benefits. There is a plethora of public service announcements that have been disseminated to discourage cannabis use, regardless if it is for recreational or medical purposes. These advertisements cause the part of society that does not support cannabis, including family and friends of cannabis users, to develop a negative bias against cannabis, leaving individuals using cannabis as medicine feeling deviant for using it (Capella, Fishbein & Kang, 2009).

In the 2000’s, a commercial aired aimed at discouraging cannabis use. The commercial depicted an individual that had just consumed cannabis and has melted on to the sofa, incoherent and sluggish (Tacoian Productions, 2008). This commercial was depicting false information about cannabis because not all cannabis products contain Tetrahydrocannabinol (THC). THC is the psychoactive component in cannabis responsible for the “high” feeling. THC is just one cannabinoid out of the 113 cannabinoids that make up cannabis. Other cannabinoids, such as cannabidiol (CBD), contain 0 to .05 % THC. The low to non-existent percentage of THC allows the individual to partake in the medicinal uses of cannabis without experiencing the psychoactive effect and still benefit from its healing medicinal properties (Benyamina, Blecha, Karila & Lafaye, 2017).
Dr. Lester Grinspoon, professor emeritus of psychiatry at Harvard Medical School, has been using, writing about, and researching cannabis since 1972. In his 2008 article, “To Smoke or Not to Smoke: A Cannabis Odyssey,” Grinspoon wrote about how the stigmatization of cannabis users deters a large cannabis subculture including influential and well-regarded members of society from speaking openly about their use. However, if more cannabis users “came out of the closet” about their use, the fear and prejudice against cannabis could decrease (Grinspoon, 2008). In his writing, Grinspoon (2008) promotes the public dialogue of cannabis use regardless of its federal scheduling. When the topic of cannabis is no longer considered taboo, it eventually becomes a norm instead of deviant, enabling social change.

Therefore, although CBD does not contain THC, it is in some ways stigmatized the same way cannabis is. Throughout history, societies have either idealized or demonized cannabis. When it comes to Western society, there is a tendency to fluctuate between the two extremes. The essential question posed for society is: As cannabis byproducts possess the probability of instigating both good and harm, how can the former be maximized, and the latter be minimized (Forti, Henquet, Morrison & Murray, 2007)?

Veterans Using Cannabis

When a service member is discharged from the military, they are entitled to medical care provided by the Department of Veteran Affairs (VA) for 5 years after their discharge date (Office of Public and Intergovernmental Affairs, 2016). With 128 nursing homes, 27 domiciliary care units, 172 medical centers that provide inpatient and outpatient care, and 193 free-standing outpatient clinics in the U.S., the VA is the largest national health care delivery system. Despite offering such a large healthcare delivery system, only 9 million veterans out of 18.2 million are using VA services (Veterans Health Administration, 2009).
One reason for the underutilization of VA services is geography. Since not all veterans live within city limits, many are left without medical care access. Forty percent of the 8 million veterans that are currently registered with the Veterans Health Administration (VHA) reside in rural regions and are likely to be of advanced age, be in worse health due to their quality of life and be uninsured other than by the VA (Fox & Rosenthal, 2000; Lyons & Rowland, 1989; Edin, Slifkin & Stearns, 2000). This lack of access to medical facilities and lack of medical coverage may be contributing reasons as to why veterans are using cannabis.

Regardless of the legal status and widespread use of cannabis in the U.S., it largely remains labeled as risky and deviant, contributing to risk avoidance (Paretti-Watel, 2003). Despite the negative attributes associated with being labeled as deviant, veterans are showing their support for cannabis use. In November 2017, The American Legion released results from a survey they conducted that revealed that 82% of veteran households believe that medical cannabis should be legalized at the federal level in order to have a legal treatment option. A few other key points from the survey revealed that 22% of veterans were treating a medical condition with cannabis and 92% were in support of medical cannabis research (American Legion, 2017). The American Legion is a non-profit organization that was chartered by Congress in 1919 to focus on the service provided to veterans and service members (History, n.d.).

As mentioned previously, because of its illegality at the federal level (listed under schedule 1), cannabis is not legal in all states. Therefore, not all veterans can legally consume it. According to the U.S. Drug Enforcement Agency (DEA), substances listed under schedule 1 have no medical value and are prohibited from medical use and subsequent to high potential of abuse. Other substances listed under schedule 1 are peyote, lysergic acid diethylamide (LSD), heroin, ecstasy, and methaqualone (Drug Enforcement Agency, 2017). However, unlike the other substances,
cannabis does not have high potential for abuse, nor does it cause cravings or withdrawal syndrome (Becker, 2018).

Despite the federal government classifying cannabis under a schedule that indicates no medical benefit when administered, veterans have testimonials that indicate otherwise. In 2017, The Associated Press published a news article in which they interviewed veterans that have found relief with medical cannabis and are now advocates. In the article, retired Marine Staff Sergeant Mark DiPasquale from New York City says, “I just felt like a zombie.” DiPasquale at one point was taking 17 opioids, including anti-anxiety pills, prescribed to him by the Veterans Affairs Clinic due to the injuries he sustained while he was deployed to Iraq in 2005. Consequently, DiPasquale co-founded the Veterans Cannabis Collective Foundation in Rochester, New York to help other veterans feel like themselves again. “Do I still have PTSD? Absolutely,” says DiPasquale. “But I'm back to my old self. I love people again” (Peltz, 2017).

In 2016, similar testimonial was published online by Time. Jose Martinez out of California lost both his legs, index finger, and right arm in 2012 to a landmine while deployed in Afghanistan. In the article, Martinez said, “Recovery was challenging in my eyes. I had pretty much failed when I stepped on a bomb and lost three limbs.” Martinez continues, “I was going insane because I did not understand why I was still alive” (Thompson, 2016). Unfortunately, in December 2015, Martinez was involved in a car accident. His car hit black ice in the high desert near his home causing the car to flip. He lost his last remaining limb and broke his maimed left arm. Doctors prescribed him pharmaceutical medication after both tragedies. Martinez says, “I started taking so many prescription pills, I was numb to the world.” As time passed, Martinez replaced all his prescription medication, sometimes up to 150 pills a day, with cannabis (Thompson, 2016).

Testimonials similar to Mr. Martinez are important because in 2016 an article published in the military’s newspaper, The Stars and Stripes, revealed that since 2001, about 1,650 U.S. troops
have lost limbs in Iraq and Afghanistan (Montgomery, 2016). Martinez’s story is not an isolated case. If cannabis helped Martinez, then there could be other veterans like him looking for alternative medical treatment.

In 2012, the Department of Veterans Affairs conducted a research on cannabis use and trends of cannabis use disorder (CUD) diagnoses among veterans during fiscal years 2002, 2008, and 2009. The study revealed that CUD diagnoses had increased more than 50% over the last 7 years, and 115% for veterans that had no other illegal substance use disorder (SUD). In addition, the study showed that the states that had legalized the medical use of cannabis had significantly higher diagnoses of CUD (Bonne-Miller, Harris & Trafton, 2012). The study indicated that veterans were using cannabis; however, it did not indicate if the use was long-term or why veterans were using cannabis. Additionally, in 2017, a study showed that veterans were using medical cannabis twice as much as the civilian population (Bohnerta, Davis, Ilgena & Lin, 2017).

The use of cannabis is individually-driven; every veteran that has turned to cannabis has their own reason and proof of functionality. This is not limited to veterans, tens of thousands of individuals are using medical cannabis because they believe that it is healthier than using their currently prescribed medication (Coomber, Morris & Oliver, 2003). Despite the popularity of cannabis, veterans may be reluctant to speak openly about their cannabis use outside of the cannabis community to prevent the label of deviant and having their veteran status tainted. With my study, I contribute to literature on the various reasons (apart from PTSD) as to why veterans are using cannabis and the social ramifications of this use. Additionally, my study provides evidence that other veterans are finding relief with medical cannabis, prompting for a more open dialogue about cannabis.
Data and Methods

Qualitative Data Collection

The data for this project was based on 52 responses from an online questionnaire consisting of open- and closed-ended questions that was aimed at veterans who use cannabis. I used primarily open-ended questions because this style allows respondents to answer questions with more emotional and detailed information. Open-ended questions gave veterans more freedom to write openly about cannabis than a structured survey. The questionnaires were disbursed online because this allowed me to reach veterans outside of El Paso, Texas. My questionnaire was cross-sectional and was collected between March 4, 2019 – April 30, 2019.

I posted a flyer on social media via Facebook where I have access to private groups comprised of veterans. This access allowed me to post my flyer (see Appendix B) and questionnaire link. I also posted the flyer (Appendix B) inside smoke shops in El Paso, TX; Alamogordo, NM; and Irvine, Sacramento & San Diego, CA. Furthermore, through social media, I established connections to smoke shops and dispensaries around the U.S. who agreed to post my flyer which widened my access to veterans nationwide. I selected these locations because dispensaries contain cannabis products and smoke shops contain the materials that are used with cannabis. The flyer contained a QR code and a link that led veterans to the questionnaire.

Sample

The target sample was U.S. military veterans and service members who are currently treating their medical conditions with cannabis in states where it is legal and illegal for medical and recreational purposes. The target sample size was 50 veterans, however I received 52 questionnaires. This study received IRB approval from The University of Texas at El Paso. The questionnaire was collected with QuestionPro because it allowed for anonymity of all respondents. QuestionPro is an online survey platform that allows respondents to participate in questionnaires.
Although QuestionPro is not exclusively for anonymous questionnaires, they provide options that protect respondents’ personal information.

The respondents were not asked to disclose any personal identifying information in order to protect their anonymity. The first page of the questionnaire was an information sheet explaining informed consent to the respondents (see Appendix A). It informed the respondent of why the study was being done and the risks and benefits associated with completing the questionnaire. It also informed the respondent that they were not obligated to take part in the study and that there was no compensation for participation. It ensured anonymity to the respondents and it included contact information for myself and the UTEP Institutional Review Board (IRB).

The results of this study were shaped by the methodology I established when designing this research. The target sample for the online questionnaire had the freedom to decide if they wanted to take part in my study in its entirety or simply respond the questions which they felt comfortable answering. This freedom may have created a self-selection bias, thus limiting the generalizability of the data due to the lack of proper representation of the entire veteran population. In an effort to limit bias in this study, the flyer for the online questionnaire was posted in social media groups that were exclusive to veterans but not limited to cannabis affiliation, meaning that the respondent did not have to treat their maladies with cannabis in order to participate in this study.

**Sample Demographics**

Results were obtained from online questionnaire responses. Respondents had the option to skip a question if they did not feel comfortable answering it. The answers that they did provide were used in my analysis. As a result, 19 of the 52 respondents skipped at least one question on their online questionnaires. These incomplete questionnaires nevertheless provided an important contribution to this study because they had thorough responses to several questions in regard to
further highlighting the relationship between cannabis and veteran’s health, providing rich qualitative data for this study. The majority of respondents were male (34 males, 11 females). The age ranged between 20 and 70, with a mean age of 37. Additionally, over 50% of the respondents identified as white-non-Hispanic (57.63%). See Table 1 below for a full description of demographic characteristics:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Race/Ethnicity</th>
<th>State of Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>23.91%</td>
<td>20-30</td>
<td>Caucasian or White</td>
</tr>
<tr>
<td>Males</td>
<td>76.09%</td>
<td>31-40</td>
<td>Hispanic or Latino</td>
</tr>
<tr>
<td></td>
<td></td>
<td>41-50</td>
<td>Black or African-American</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-70</td>
<td>Native Hawaiian or Alaskan Native</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was significant variation in socio-economic status among the respondents. Respondents could indicate multiple answers for their occupations. The majority of the respondents, 30%, were retired, while 25% reported being employed. In terms of income-level, 37% of respondents reported their income level between $36,000-$50,000, while 26% reported their income to be less than $20,000. In terms of education, 30% of the respondents reported having some college, while 21% reported having a bachelor’s degree. Table 2 summarizes these patterns:

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Income level</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>25.00%</td>
<td>25.50% High School</td>
</tr>
<tr>
<td>Unemployed</td>
<td>16.07%</td>
<td>$21,000-$35,000</td>
</tr>
<tr>
<td>Self-Employed</td>
<td>16.01%</td>
<td>$36,000-$50,000</td>
</tr>
<tr>
<td>Student</td>
<td>11.70%</td>
<td>$56,000-$75,000</td>
</tr>
<tr>
<td>Retired</td>
<td>30.00%</td>
<td>$75,000 or more</td>
</tr>
<tr>
<td>Other</td>
<td>11.70%</td>
<td>Masters</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doctorate</td>
</tr>
</tbody>
</table>
The respondents were asked what their rank was while serving. This is because enlisted members and officers have different roles in the military. Commissioned officers in the military manage enlisted members, they plan missions, assign and give orders. Ninety-two percent reported that they served under an enlisted rank, while 8% reported serving under a commissioned officer rank. Fifty-seven percent of the respondents reported having served in the U.S. Army, while 19% reported having served in the U.S. Marine Corps.

Sixty-three percent of the respondents reported having served in combat, while 37% reported not having served in combat. Forty-two percent reported they served in the war in Afghanistan (Operation Enduring Freedom, OEF), 25% reported they served in the war in Iraq (Operation Iraqi Freedom OIF), 14% reported they served in the Persian Gulf war, (Operation Desert Shield, Operation Desert Storm, and Operation Desert Sabre), and 5% reported they served in the Vietnam War. Table 3 summarizes the military background of respondents:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Branch</th>
<th>Combat Service</th>
<th>Conflict Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enlisted</td>
<td>U.S. Army</td>
<td>Yea_63.30%</td>
<td>War in Afghanistan (OEF) 42.40%</td>
</tr>
<tr>
<td>Commissioned Officer</td>
<td>U.S. Marine Corps</td>
<td>No_36.70%</td>
<td>War in Iraq (OIF, OND) 25.40%</td>
</tr>
<tr>
<td>Warrant Officer</td>
<td>U.S. Air Force</td>
<td>7.60%</td>
<td>Vietnam War 5.10%</td>
</tr>
<tr>
<td></td>
<td>U.S. Coast Guard</td>
<td>0%</td>
<td>Korean War 0%</td>
</tr>
</tbody>
</table>

The top fields of occupation while serving were: combat operations (23%) and transportation, supply, and logistics (13%). It was no surprise that most of my respondents reported working in combat operations while serving in the military as they are the demographic that experience the most physical and mental trauma while serving. The full breakdown of occupations appears in Figure 1 below. Seventy-one percent of the respondents were diagnosed with service-connected disabilities through the Department of Veterans Affairs. All of the respondents that
reported having served in combat have been diagnosed with service-connected disabilities. Additionally, 69% had been diagnosed with PTSD related to their military service.

![Figure 1: Military Field Occupations](image)

Respondents were asked if they used cannabis for medicinal purposes, and 93.9% of the veterans responded yes. Of the respondents that reported using cannabis for medicinal purposes, 97.8% reported treating mental health conditions, while 87% reported treating chronic pain. In terms of the type of cannabis used, respondents were given the options of reporting use of cannabis with higher concentrations of THC or lower concentrations of CBD, meaning they used products that had more than 60% of THC, or products with less than 40% CBD. Forty-four percent of the respondents reported using cannabis with a higher concentration of THC and lower concentration of CBD, while 24% reported using cannabis with higher concentration of CBD and lower concentration of THC.

This distinction is important because it gives us an insight as to what disorders veterans are treating using THC and what disorders they are treating with CBD. It is also important because different concentrations will work for different people. Thirty-four percent of the respondents that were using cannabis with higher concentrations of THC were treating mental health issues, while 31% were using it to treat chronic pain. Additionally, 30% of the respondents that reported using
higher concentrations of CBD indicated they were treating mental health conditions, while another 30% were using it for chronic pain. The uses of cannabis are summarized in Table 4 (crosstab).

<table>
<thead>
<tr>
<th>Medical Issues Treating with Cannabis</th>
<th>Cannabis with a higher concentration of THC and a lower concentration of CBD</th>
<th>Cannabis with a higher concentration of CBD and a lower concentration of THC</th>
<th>Cannabis with CBD only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>34%</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>31%</td>
<td>30%</td>
<td>28%</td>
</tr>
<tr>
<td>Neurological Disorders</td>
<td>8%</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td>Musculoskeletal Disorders</td>
<td>6%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Nerve Issues</td>
<td>15%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Table 4: Cannabis Use among Respondents
Data Analysis

I used NVivo to code the data I received from the online questionnaires. The data was stored in a password protected computer followed by a password protected folder. As the online questionnaires were submitted, I developed a database through my data collection and assigned numeric identifiers to participants. When the questionnaires were completed, the data was coded for pre-existing codes and themes in order to effectively identify themes and relationships among the sample. The codes were developed based on the responses from the online questionnaires. The themes that were identified are as follows: 1) deviance; 2) medical cannabis uses; 3) medication side effects; 4) disability status; 5) combat experience; 3) mental health; 4) physical health; 5) VA experience; and 6) societal experiences. I focused on these key themes because they capture the experiences related to the reasons for medical cannabis use by U.S. veterans. These experiences serve as examples of successful medical treatments outside of the traditional treatments currently offered by the Department of Veterans Affairs. Thus, these themes were developed because they represent the reality of why U.S. veterans are using medical cannabis. Additionally, the themes that I developed allow me to evaluate how medical cannabis treatment challenges the effectiveness of the traditional treatment options afforded to U.S. veterans.

Since my research is a qualitative study, I decided to use inductive reasoning and narrative analysis to analyze the data in two stages. Inductive reasoning allows themes to emerge during the data analysis. Narrative analysis allowed me to interpret the online testimonials (Strauss & Corbin, 1990). In the initial stage I surveyed the online questionnaires for seemingly relevant issues. I performed this by reading through each questionnaire and identified the repeated issues. The repetition of experiences rendered issues relevant and as a topic requiring further analyzing. The codes were developed to reflect what the veterans were answering in order to effectively analyze the data for the results section part of the thesis. Once the repeated issues and similarities in the
responses had been identified, I began to code for key themes and created subthemes and subcategories. The testimonials supplied by the respondents provided evidence in relation to the themes for why U.S. veterans are using medical cannabis to treat their maladies.
Results

Reasons for Cannabis Use among U.S. Veterans

The results from the online questionnaire revealed three major findings when it came to why veterans were using cannabis instead of or in addition to their prescribed medications. The first finding was veterans experiencing negative side effects from the pharmaceutical medication that they were prescribed. The second finding highlighted a more frightening reason: veterans reported that their Veterans Affairs physician would not listen to them during their appointments, which in some cases led to a suicide attempt. The last finding that the questionnaire revealed was using cannabis for social integration.

Pharmaceutical Side Effects

One of the primary reasons respondents reported using cannabis was because of the harmful side effects from pharmaceutical medications prescribed to them by their local Veterans Affairs clinic. Veterans reported a range of different side effects. Monica, a native Hawaiian 38-year-old female from Florida, experienced weight gain, higher anxiety, and mental exhaustion among other side effects. She wrote, “Yes, I stopped taking anti-depressants and others because I experienced many negative side effects from them like higher anxiety, mental exhaustion, weight gain, and upset stomach when taking them and I do not experience any of those using cannabis. In fact, I experience the opposite.” Ted, a white 56-year-old male from Texas, reported feeling like a zombie after he would take Tramadol. He wrote, “I quit Codeine, Tramadol and Ibuprofen. The Codeine caused bad side effects which the doctors wanted me to take other meds for. The Tramadol turned me into a zombie and changed my personality, among other things, and the Ibuprofen (prescribed levels) wrecked my liver.”

Peter a 30-year-old male from Texas was experiencing an accrual of bad dreams due to his medication. He wrote, “The depression and anxiety medication made my bad dreams accrue more
often”. Additionally, Richard an American-Indian 50-year-old male from Michigan and Lily, a white 28-year-old female from Texas reported having felt worse after taking anti-depression medication. Richard wrote, “Prozac was making my depression worse.” Lily wrote, “Pharmaceuticals impaired my judgment and made my mental health worse; I lived in a fog of depression. The side-effects of the pharmaceutical drugs made me irritable and sick. I couldn’t allow my body to be damaged by pharmaceutical use.”

One theme that kept emerging when it came to pharmaceuticals was the sheer number of pharmaceutical medications that veterans were prescribed. Jeremy, a white 55-year-old male from Texas, wrote, “Because taking 40 mg of oxycodone, 1000 mg of muscle relaxers, and 2500+ mg of Tylenol a day was getting out of hand. Also, I hated my PTSD drugs.” Patrick, a white 33-year-old Male from Texas, reported having to take 15 different prescriptions, most of which were treating side effects from his medications. He wrote, “After years in the VA system my prescription counts just seemed to grow with every side effect that wasn’t tolerable. I decided to search other options when I hit 15 different prescriptions and still couldn’t function.” Similarly, Phoebe, a white 47-year-old female from California, was experiencing more health problems because of the dozens of medications that she was being prescribed by her Veterans Affairs Clinic. She wrote, “I was taking so many pills that it was causing more health problems. I wanted to take back my health, cannabis replaced over a dozen prescription medications.”

It was not surprising to see veterans switching from taking large amounts of pharmaceutical medications to a healthier option since in the military service-members strive to be healthy individuals in order to maintain a battle-ready body. To be unhealthy in the military is a form of military deviance. Instead of continuing a treatment regimen that would harm them, participants reported that they opted for what they viewed as a healthier option, cannabis. In keeping with the identity of the healthy service member. Robyn, a White 31-year-old veteran out of Texas, wrote:
I am a much happier person. I no longer have to be on stronger, higher doses of anti-depressants like Paxil or Prozac. I’m not drowsy and stuck in bed all day as a result. I have the energy to play with my children, I am not afraid to go out in public spaces, I’m not as worried about who might be standing behind me. Cannabis has given me the ability to enjoy the present, and that’s something I haven’t had since I was a kid.

Robyn’s testimonial indicates how while she was taking pharmaceutical medications, she was drowsy and had no energy to leave her bed. Even in her own home, Robyn was not able to play with her children after she would take prescription medication. After making the change to cannabis, Robyn was able to enjoy her life and her children. Joey, a Black 31-year-old male from Texas, wrote a similar response as to how he believes cannabis use was healthier than relying on pharmaceuticals like Abilify and Lithium. He wrote, “I decided to use cannabis due to lower occurrences of negative symptoms in comparison to synthetic pharmaceuticals such as Abilify and Lithium and electroshock therapy.”

These results showed that all of these veterans tried pharmaceutical medications prior to trying cannabis. They followed the protocol that the Department of Veterans Affairs has in place for veteran’s health services. They registered with The Department of Veterans Affairs and their local Veterans Affairs Clinic. They reported to their appointments and informed their medical team about what they were experiencing. They took their prescribed medication looking to find relief. However, instead of finding relief, some found more discomfort, and in some cases, developed harmful side effects. They were not considered to be deviant until they deviated from the traditional medical treatments and opted for what is federally considered an unorthodox and illegal medical treatment.

These results also show a lack of accountability for pharmaceutical medication prescriptions when it comes to how they are harming the veteran. Doctors and other pharmaceutical medication prescribers use clinical practice guidelines for guidance when it comes to treatment decisions. However, these clinical practice guidelines are often written by experts that
have financial ties with the pharmaceutical industry (Brown, Lee & Garber, 2019). Most of the
responses above indicate veterans being prescribed large quantities and several different types of
pharmaceutical medications at the same time. This poses the question of accountability when it
comes to the providers and the pharmaceutical industry. Beyond the role of providers in writing
prescriptions, respondents reported a wide array of negative interactions with their providers.

**Poor Interactions with Providers Not Listening to the Veteran**

Poor interactions with providers was an alarming reason as to why veterans were making
the change to cannabis. This theme was continuously mentioned by several veterans. Veterans
alleged that their Veterans Affairs Clinic physicians are not listening to them during their medical
appointments. Veterans reported that when they spoke to their physicians, the physicians often
would not listen to what they were being told and would overmedicate the veteran. In the case of
Oscar, a white 42-year-old male from Texas, his physician did not listen to him at all when his
prescription was changed from Lunesta to Ambien, despite the veteran communicating to his
physician that he had experienced severe side effects to Ambien. Oscar described this experience:

> The very first visit to the VA in Odessa, TX, a psychiatrist would not refill my Lunesta
> prescription. He said I had been on it long enough and it was habit forming. He wanted to
> give me Ambien, but I had some severe side effects to it in the past. He told me to have a
> nice day and I tried to kill myself shortly after because I could not sleep. A veteran friend
> gave me some cannabis and it helped with me getting to sleep and then I noticed I was not
> having nightmares either. I then decided that I could use it to get off the other
> pharmaceutical medications I was on as well. I have been pharmaceutical free since
> December 2017. I use it daily to combat symptoms.

As Oscar’s response indicates, these poor interactions were part of what led to a failed
suicide attempt. This also led him to pursue other treatment options following the suicide attempt.
More broadly, negative interactions like Oscar’s can have severe effects when it comes to the
veteran’s mental health. Veterans reported feeling suicidal due to the lack of attention and care
from their physician. As Oscar’s experience shows, some suicide attempts may stem in part from
the veteran being prescribed the wrong medications, as well as the feelings of helplessness for their health because the providers at the Department of Veterans Affairs are failing the very people they are supposed to be healing.

Oscar’s experience is especially important to understand since 3 veterans committed suicide at Veterans Affairs clinics just in April 2019. In fact, since the War on Terrorism was declared, 20 veterans die by suicide every day (Mental Health, 2018). This number includes an estimated 14 per day veterans that have had “little or no contact” with their local Veteran Affairs clinic within the recent months (Shane, 2018). Thus, it is not only poor interactions, but the absence of care, fueling suicides. The Department of Veterans Affairs has received $6.2 million in an effort to establish programs for veterans in order to prevent suicides. However, according to Leo Shane from The Military Times, they only used $57,000 for suicide prevention media outreach. Veterans are having to fight for their lives and the lives of their comrades all over again. We are home, we are out of the military, yet we are caught in a battle off the battlefield.

I am a part of several social media veteran-only pages. On a number of occasions, I have seen a veteran simply writing that they are done and do not want to live with their pain any longer. Almost instantly, they begin receiving replies from fellow veterans urging them not to give in, urging them to see the value in their life despite their current feelings. In some cases, veterans have jumped in their cars and driven to the suicidal veteran’s location regardless of their familiarity. We vowed to never leave a fallen comrade, and we continue to honor it.

These veterans are mothers, fathers, daughters, sons, and friends, but when that darkness takes over, the veteran does not see any of that. They just see and feel their pain, and they know how to escape the pain forever. One simple act can make it all go away, and if they do not have the support that will pull them out of that darkness, then the veteran gives into the darkness, and becomes part of a statistic that haunts veterans daily. Emily, a Hispanic 31-year-old female from
Kentucky, experienced a failed suicide attempt after being prescribed medications that were not helping her depression or anxiety. Emily alerted her physician that the medications were not helping and was told that the treatment is long-term, and the physician did not change her medications. Emily wrote:

I started using Sertraline, aka Zoloft, and Buspar on 2016. I still felt depressed, anxious and had uncontrollable emotions. The psychiatrist explained that it was a long-term treatment and to wait a couple of weeks until the effects kicked in. Two years after, I was more irrational than before. Drinking every day since 10 am. Thought about suicide a lot. Lost a job. Got another one but couldn't stop thinking about how I was going to mess up, so I quit. After a failed suicide attempt with codeine I tried cannabis because, if I was going to end my life, might as well try everything, right? So, I told my husband to find some (he didn't know my plans). He did. Our marriage was failing, of course, and he said he wanted me to try anything to fix us. We started smoking and I started listening to people better. My anxiety has gradually decreased. And after eight months, I feel happier. I still stress about things, fight with my husband, and have insomnia occasionally. And have lost a lot of weight that I had put on, using the prescription plus all the depression overeating that I did.

Emily’s claims were not taken seriously by her physician. If the patient is expressing that the medication is not helping them, why isn’t the physician listening? My personal experience as a veteran leads me to believe that these physicians are jaded, and they have generalized all of their veteran patients into a category where their voices are not heard. They simply follow a routine of greeting the patient, reviewing their medications, asking how they are feeling, and then white noise seems to follow after that, and the veterans are sent on their way. The biomedical model of care is dominated by the pharmaceutical medication treatment that the providers seem to place priority on. Evidently, as my respondents have reported, this model is causing harm and veterans are no longer willing to be a part of it.

However, the Veterans Affairs healthcare providers are simply following a model that that have been enculturated into. In July 2019 Hero’s Media Groups published an article highlighting a 2017 study that provided evidence that 1 in 3 veterans are administering more than ten pills a day. This study also indicated that the amount of opioid overdose deaths in the veteran community
increased by 65% from 2010 to 2016. This is a result from a medical regimen that has been established and referred to as the “Combat Cocktail”. This medical regime was a common practice during the conflicts in Iraq and Afghanistan and it includes anxiety drugs, pain killers, and antidepressants that are prescribed to the veteran simultaneously. This medical regimen has been known to cause the patient to feel drowsy. Because of this a stimulant is prescribed so the veteran is able to be awake throughout the day. However, if the prescribed stimulant then causes the veteran to have difficulty sleeping then the provider will prescribe a hypnotic to counteract this effect (Daniels, 2019).

Other veterans wrote similar testimonials to Emily’s. Logan, a white 26-year-old male from Texas, wrote, “The prescriptions from the VA just aren’t effective, and my doctor doesn’t seem to listen. His answer is just keep taking them.” Kirk, a black 46-year-old male from Texas, wrote, “Depending on which pills my non-caring VA automaton threw at me depended on whether I felt anything at all, I had the emotional stability of a waiting room full of pregnant and pms-ing nineteen-year old’s, or I would randomly contemplate suicide out of the blue.”

Ultimately, these veterans made the change to cannabis as a last resort from traditional treatments. Once they made the change, these veterans reported that they began feeling a lot better. However, even in states where cannabis is legal, veterans cannot have it prescribed to them by their Veterans Affairs healthcare provider simply because it is federally illegal. Thus, this forces veterans to pay out-of-pocket for their medication or continue using the pharmaceutical medication that is harming them.

Social Integration Assistance

When asked about social integration assistance, 50 veterans reported that cannabis assisted them with social integration after the military. This is extremely important because it is not uncommon for veterans to experience social integration shock after leaving the military (Morin,
2012). For years, veterans are taught to behave, walk, and talk a certain way. Leaving the military, these actions force an individual to stick out like a sore thumb. Behaviors that are normal for veterans are seen as abnormal or deviant for civilians. Veterans have to learn how to exist within a society that has had a different socialization and they are outnumbered.

It seems like an easy task to just fall back into society, however, the veteran has behaviors that have become deeply imbedded. Monica, a Native Hawaiian 38-year-old female from Florida, claims cannabis has changed everything for her. Monica was able to be the spouse and mother, her family needed her to be. Monica’s emotional state also caused strain in her closest friendships. After changing to cannabis, she was able to complete tasks that seem simple to others, like washing the dishes without having to force herself. Most importantly, Monica is happy with herself and is growing as a person. Monica wrote:

All of it! It [cannabis] has changed all of it. Minor daily tasks like doing dishes and going on errands use to be momentous, if I summoned the energy at all. Being so unhappy and unwell strained my closest relationships, particularly with my children. I was a garbage parent and I was consumed with thoughts about that without any ability to summon more than just a desire to change. Using cannabis though, I have been able to take care of myself and feel positive changes! I am active and engaged, caring for myself and my home and my family with enthusiasm and calmness rather than always being tired, irritated, sad, and overwhelmed at the slightest stress. I am happy and inspired. My spouse was completely against my use of it for years and then after I showed such improvement in my life with the help of my tracking and monitoring, my spouse was convinced that cannabis was indeed a big part of me being better, healthier. I enjoy parenting, I enjoy my marriage, and I enjoy myself so much more and that makes all of life better. I am enthusiastic about taking care of my body and mind and have the mental and physical energy to take care of my home and daily tasks and projects. I am creating art again. I make more responsible choices because I want to and not because I feel obligations. I am living again rather than just existing.

Family Relationships

A number of other respondents reflected similar sentiments about how cannabis facilitated their ability to accomplish daily tasks within the family. Oscar, Manny, and Karla from Texas reported how cannabis helped them with their family relationships. Oscar, white 42-year-old male from Texas, reported the feeling of being able to be a father and husband again to his kids and
wife. He wrote, “It helps me with my quality of life. I never had that while I was on my pharmaceutical meds. I can be a father to my kids and a husband to my wife again.” Manny, a white 35-year-old male from Texas, simply stated that he would be divorced and having to share his children if it was not for cannabis. He wrote, “It [cannabis] saved my life. I would not be professionally where I am at without it. I would not be married and would have to share my children.” Karla, a white 33-year-old female from Texas, recalls her life as a fog of exhaustion, but after her change to cannabis, she was able to complete her daily responsibilities. She wrote, “I can still do my daily responsibilities and not be drugged out on pills. The pills always made me exhausted and like I was living in a fog.”

Public Fears

Close to 3 million U.S. military members have served in Operation Enduring Freedom, Operation Iraqi Freedom and or Operation New Dawn. Veterans have reported a high prevalence in mental health problems including difficulty transitioning from their military service into society (Elnitsky, Fisher, & Blevins, 2017). Several participants in my study, including Logan, Lily, Jeremy, Morgan and Patrick from Texas reported being able to be out in public. Logan and Lily a 28-year-old female both reported being able to attend class and function in society after switching to cannabis. Logan wrote, “I'm able to go to class and function in society. Sure, the pain is still there, but it gives me the tools I need to look beyond it.” Lily experienced relief in class as well, she wrote, “It’s made life clearer and manageable. I can focus in class and I don’t lose my shit at the drop of a ball.” Morgan, a 39-year-old male reported being able to function the way he did before he was injured in the military and was able to live a normal life. He wrote, “I’m able to function like I did before my injuries from the military. I’m able to go out in public and not worry about having a breakdown I don’t have to look over my shoulder anymore and worried about is something bad going to happen marijuana allows me to have a normal life.”
Patrick, a white 33-year-old male recalls feeling like a hermit when he was on pharmaceutical medications. He wrote, “I’m not a hermit anymore, at the max of my prescriptions I never left my house. Now I’m only home about 10 hours a day including sleep time. The rest of the time I’m either at work or riding my motorcycle with friends.” After making the change to cannabis he now spends his days either at work or riding his motorcycle with friends. Jeremy, a white 55-year-old male writes how his pain is now bearable enough for him to function in society. He wrote, “It made my life of pain bearable while allowing me to function in society.”

Veterans are finding that they can exist as they are, within this society. They do not have to feel like they do not belong. The participants reported that cannabis is helping them to complete daily tasks, go out in public without anxiety, and maintain important relationships. In several of these testimonials, veterans reported that their prescription medication contributed to their isolation. Ironically, they described feeling “drugged” by their medication and feeling normal with a federally illegal substance.

**Recreational Use**

Within the questionnaire, veterans were also asked if they used cannabis for recreational purposes. Twenty-two percent of the veterans that completed the questionnaire reported using cannabis for recreational purposes. Additionally, that 22% of veterans were also asked if they treated any medical conditions with their recreational use. Table 5 illustrates recreational users, 33% of veterans were also treating a mental health condition while 30% of veterans were treating chronic pain.
Through recreational cannabis use, veterans like Ted, Luke, and Rachel from Texas reported finding relief from their ailments. Ted, a white 56-year-old male recalls using cannabis recreationally as a young man, now as a veteran, Ted began using cannabis to find relief from his ailments. He wrote, “I heard stories about pain, stress, and other symptom relief from using cannabis. I remember in my youth when I used cannabis recreationally and decided to try it again only this time for the purpose of finding relief from my ailments. After some experimentation and listening to recommendations from other users, I found the strains that work best for me. I find relief and comfort at a level I can live with.” Ted’s testimonial shows us that similar to traditional treatment methods, cannabis users experiment with different strains of cannabis in order to find the best one that addresses their needs.

Luke, a Hispanic 25-year-old male writes that his recreational use of cannabis has helped stabilize his social issues as well as treating his headaches, PTSD, and bipolar disorder. He wrote, “It helps stabilize my daily social issue as well as treating my bi-polar disorder. I also have PTSD from childhood trauma, and it helps deal with those issues as well as headaches and injuries from my enlistment. I’ve done the research and have seen first-hand the healing properties of the plant and CBD.” Rachel, a white 32-year-old female reported that she suffers from several conditions that cause her chronic pain and the traditional methods of treated them were not working. So, after several discrete recommendations from her providers, Rachel turned to cannabis for relief. She

<table>
<thead>
<tr>
<th>Medical Issues Treating with Cannabis</th>
<th>Recreational Cannabis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>33%</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>30%</td>
</tr>
<tr>
<td>Neurological Disorders</td>
<td>9%</td>
</tr>
<tr>
<td>Musculoskeletal Disorders</td>
<td>6%</td>
</tr>
<tr>
<td>Nerve Issues</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
</tr>
</tbody>
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Table 5: Recreational Cannabis Use among Respondents
wrote, “I have several chronic pain conditions that do not respond to traditional pain medications. I had several doctors suggest discretely that I try cannabis after getting out of the Army.”
Deviance vs. Normalization

In addition to the themes related to cannabis use, the online questionnaire revealed that not all veterans feel or are viewed as deviant for using cannabis. On the contrary, they are often viewed as a normal veteran looking to be healed and find peace. For this section, I have divided the findings into two subthemes: deviance and normalization. This is because the questionnaire results showed that veterans experienced different degrees of feeling that their cannabis use was deviant or normalized within society. Within my discussion of deviance, I will discuss the veterans that responded feeling deviant for their cannabis use and what generated these feelings. In the normalization section, I will review the veterans that felt their cannabis use was normalized and are advocating for medical cannabis as a treatment for veterans. This section highlights to what degree cannabis is considered deviant and to what degree it is considered normal.

Deviance

In exploring deviance, respondents were asked if they had spoken to anyone outside the cannabis community about their cannabis use. This question was asked in order to evaluate if the veteran felt deviant by using cannabis. If a veteran does not feel deviant, they will be more likely to speak openly about their use without fear of social ramifications. This question also aims at understanding information control because the veteran can elect to tell a certain group of friends about their cannabis use but not others. Thus, veterans may feel deviant within some social groups, but not others. Further, cannabis laws in a person’s place of residence can also impact whether one speaks about their cannabis use.

Danny, a white 48-year-old male from New Mexico, reflected one of the strongest sentiments of feeling deviant for his cannabis use. He wrote, “They see me as a druggie who just wants to get high. They don't understand the benefits I receive.” In the cases of Ted, a white 56-year-old male from Texas, and Barney, a Hispanic 36-year-old male, neither speak about their use
in order to avoid the label of deviant. Ted wrote, “It is almost a crime to say the word cannabis where I live. So, I don't say anything.” However, for Rachel, a white 32-year-old female from Texas, it is a bit different because she can speak about it with her family but not her church community, which is part of her identity. She wrote, “I’ve written a blog post about my experience, and the responses were mixed. I have mostly support from my family, but I don’t think the traditional church community understands cannabis yet. I still see a lot of misinformation being spread on social media from my church friends.”

In the case of Rachel, cannabis use is accepted by her family members, but not her church. These group memberships can affect the veteran’s social identity, especially if they have to continue to hide their cannabis use within a group that comprises an important part of the individual’s identity. If veterans have used religion as a form of therapy, or just use religion because they were socialized to do so, then religion has become part of their identity. However, Rachel felt that her cannabis use conflicted with her religious identity, generating feelings of deviance.

Forty-three respondents reported that they had spoken to people outside of the cannabis community. Thirty-three of those respondents were from Texas and of those 33 respondents, 29 respondents had spoken about their cannabis use outside of the cannabis community. This was an interesting result because it was unexpected. Based on my personal experiences living in Texas and having family members that viewed my cannabis use as deviant, I believed that veterans would be silent about their use in an effort to avoid the label of deviant. Additionally, I did not expect to have such a large number of veterans from Texas be so open about their use outside of the cannabis community.

While some veterans are speaking about their cannabis use, in some cases, this discussion is limited to other veterans that also use cannabis and/or trusted family and friends. Veterans are
controlling information about their cannabis use based on the group they are with. Briana, a Hispanic 26-year-old female from Texas, wrote that who she discusses cannabis use is dependent “on who it is and how the subject came to be.” Monica from Florida more specifically wrote she will only speak about her use with people who are in the same situation as her. She wrote, “I only talk to my spouse, a select group of people who are also in the same situation, and a few private internet support groups.” Karla, a white 33-year-old female from Texas, talks about her cannabis use but keeps it “as private as possible.” Albert, a white 27-year-old male from Texas, has family who expressed to him that cannabis comes from the devil, so he no longer speaks about his cannabis use with them. These veterans are experiencing some feeling of deviance from their use of cannabis and are controlling that feeling by controlling with whom the information will be shared.

**Cannabis Normalization**

As discussed above, veterans reported different degrees of feeling deviant. In other cases, veterans are speaking openly about their use. In some cases, this is in effort to normalize cannabis use and battle the negative stigma surrounding cannabis. Additionally, the responses revealed that not only are veterans speaking to people outside of the cannabis community, but they are also publicly advocating for veterans’ access to cannabis. The largest group of advocates come from Texas. In this context, the use of cannabis is normalized as a form of medical treatment as opposed to the traditional treatment of pharmaceutical medication. Robyn, a white 31-year-old veteran out of Texas, is very open about her use. She wrote:

I am very vocal about medical cannabis and the need to change the laws in Texas. It is a running joke in my circle that I can’t go anywhere without talking to someone about it, in laws, people at the store, servers at dinner, etc. I think it’s important to have these conversations and normalize the discussion about cannabis as medicine because our country is moving in this direction. The stigma surrounding cannabis is founded upon 20th century ignorance and fear mongering, and it is our job to shift the narrative through educating the general public. Cannabis users are not basement stoners wasting their lives. We are military veterans overcoming our pain and PTSD, we are seniors managing
arthritis, we are parents stopping our children’s seizures. It is important that we have these conversations with the people we know and the people we don’t, because “reefer madness” is a stigma that continues to prevent legitimate policy change.

Robyn advocates for cannabis legalization daily in an effort to normalize the use of cannabis. She believes that if cannabis users are open about their use, the negative stigma surrounding it will disappear and cannabis use will be normalized. She is not alone in her effort. In fact, there is a group of veterans from Texas that have set up a social media page on Facebook in an effort to show that Texas veterans want legal access to cannabis as a medical treatment option.

Texas Veterans for Medical Marijuana is a group comprised of veterans that want legal access to cannabis. Recently, several of the members of this organization were advocating in Austin Texas in support for HB 1365. The organization advocates for a whole plant medical cannabis program with a state administered patient registry, medical cannabis dispensaries licensed by the state, and growing operations. Additionally, they advocate for the right to grow their own plant at home. As a part of this activism, the group set up a display of empty prescription medication bottles inside of a coffin in Austin, Texas on January 8, 2019 in effort to show that access to cannabis for veterans is a life or death situation.

Photo retrieved from Texas Veterans for Medical Marijuana
Similar to the veterans from the Texas cannabis activist group, Tom, a white 63-year-old male from Texas and Phoebe, a White 47-year-old female from California both identify as cannabis activists and reported speaking to everyone about their cannabis use. Tom wrote that he speaks about his use to “Everyone. I am a marijuana activist.” When asked if she speaks about her cannabis use, Phoebe wrote, “Yes! I moved to California and became a cannabis advocate. I speak to EVERYONE about cannabis and how it can help them.” Patrick, a white 33-year-old male reports being very vocal about his usage in an effort to relieve the stigma that surrounds cannabis users. He wrote: “Absolutely, I’m very vocal about my cannabis use to try and relieve the stigma around cannabis users.” Similarly, Logan from Texas mentions speaking to individuals outside of the cannabis community in an effort to put antiquated legal system to an end, writing, “Because the antiquated legal system and this fallacy war on drugs needs to end.” Richard, an American-Indian 50-year-old male from Michigan speaks to individuals outside of the cannabis community in order “to educate” them on the benefits of cannabis. Both Patrick and Logan’s report in speaking about their cannabis use also reflects why cannabis is still federally illegal today: an antiquated law based on a stigma. Cannabis was made illegal 82 years ago in 1937 (Armentano, 2017) due to the false claims from Mr. Anslinger (Adler& Adler, 2016).

Other veterans like Jeremy, a white 55-year-old male from Texas, believe that we need other treatment options to prescription medication treatment. This is an opinion that is also shared
by Texas Veterans for Marijuana Access. Marshall, a white 63-year-old male from Minnesota speaks about his use because he doesn’t believe in hiding a treatment that works. He wrote, “No sense hiding what works.” This kind of mentality helps other people see that cannabis can be used as a medical treatment. Jonathan, a white 28-year-old male from Texas does not limit his talk about cannabis to people from within the community. He reported speaking about his cannabis use all the time. Jonathan’s report of speaking about cannabis all the time is further evidence of the normalization of cannabis use some veterans have adopted. He wrote, “All the time. I am open with my stance on cannabis.”

Texas veterans seem to be more vocal about their use and activism than veterans from other states. Specifically, this activism was related to using cannabis for medical purposes. It is veterans that speak out in defense of their use that will help change the stigma surrounding cannabis and normalize it for medical purposes. Within this subgroup of veterans, cannabis has been normalized because of its healing power and it is actually considered deviant to use pharmaceutical mediations instead of cannabis. It is in part through small veteran groups that changes in laws related to cannabis can be made. This may in part be because it seems that cannabis is socially acceptable when veterans are using it for medical purposes as opposed to recreational purposes.
Discussion

The results show that despite no longer serving in the military, veterans are facing daily battles on the home front. These are battles they have not spent years training for in order to possess the ability and skills to survive. However, regardless of these battles, veterans are choosing to live and are developing lifesaving tools including using cannabis as medication. Additionally, veterans are gearing up every day to fight for the right to have a choice outside of the traditional medical treatments, instead of being forced into taking medications that veterans are reporting as harmful.

**Why are veterans using cannabis?**

The participants in my study reported three major reasons as to why they turned to cannabis: 1) The negative side-effects they experienced from their prescribed pharmaceutical medications; 2) Physicians not listening to them during their appointments at veteran affair clinics; and 3) To assist in social integration after military service. Additionally, results from my study indicated that 100% of the veterans using medical cannabis reported having served in combat and also reported having a rating for service-connected disabilities with the Department of Veterans Affairs. This finding suggests cannabis is being used as a successful medical treatment for veterans that have served in combat and are looking to find relief. Even respondents that reported using cannabis for recreational purposes also reported finding relief for their medical conditions.

**When is the use of cannabis socially acceptable?**

Results from my online questionnaire indicated that cannabis use among veterans is socially acceptable when veterans are using it to find relief, as the medicinal use of it has been normalized within the veteran community. Additionally, my research showed that veterans in Texas, California, Michigan, and Minnesota are forming advocacy groups in order to change laws that are related to the use of medical cannabis, thus working toward expanding its social
acceptance. Male and female veterans are not allowing the negative stigma that is associated with the use of cannabis to get in the way of healing themselves.

On the contrary, some veterans are vocal about their medical cannabis use in an effort to advocate and educate for the positive and healing properties it possesses and to eliminate the negative stigma. Furthermore, they are not allowing federal law to dictate what treatment they can use in order to heal and find peace, even if that means using the black market to obtain their medicine. This kind of behavior is what Durkheim was referring to when he said deviance can lead to social change. According to Durkheim (1958), crime can make way for social change if it shifts the collective conscience. Durkheim believed that by questioning the norms set by society through deviance, resulting deviance creates the possibility for change. As much as it pains me to write this, veterans that are using cannabis are technically breaking the law because cannabis is a federally illegal substance for both medical and recreational use regardless of state laws (Title 21 United States Code (USC) Controlled Substances Act, 1971). However, in breaking the law and talking about their cannabis use, veterans are contributing to social change that will eventually lead to federal laws changing in regard to cannabis.

When is cannabis use viewed as deviant?

Veterans reported feeling the most deviant when they spoke about their medical cannabis use to individuals outside of the cannabis community. Respondents expressed a sense of misunderstanding when it came to the subject of cannabis from their other social groups. This impacted their ability to communicate within their groups, thus impacting their social identity tied to these groups. As a result, veterans reported exercising information control in order to avoid the label of deviant within these social groups. Additionally, veterans are employing information control in an effort to speak about medical cannabis in order to educate their other social circles about its medical attributes.
Are veterans using cannabis for pain and/or mental relief?

My findings indicate that the veterans that participated in my study reported treating chronic pain in addition to mental health conditions. Other findings in my research suggest that cannabis possesses several medical attributes that veterans are using in order to treat their service-connected disabilities, in addition to PTSD. This is an important finding since most of the literature that I came across was limited to veterans using medical cannabis for PTSD treatment. The veterans that took part in my study reported using cannabis for chronic pain, neurological disorders, musculoskeletal disorders, conditions resulting in nerve discomfort, and to assist in social integration into civilian population after their military service.

In what ways does the healthcare system contribute to cannabis use among veterans?

Veterans reported that a contributing factor as to why they turned to cannabis was their physicians at their Veterans Affairs clinic were not listening to them during their appointments. This points to an alarming trend in the biomedical model of care within the physicians at the Veterans Affairs clinics that suggests they are prescribing medications without understanding what the veterans are experiencing. This finding leads to further understanding as why veterans are using cannabis.

Veterans expressed a contributing reason to why they turned to medical cannabis was being prescribed a too many pharmaceutical medications by their physicians at Veterans Affairs clinics. Additionally, testimonials from the questionnaires indicated that veterans were prescribed medications that were not only treating their medical conditions, but they were also prescribed medications in order to treat side-effects from other medications. This led to veterans feeling like they were taking too many pills on a daily basis.
Limitations and Future Research

This study was limited in that a larger response would have been received if more time had been allowed for disseminating my online questionnaire. Additionally, an important factor was the number of veterans I had access to as opposed to the actual number of veterans that use medical cannabis. More time would not only have allowed for a larger response, but it would have yielded the ability to reach more veterans nationally. That being said, a significant limitation was also that this study was based on online responses from a questionnaire as opposed to in-person interviews limiting how I could connect with my respondents and my ability to probe and ask follow-up questions. However, making this sacrifice enabled me to reach a larger number of veterans living in diverse geographical locations.

The methodology that I implemented posed limitations on this study that may have affected the internal and external validity. The questionnaire that I designed to measure the degree of deviance that the respondents experienced was largely based on my own experience. This method limited the generalizability of this study to the general public because the feeling of deviance is subjective. The question was not direct in asking if the respondent felt deviant based on their cannabis use. Instead the question read: Have you spoken to anyone outside of the cannabis community about your usage? Deviance was measured this way due to my own experience of how I first experienced feeling deviant due to the reaction I received from an individual outside of the cannabis community. Additionally, I did not want the rhetoric of asking the question directly to affect how the respondent would feel by answering yes and risking offending the respondent.

Furthermore, my status as a veteran and my experience with medical cannabis, society, and the VA played a significant role on how the questions were designed and how I analyzed the data. This also limited the sample that I was targeting for my study. By focusing on U.S. veterans that use medical cannabis, the results did not provide data for a comparison to veterans that have never
used medical cannabis and exclusively use traditional medical treatments offered by the Department of Veterans Affairs. A comparison of medical cannabis users and non-medical cannabis users may have provided for a larger applicability to a broader U.S. veteran population.

The federal scheduling of cannabis also posed limitations on this study. Due to cannabis not being legal federally, it is up to the individual states to regulate cannabis laws. Because of this, not all veterans have legal access to cannabis. Therefore, this may have limited participation as some veterans would not want to report their medical cannabis use. Because of the federal illegality of cannabis, not all users will be a keen to take a university questionnaire due to the fear of being tracked down. This may be particularly true for veterans that receive disability and pension payments from the Department of Veterans Affairs due to fear of losing their benefits. Additional limitations are the number of veterans that see the flyers within the allotted time of the study, as well as the willingness to divulge personal and illegal activity despite the anonymity of the questionnaire.

In future research, I would like to continue contributing to medical cannabis research by creating more studies that are related to veterans using cannabis in an effort to assist in changing the medical treatment options that the Department of Veterans Affairs offers to veterans in addition to the existing treatments. Based on the responses from my online questionnaire, my research can be used to develop further research on the effectiveness of veterans treating their conditions with medical cannabis in addition to or in lieu of pharmaceutical medications. Currently, what remains unknown is the exact number of veterans that are using cannabis. Future research with the Department of Veterans Affairs can address this unknown by distributing a questionnaire to a wider veteran audience among a representative sample of veterans.
Policy Implications

The policy implications of my study can be nationwide legal access to medical cannabis for all veterans. In addition, this research can lead to the Department of Veterans Affairs recognizing a need to provide holistic methods, in addition to, or in lieu of pharmaceutical medication. With the Department of Veterans affairs accepting medical benefits of cannabis, subsequent departments may follow thus freeing more grants to research cannabis.
Conclusion

This study collected data through 52 anonymous online questionnaire responses composed of both open- and closed-ended questions. The target sample for this study was veterans in the United States, in states where medical cannabis is legal and illegal, who are using medical cannabis to treat their maladies, including their service-connected disabilities. The focus of this research was to contribute to literature in an effort to understand the reasons why veterans are using medical cannabis and how cannabis has affected not only their health but their social identity as well.

This thesis contributes to the current research related to veterans using medical cannabis as a medical treatment option by providing new evidence of veterans using cannabis to treat various medical conditions. Additionally, my study contributes to current research related to the reasons why veterans are turning to medical cannabis by providing current testimonials of the effects medical cannabis has had on their health. My research indicates that veterans are using cannabis not just to treat PTSD, as current research relating to veterans using medical cannabis suggests (Bennett, Golub, Guarino, & Luther, 2015; Babson, Boden, Bonn-Miller, Short, & Vujanovic, 2013; Betthauser, Pilz, & Vollmer, 2015), but veterans are also using it to treat other medical conditions as well as to assist them with social integration after their military service. This is an important contribution because as history has shown, veterans will exist in every generation. Therefore, we need to arm our medical professionals with the best tools to effectively treat veterans once their service to our country is complete. Furthermore, research showing successful treatments in veterans using cannabis will yield evidence to further the treatment options that are available for active duty service members.

In conclusion, veterans are reporting using medical cannabis because the pharmaceutical medication that they were prescribed by their Veterans Affairs physician was harming them instead of helping them find relief. Veterans are also reporting that their physicians at the Veterans Affairs
clinics are not listening to them during their medical appointments, reflecting an alarming trend among physicians within the Department of Veterans Affairs. Veterans are also reporting using cannabis to help with social integration assistance when they transition back to a civilian society, as well as to treat chronic pain, conditions causing nerve discomfort, neurological disorders, and musculoskeletal conditions. Additionally, my study indicates that veterans are fighting the negative stigma associated with cannabis by speaking out about their use outside of the cannabis community, educating the public through their own experience, and at times even advocating for state and federal laws to change.

Veterans are reporting that medical cannabis has saved their lives. However, veterans are stuck in a legal paradox because of the federal legality of cannabis. We are illegally alive by choosing to treat our maladies with medical cannabis instead of running the risk of being legally dead by continuing a medical treatment plan that is being reported as ineffective, dangerous and at times deadly. There is a need to provide more medical treatment options beginning with federally legal access to medical cannabis for veterans because no veteran should be forced to depend on an undependable black market in order to secure their medication.
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Appendix A Informed Consent

University of Texas at El Paso (UTEP) Institutional Review Board
Research Information Sheet

Protocol Title: The Battle off the Battlefield
Principal Investigator: Viridiana Edwards
UTEP [Sociology]:
Sponsor:

Introduction

You are being asked to take part voluntarily in the research project described below. Please take your time making a decision. Before agreeing to take part in this research study, it is important that you read the consent form that describes the study.

Why is this study being done?

You have been asked to take part in a research study of U.S. Veterans that have or are currently using Cannabis to treat their medical conditions.
Approximately, 25, will be enrolling in this study at UTEP, local business and online through a flyer with a QR code that will direct them to the questionnaire.

You are being asked to be in the study because you are a Veteran that has or is currently using Cannabis for treat your medical conditions.

If you decide to enroll in this study, your involvement will last about 25 minutes
If you agree to take part in this study, you will be asked to: Participate in an anonymous online questionnaire consisting of 27 questions.

Risks and Benefits

Risks- Potential loss of privacy and confidentiality
Benefits- There are no known risks associated with this research. There will be no direct benefits to you for taking part in this study. This research may help us to understand *Why veterans are choosing Cannabis as oppose to Pharmaceutical Medications.*

What other options are there?

You have the option not to take part in this study. There will be no penalties involved if you choose not to take part in this study.
If you choose to take part, you have the right to skip any questions or stop at any time. If there are any new findings during the study that may affect whether you want to continue to take part, you will be told about them.

Will I be paid to participate in this study? What are my costs?

There are no direct costs. You will not be compensated for taking part in this research study.

What if I want to withdraw, or am asked to withdraw from this study?

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you do not take part in the study, there will be no penalty or loss of benefit.

The researcher may decide to stop your participation without your permission, if he or she thinks that being in the study may cause you harm. The researcher may also exclude your responses if you do not meet the sampling criteria.

What about confidentiality and my personal information?

*This study is an anonymous study and no personal identification will be required to participate. Once you have followed the QR code provided in the flyer, you will then be directed to the online questionnaire, at which point you will not be asked your name, address, phone number or any other question that will lead to your identification.*

Your part in this study is confidential. Your individual privacy will be maintained in all published and written data resulting from the study. All records and Data will be stored in a password protected computer followed by a password protected folder.
Organizations that may inspect and/or copy your research records for quality assurance and data analysis include, but are not necessarily limited to:

- UTEP Institutional Review Board
- Question Pro- privacy restrictions/information can be found on the following link. https://www.questionpro.com/info/aboutUs.html

Who do I call if I have questions or problems?
If you have questions or concerns, or if you have a research-related problem you may email Viridiana Edwards at vedwards2@miners.utep.edu

You can contact the Human Subjects Protection office to speak to someone independent of the research team if you have questions or concerns about your rights as a research participant, please contact the UTEP Institutional Review Board (IRB) at (915-747-7693) or irb.orsp@utep.edu.

Authorization Statement

I have read each page of this paper about the study (or it was read to me). I know that being in this study is voluntary and I choose to be in this study. I will get a copy of this consent form now for me to keep. Online studies: “Please feel free to print a copy for your records.”

I agree to participate in this research project. By completing the questionnaire provided
Hello fellow Veterans! My name is Viridiana Edwards, I am a U.S. Army Veteran that was medically retired after ten years of service due to injuries sustained while serving in Afghanistan. I am currently a graduate student at The University of Texas at El Paso (UTEP) conducting a research study on Veterans that use Cannabis to treat their medical conditions for my Masters Degree Thesis. The survey is completely anonymous and no personal information will be required to participate. The link or QR code below will direct you to the survey. I appreciate your participation!

Viridiana Edwards
The University of Texas at El Paso
Department of Sociology and Anthropology
U.S. Army (Medically Retired) OEF, OND, Operation New Horizon
Email: vedwards2@miners.utep.edu
Vita

Viridiana Edwards was born and raised in the city of El Paso Texas, she currently resides in San Antonio Texas. Edwards joined the United States Army in 2005 at the age of 17. The author served honorably and was medically retired due to the injuries she sustained while serving in Afghanistan in June of 2015. Edwards became an undergraduate student at Park University at Fort Bliss Texas where she achieved a Bachelor of Science degree in social psychology in 2017. After completing her undergraduate degree, the author decided to pursue a Master of Arts in Sociology at the University of Texas at El Paso (UTEP). While at UTEP the author continued her research on the prevalence of U.S. veterans using medical cannabis to treat their maladies through a qualitative research lens. While she pursued her master’s degree, she also served as the sergeant at arms for the UTEP Sociology club. In addition to researching medical cannabis, the author is also an advocate for medical cannabis access for veterans. Her research, “The Battle off the Battlefield’ was selected to be presented at the 2018 Southwestern Sociological Association in Orlando Florida. Edwards will continue researching medical cannabis as a treatment option for veterans in order to assist other veterans that are looking for relief.