Using participatory arts-based research to explore the experiences of cannabis consumption among women from marginalized social positions in downtown Hamilton

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By

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Abstract

This research explores the subjective experiences and perspectives of women who occupy marginalized positions in Canadian society who consume cannabis. While cannabis use has been normalized among certain populations since legalization, it remains unclear how this new terrain will impact women's experiences of access, consumption, and disclosure, especially those experiencing marginalization along various axes of identity such as gender, race, and class. The women participated in the art-making process of creating their own personalized body map, a life- sized image of one's body that includes shapes, images, colours, and symbols to visually represent their life story. Accompanying and complimenting the artwork, were the women's narratives that reflected their lives, relationships, and experiences related to cannabis consumption, offering a nuanced and complex understanding of their experiences. An intersectional feminist lens foregrounds the research, drawing on the principles of Feminist Participatory Action Research (FPAR), to examine the experiences of women who consume cannabis, the ways in which their cannabis use may be perceived and understood by health and social care providers and systems, and whether they will benefit from legalization in the same way as those with more privileged identities. The theoretical and methodological choices are intended to emphasize how social positionings impact and differentiate women's' experiences while also considering how particular identities are influenced by structural forces, unequal social relationships, and power imbalances. Moreover, this research study seeks to centre the lived experiences and voices of women, while analyzing the complex, multi-dimensional, and overlapping factors that impact women's decision-making processes, motives, and experiences with cannabis use. The research is essential to create new knowledge that can inform social work and allied professional policies and practices to serving women, and shift the current discourse surrounding women's cannabis use, thereby reducing stigmatizing practices and policies in health and social related fields.

Keywords: cannabis; women; gender; art; participatory; qualitative research; intersectional feminist theory; FPAR.

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Table of Contents

Prologue

I became connected with the YWCA Hamilton during my student placement as an undergraduate student in 2022. YWCA Hamilton, located at 75 MacNab Street South, is the site of the YWCA's Transitional Living Program which provides safe, affordable, and temporary housing for 68 single women and non-binary individuals experiencing homelessness and gender-based violence (YWCA Hamilton, 2024). This YWCA site also offers an overnight drop-in space for women and non-binary individuals experiencing street-level homelessness (Carole Anne's Place), and a range of co-located community-based programming such as peer support, social recreational programming, a gender-specific safe consumption space, case management, and other low-barrier, wrap around health services (YWCA Hamilton, 2024). My specific placement was with the Emergency Reproductive Care (ERC) Program, a new pilot project being rolled out to enhance supports for individuals experiencing pregnancy and homelessness (Vaccaro, 2024). While I do not have any personal experience with homelessness, a commonality among program participants was my experience with pregnancy and many other aspects of reproductive health care. I was familiar with the complications and uncertainties that often accompany the prenatal period along with the experience of mothering on many levels. I had also gained experience and comfort from previous years working front-line as a mental health and addictions worker in both community and clinical practice. These skills would also prove to be valuable in working with the program participants. More importantly, however, was the way my personal and professional values aligned with the program's values of harm reduction, pro-choice, gender inclusivity, intersectional feminism, and low-barrier support (Vaccaro, 2024).

Following my placement and undergraduate career, while awaiting the start of the MSW program, I took on a research assistant position with the YWCA's Good Beginnings Program

and at the same time, was granted an Undergraduate Student Research Award (USRA). USRA recipients are granted opportunities to gain valuable research experience that compliments their academic studies, and I was fortunately connected with a body mapping research project that was a component of the Women, Art, and Cannabis study. This project was under the supervision of Dr. Saara Greene, and funding was granted by the Social Sciences and Humanities Research Council (SSHRC, 2019-2023). As someone who initially intended to engage in feminist, arts-based research in the realm of reproductive health, the leadership and methodology surrounding this project could not have been more aligned for me. The experience provided me with a knowledge base to apply to my own future research and built my capacity as an arts-based researcher, and I am so forever grateful for this incredible opportunity. The body mapping workshops were also conducted within the YWCA Hamilton and all participants were connected, either previously or currently, to the program, rendering familiarity amongst the research team.

After connecting so intimately with these women and immersing myself so deeply in the data over the course of the summer, I could not turn down the opportunity to make this project a component of my MSW thesis when I was offered a chance to continue with the research. Once my MSW studies were complete, I made the decision to reach out to consenting participants to review their data, share the findings, and ensure that I had interpreted their stories in a way that was both accurate and person-centred. An important ethical consideration when doing research with communities, is returning the research in a respectful, meaningful, and accessible way, and this was an approach I was committed to upholding (Boilevin et al., 2019). This took place in April and May 2024, approximately one year following the initial body mapping workshops.

This project has been a big part of my world for the past year and a half. I feel sad to finally be letting it go, yet so full of hope to share the powerful stories of these amazing women.

I do not claim to 'know' or understand the complexity of their experiences. I do, however, see how social inequities are perpetuated within our oppressive systems and structures, and how power is embedded into absolutely every aspect of our being. The strength and resiliency demonstrated by these women was unparalleled. No amount of acknowledgement, financial compensation, meals, and thanks can begin to honour their contributions or disrupt the power imbalances that inevitably exist in research. In many ways, this thesis is a necessary continuation of my unfinished work as an undergraduate student researcher, but also my unfinished work as a social worker. This research has brough forth new revelations, insights and self-reflection that was necessary for my personal and professional growth and will be shared throughout this thesis.

Chapter 1: Introduction

Cannabis is a genus of flowering plant in the Cannabaceae family that has been widely used throughout history for medicinal purposes (Bridgeman & Abazia, 2017, Bruni et al., 2018). Cannabis products are generally described as prescription, medical, or recreational, with many possible methods of consumption (Bruni et al., 2018 as cited in Cameron, 2023).

Over the past two decades, Canada has seen a movement towards the acceptance of cannabis use, as it has shifted from an illicit drug, to a medically based federally regulated narcotic, to a legally sanctioned, adult recreational substance (Government of Canada, 2021). Under the current legalization, cannabis production and distribution are more effectively regulated, and it is presumed that the adverse cannabis-related health and social outcomes will be minimized (Fischer et al., 2022).

Data from the Canadian Cannabis Survey (CCS), conducted quarterly in Canada since legalization in 2018, reveals that rates of cannabis use among the general population aged 16 years and older have increased post-legalization from 22% in 2018 to 26% in 2023 (Government of Canada, 2024). Rates of cannabis use have been rising among Canadian women in recent years, increasing from 11% in 2018 to 15% in 2023, while rates among men remain consistent (Canadian Center on Substance Use and Addiction, 2024; Government of Canada, 2024).

The literature regarding cannabis consumption post-legalization is in its infancy, however, trends are beginning to emerge. Health related literature continues to be predominantly focused on the negative impacts of cannabis consumption, pointing to a range of adverse health conditions, with very little attention being paid to the benefits of use (Archie & Cucullo, 2019; Kitchigina, 2021; Onaemo et al., 2021; Sholler et al., 2021). Such studies perpetuate the rhetoric of cannabis as a harm and fail to consider the broader social determinants that impact health

outcomes. Research regarding women's cannabis consumption is also somewhat limited, and what has been written points to the gendered norms and expectations that more profoundly impact women's patterns of use, decision-making, motives, experiences, and context surrounding cannabis consumption (Greaves & Hemsing, 2020). Further, the literature surrounding women and cannabis use highlights how certain groups of women, such as women who are pregnant and/or parents, leads to an increased surveillance and assessment of risk, and experiences of stigmatization (El Marroun et al., 2009; Fergusson et al, 2002; Hayatbakhsh et al., 2012; Passey et al., 2014). These narratives promote abstinence as the dominant response to managing 'risk'. Lastly, the theme of harm reduction surfaces across the literature, illustrating cannabis' potential to reduce or limit the use of illicit substance and/or prescription pharmaceuticals (Boehnke et al., 2016; Corroon et al., 2017; Dreher, 2002; Goncalves & Nappo, 2015; Kral et al., 2015; Lau et al., 2015; Peters, 2013; Reiman et al., 2017; Samolilov et al., 2018; Wrenger et al., 2014).

What remains unknown, is how this new legal landscape will impact women's experiences of access, consumption, and disclosure of cannabis consumption and whether women who experience marginalization along various axes of identity such as gender, race, and class will benefit from legalization in the same way as those with more privileged identities (Fischer et al., 2022; Greene, 2018). Without an intersectional lens to examine such experiences, it is unclear how women's cannabis use may be perceived and understood by health and social care providers and systems (Kozak et al., 2022).

The lived experiences and voices of women who consume cannabis, especially those occupying marginalized axes of identity, are largely absent in the research. The purpose of my thesis is to counter this, by engaging women in a way that centres their experiences and perceptions of cannabis use, and how this translates to their disclosure, or lack thereof, to health

care and social service providers. This project is underpinned by an intersectional feminist lens that provides the tools to analyze the complex, multi-dimensional, and overlapping factors that impacts women's decision-making processes and experiences with cannabis use. Women are engaged using the participatory arts-based research method of body mapping in which both the women's artwork and narratives become a point of analysis. The research is essential to create new knowledge that can inform social work and allied professional policies and practices serving women (Greene, 2018). Moreover, the current study will hopefully contribute to a shift in the current discourse surrounding women's cannabis use, reducing stigmatizing practices and policies in health and social related fields.

Chapter 2: A Review of the Literature

My research is focused on better understanding the experiences and perceptions of cannabis use for women who occupy marginalized identities. Very little research exists that centres the perspectives of women who choose to consume cannabis. Rather, the literature focuses on cannabis consumption in relation to physical and mental health, reproductive health, and stigma.

The literature points to themes of physical and mental health, gender norms and expectations, harm reduction, reproductive health, and stigma, while simultaneously identifying gaps that support the need to investigate women's motives, disclosure, attitudes, behaviours, and encounters with health and social service providers surrounding their cannabis consumption. Doing so through a gendered, intersectional lens will place the voices of women at the forefront of creating new knowledge that can inform health and social work, allied professional policies, and practices to serving women (Greene, 2018).

2.1 Context of Legalization in Canada

Over the past two decades, Canada has seen a shift toward the acceptance of cannabis, the first of which was evidenced by Health Canada's legislative framework that legalized medical cannabis in 2001 (Health Canada 2024). In this context, legislation was passed to allow individuals with designated chronic illnesses to access and use cannabis, while also authorizing homegrown production (Haines-Saah et al., 2014). New regulations in 2013 shifted cannabis access regulations to licensed commercial growers and in October 2018, Canada became the second country in the world to legalize cannabis sale, possession, and non-medical use by adults under the Cannabis Act (Government of Canada, 2018). This shifted cannabis from a medically based, federally regulated narcotic, to a legally sanctioned, adult recreational substance (Government of Canada, 2021). It was assumed that under legalization, cannabis products would be more

effectively regulated as distribution shifted from criminal to legal markets, and that adverse cannabis-related health and social outcomes could be minimized (Fischer et al., 2022). Leading up to and following legalization in Canada, cannabis consumption has moved away from a discourse of deviance to that of acceptance, whereby consuming cannabis is viewed as a normalized behaviour (Duff & Erickson, 2014; Parker, 2005). Prevalence rates for cannabis consumption have risen in Canada since the late 1970s (Government of Canada, 2014), with minor fluctuations in the early 1990s and again more recently, with estimates of total population use ranging as high as 30% (Health Canada, 2022; Carter et al., 2007; Keethakumar et al., 2021). Despite these documented changes in public perception about cannabis consumption, it remains unknown how this new legal landscape will impact women's experiences of access, consumption, and disclosure of cannabis outside the medical framework (Fischer et al., 2022; Greene, 2018).

2.2 Physical and Mental Health

There is an extensive body of literature written on cannabis and physical and mental health, focusing on both the positive and negative impacts that cannabis consumption has on a range of health conditions (Haug et al., 2017; McCormick et al., 2017; Volkow et al., 2016; Walsh et al., 2016 as cited in Cameron, 2023).

i) Physical Health

The use of cannabis for chronic pain has been described in ancient and current times and is well supported through the medical literature (Baron et al., 2018). There is substantial evidence for the use of cannabis for chronic pain management among adults (Baron et al., 2018) and it has been endorsed as a tool for relieving symptoms and pain associated with several physical health concerns, diagnoses, and illnesses (Cameron, 2023). For example, individuals diagnosed with

Multiple Sclerosis (MS) report relief from pain and illness specific symptoms such as tremors and loss of equilibrium (Clark et al., 2004; Page & Verhoef, 2006; Page et al., 2003 as cited in Bottorf, 2011; Grafe et al., 2023; Rossi et al., 2010), those living with HIV/AIDS indicate cannabis consumption decreases pain, nausea/vomiting, and anxiety/depression, all symptomatic of the illness (Braitstein et al., 2001; Prentiss et al., 2004), and cancer patients have reported improved appetite and nausea reduction (Waissengrin et al., 2015).

Beyond the management of chronic illness and disease symptoms, other physical health benefits of cannabis use have also been highlighted in the literature. Studies indicate cannabis' role in the relief of nausea and vomiting (Duran et al., 2010) and insomnia and other sleep disturbances (Sznitman et al., 2020; Wong et al., 2019). Further, from a gendered perspective, research notes the benefits of cannabis to women's health, mitigating symptoms that are both common and specific to the experiences of women. For instance, there are indications that cannabis mitigates symptoms of fibromyalgia (Blake et al., 2006), joint pain and arthritis (Baron et al., 2018), migraines (Mechtler et al., 2021), Attention Deficit Hyperactive Disorder (ADHD) (Paul et al., 2020), menstrual symptoms (Lammert et al., 2018; Slavin et al., 2017) and menopause (Slavin et al., 2017).

ii) Mental Health

There is a small body of research that supports the role of cannabis in mitigating anxiety and depression (Boys et al., 2001; Ivsins & Yake, 2020), with the bulk of studies focusing on symptom relief for those exposed to trauma, and some, more specifically, focused on individuals diagnosed with Post Traumatic Stress Disorder (PTSD) (Bonn-Miller et al., 2007; Browne et al, 2018; Farrelly et al., 2022; McNaughton, 2008; Nelson, 2021; Paul et al., 2020). For example, one cross-sectional study argues that trauma-exposed individuals are more likely to consume

cannabis and in higher amounts and present motives of cannabis use as a function of emotional vulnerability factors, highlighting there are several motives for cannabis use, all of which vary between and within individuals (Bonn-Miller et al., 2007). Browne and colleagues (2018) examine the prevalence of cannabis use specifically among women veterans with experiences of sexual trauma, arguing that cumulative trauma exposure increases the prevalence of cannabis consumption (Browne et al, 2018). Despite the narrow demographic focus of the study, the authors make note of a higher prevalence of use among veterans who identified as queer, racial and ethnic minorities, unmarried individuals, and women reporting lower income, suggesting a need to examine these unique factors, perhaps both independently, and at intersecting axes of oppression (Browne et al., 2018). Both the studies by Bonn-Miller and colleagues (2007) and Browne and colleagues (2018), illustrate a correlation between cannabis use and experiences of trauma, indicating that individuals exposed to trauma are more likely to use cannabis because of its effect on mitigating the hyperarousal symptoms associated with PTSD (Bonn-Miller et al., 2007; Browne et al., 2018).

iii) The "Consequences" of Use

Despite such findings, the bulk of cannabis-related research on physical and mental health remains focused on the negative health impacts of long-term and habitual consumption. Available research documents correlation between cannabis consumption and impaired respiratory function (Hancox, 2010; Moore et al., 2005; Sachs et al., 2015; Tashkin et al., 2012; Tetrault et al., 2007), psychotic symptoms (Marconi et al., 2016; Moore et al., 2007; Onaemo et al., 2021; Patel and Hillard, 2009), cognitive impairment (Curran et al., 2002; King et al., 2011; Solowij et al., 2002), cardiovascular diseases (Mittleman et al., 2001; Sholler et al., 2021; Tait et al., 2016; Zhang et al., 1999), and addiction (Archie & Cucullo, 2019; Budney et al., 1999; Hall,

2010; Hall & Degenhardt, 2009; Haney, 2005; Kitchigina, 2021; Oleson & Cheer, 2012; Volkow et al., 2014; Zehra et al., 2018).

It is important to note that these studies do not bring into consideration the ways broader social determinants of health may have also impacted study participants, understood as the environmental, economic, and societal factors that influence health outcomes of populations (Government of Canada, 2024). The social determinants of health are the conditions in which individuals live, work, and play that impact their health outcomes, including gender, race, employment, housing status, education, and food security (Government of Canada, 2024). Since these factors impact a wide range of health, functioning, and quality of life outcomes, failing to understand, consider, and account for the determinants in relation to cannabis consumption provides an incomplete picture of the existing health inequities that present within certain populations. Further, it is likely that the findings in these studies are more appropriately linked to structural issues like inadequate food security, intimate partner violence or poverty, which are known to be factors in other drug-taking, a behaviour that occurs concurrently with cannabis use (Stengel, 2014). Further research is needed to tease out the impacts of cannabis in isolation since cannabis use often occurs alongside many other variables, and populations who regularly consume cannabis are often those negatively impacted by the social determinants of health (Hendricks et al., 2011; Muckle et al., 2011). A large portion of the available literature is focused on problematizing cannabis use and magnifying consequences of use. As a result of these deficit-focused narratives, there is also a breadth of literature aimed at mitigating the impact of cannabis consumption while offering treatment strategies to reduce or abstain from cannabis use.

2.3 Gender and Cannabis

A body of research regarding substance use more broadly considers how gender influences how substances are consumed, the physical, mental, and social impacts of substance use and effective treatment, health intervention strategies, and policies (Greaves & Hemsing, 2020).

Consuming cannabis has been framed as "morally permissible" for those with "power and social status" coupled with a marked difference in the stigmatizing of women's cannabis consumption compared to men (Haines-Saah et al., 2014; Parker, 2005). Additional features of a person's identity (e.g., sexual orientation, race, class) can compound these experiences of stigma, resulting in the normalizing of cannabis consumption for women who exist along more privileged social positions in Canadian society (Bottorff et at., 2013; Greene, 2018).

i) Gender Differences of Cannabis Use

The literature surrounding women and cannabis point to differing behavioural, clinical, and neural impacts of cannabis use (Sherman et al., 2017). Women report to use cannabis less frequently and in lower quantities than men, preferring to consume via pipe as opposed to men's preference of joints and/or vapourizers (Cuttler et al., 2016; Keethakumar et al., 2021). Women's cannabis use is also distinct from men's use in that women indicate the motives for their use is connected to treating health conditions including anxiety, nausea, chronic pain, and insomnia, as opposed to the recreational reasons reported by men (Azcarate et al., 2020; Bruce et al., 2021; Cuttler et al., 2016; Keethakumar et al., 2021). Additionally, differences exist regarding withdrawal symptoms, with women reporting greater total withdrawal severity and negative impact of withdrawal symptoms than men (Hernandiz-Avila, 2004; Khan et al., 2013; Sherman, et al., 2017). Perhaps related, are differences in treatment-seeking behaviours, with women reporting greater concern about their use and hence, more likely to seek treatment (Sherman, et al., 2017).

Despite these differences, it is the gendered norms and expectations that more profoundly impact women's usage, decision-making, motives, experiences, and context surrounding cannabis consumption (Greaves & Hemsing, 2020). Boyd's (2017; 2019) scholarship focuses on the ways gendered drug policies disproportionately penalize women, specifically those who occupy unjustly marginalized identities such as Indigenous women, racialized women, and women experiencing poverty, making them more vulnerable to violence and imprisonment as a consequence of their substance use (Boyd 2017; Boyd 2019). Other studies have gone further to conduct a gender, class, and race analysis within the context of drug policy and practice, demonstrating how the regulation of women intersects with the regulation of sexuality, pregnancy, breastfeeding, and mothering (Boyd, 1999, 2015; Campbell & Herzberg, 2017; Reinarman & Granfield, 2015, as cited in Boyd, 2019). Globally, other scholars have called attention to how drug policies and practice negatively and uniquely impact women who come into contact with health care, social welfare, and criminal justice systems, where marginalized populations of poor and racialized women are disproportionately impacted by punitive policies and practice (Amnesty International, 2017; Boiteux, 2015; Boyd, 2015; Boyd, 2017; Kensy et al., 2012; Malinowska-Sempruch & Rychkova, 2015; WOLA et al., 2016 as cited in Boyd, 2019). A few studies have begun to focus on cannabis use from a gendered lens. For example, a study by Asmussen and colleagues (2013) calls attention to the role of societal gender norms in determining under what circumstances cannabis use is perceived as acceptable. Their study explores how most substance use, including cannabis, is deemed to be a masculine behaviour (Asmussen et al., 2013; Cameron, 2023). A small body of literature also explores the ways gender and pain has been conceptualized, resulting in a bias towards treating women for chronic pain with medicinal cannabis (Hoffmann & Tarzian, 2003; Myers et al., 2003).

Some other studies seeking to examine cannabis use from a gendered lens exist, albeit many studies lack the depth of analysis required to provide an intersectional lens to examining gendered experiences, policies, and practices. One such study suggests gendered preferences for cannabis routes of administration (Baggio et al., 2014), and another argues that dominant gender norms may be reinforced or resisted through cannabis use behaviours (Haines et al., 2009). It remains, however, that this area requires considerable attention and growth in light of the high level of cannabis use among women, as well as the shifting legal climate across the globe. Current research conducted from a gendered and intersectional theoretical lens is either limited or have not been included in the body of ‘‘evidence’’ used to inform clinical practices (Dreher, 2002; Kozak, 2017; Kozak, 2022). Further, much of the existing research on women and cannabis has been situated within biomedical, public health, and social care frameworks that situate women as vulnerable to cannabis related harms and adverse health outcomes (Fattore, 2013; Hall & Degenhardt, 2014; Nakamura et al., 2011; Verdoux et al., 2003). This positions prevention and treatment planning as the most appropriate responses, and ultimately, privileges abstinence.

ii) Reproductive and Maternal Outcomes

Research on women’s consumption of cannabis has predominantly focused on the harms of cannabis consumption, specifically on reproductive, maternal health and neo-natal health, with attention focused on the impact of cannabis consumption during pregnancy, risks of transmission through breastmilk and the impact of cannabis use on parenting (El Marroun et al., 2009; Fergusson et al, 2002; Hayatbakhsh et al., 2012; Passey et al., 2014).

The rates of women who report using cannabis during pregnancy are increasing in Canada since legalization (Corsi et al., 2019; Young-Wolff et al., 2017). Motives for use during

the prenatal period are often associated with pregnancy-related nausea, anxiety, and general discomfort (Volkow et al., 2017). While there is some evidence of an association between consuming cannabis during pregnancy and preterm birth (Gray et al., 2010; Hayatbakhsh et al., 2012; Massey et al., 2018), lower infant birthweight (Haight et al., 2021), lower Apgar scores (Conner et al., 2016), stillbirth (Conner et al., 2016; Metz et al., 2017), and admission to a neonatal intensive care unit (NICU) (Hayatbakhsh et al., 2012), many other studies have concluded that the association between prenatal cannabis use and adverse outcomes becomes almost negligible when tobacco, alcohol and other substance use is accounted for (Crume et al., 2018; Fergusson et al., 2002; Ko et al., 2018). Furthermore, these studies do not consider the ways participants are impacted by broader social determinants of health already known to produce poor maternal and newborn outcomes. (Alhusen et al., 2013; van Gelder et al., 2010). Those who consume cannabis during the perinatal period are often impacted by other 'risk' factors including financial stress, domestic violence, illicit substance use, mental health disorders, and/or fewer prenatal visits (Passey et al., 2014; Ryan et al., 2018).

While some evidence exists that suggests that tetrahydrocannabinol (THC), the psychoactive ingredient in cannabis, transfers to the breastmilk of mothers (Marchei et al. 2011; Ryan et al., 2018), the impact this has on the infant remains unclear (Ryan et al., 2018). Very few studies have demonstrated the effects on infants exposed to THC via breastmilk, and of those attempts, results are extremely limited as the studies did not control for other substances, contained small sample sizes, were outdated, and/or included only self-selecting breastfeeding participants (Astley & Little, 1990; Graves et al., 2022; Tennes et al, 1985). In the absence of reliable data to inform decisions about breastfeeding and cannabis use, consumption during

lactation and breastfeeding is discouraged out of caution until more conclusive data can suggest otherwise (Graves et al., 2022; Ryan et al., 2018).

Currently, Canadian public health and other health and social care guidelines regarding cannabis during pregnancy and breastfeeding promote abstinence due to risks and harms to the fetus or infant (Public Health Ontario, 2018). Therefore, the dominant response of medical professionals is to minimize and manage risk, enacted through formal and informal actions and protocol via health care and social service providers' interactions with pregnant women (Kozak et al., 2022). It is argued that when the focus of cannabis consumption is solely on the possible risk and adverse effects of cannabis on the health of women and their children, the result is increased surveillance of women's pregnancies and mothering practices (El Marroun et al., 2009; Fergusson et al, 2002; Hayatbakhsh et al., 2012; Passey et al., 2014).

iii) Gender, Surveillance, and Stigma

Given the shifting legal landscape in Canada, research at the intersection of cannabis, pregnancy, breastfeeding, and motherhood demonstrates growth in medical, health, and social care domains (Greene, 2018). Although timely and important, a consequence of this intense focus may also contribute to the surveillance of women's pregnancies and mothering practices which leads to stigmatization (Greene, 2018; Passey et at, 2014).

Stigma is a social construct that uses dominant attitudes and messaging to label individuals with negative attributes (Goffman, 1963; Link & Phelan, 2001). Stigma is a form of oppression that reinforces social inequalities including gender inequality (Goffman, 1963). There is research to suggest a reoccurring theme of stigma that relates to women's and mother's cannabis consumption despite its increasing normalization (Greene, 2018). Women who break the gender norms and expectations of what it means to be a 'good mother' especially during

pregnancy, become labeled as 'risky' by health and social care providers, and subjected to increased monitoring and control (Campbell & Ettorre, 2011 as cited in Stengel, 2014). Surveillance has served to stigmatize women and construct their behaviour as the cause for anything that could go wrong during and after the pregnancy (Stubber & Myer, 2008). Women often avoid seeking treatment altogether, out of fear; fear of acquiring a stigmatizing label (Link and Phelan, 2006), and fear of child removal (Davis & Yonkers, 2012), and in contexts where cannabis remains illegal, fear of incarceration (Friedman et al. 2009; Marcellus, 2004).

Studies have found that internalized negative feelings about cannabis consumption during pregnancy is a common barrier that prevents women from accessing health and social care services and being honest with their health and social care providers about their needs (Campbell & Ettorre, 2011; Greene et al., 2023; Macrory & Boyd, 2007, Poole & Isaac, 2001). In a study by Stengel (2014), the author examines the ways in which risk is both constructed and managed by service-providers supporting in the pregnancy and childbirth of women who use illicit and licit drugs (Stengel, 2014). The participants indicate that surveillance both reinforced and reminded them of the stigmatizing label bestowed on them due to their drug use while pregnant, and further manifested into an internalized stigma (Stengel, 2014). Another study by Greene and colleagues (2023), found that fear and stigma prevent pregnant, breastfeeding women and mothers from accessing cannabis information and support from their care providers (Greene et al., 2023). Importantly, this work highlights the need to develop health and social care responses that are grounded in the lived experience of women and mothers and does so by employing an intersectional lens to examine the complexities of overlapping identities (Greene et al., 2023).

These experiences of stigma are confounded by women and mothers who have historical experiences surveillance within healthcare, criminal justice, and child welfare systems (Greene,

2018; Greene et al., 2023). It has been widely documented that Black and Indigenous mothers and mothers with histories of poverty, child welfare involvement, and who experience mental health challenges and addiction, are particularly vulnerable to surveillance and risk-based assessments which influence maternal care outcomes and understanding of choice (Blackstock et al., 2006; Boyd, 2019; Davis, 2019; Greene et al., 2014; Stengel, 2014). It is, therefore, not surprising that within such systems that promote abstinence, that women and mothers will choose discretion regarding disclosure (Greene et al., 2023). Cannabis use remains a concern for women and mothers and has become another axis of identity on which women who are pregnant, breastfeeding, and mothering experience stigma (Bottorff et al., 2013), with the potential to create barriers to health and social care services (Holland et al., 2016; Stengel, 2014).

2.4 Harm Reduction

Harm reduction is a model aimed to reduce the negative health, social, and legal consequences associated with drug use (Harm Reduction International, 2022). Grounded in a social justice and human rights approach, harm reduction encompasses a range of strategies and ideas that exist apart from the sometimes unrealistic or undesirable approach of abstinence (Harm Reduction International, 2022). Research suggests that cannabis has the potential to reduce illicit drug use related harms, achieved through substitution, whereby intentional cannabis consumption is used to decrease one's reliance on another more harmful substance (Duhart Clarke et al., 2024; Larnder et al., 2022; Valleriani et al., 2020).

Several studies have illustrated the potential of using cannabis as a harm reduction tool. For example, Dreher (2002) found that women in Jamaica who used cannabis in conjunction with crack-cocaine reported a reduction in frequency of crack-cocaine use (Dreher, 2002). In another study, Kral and colleagues (2015) investigated the impact of cannabis on individuals

who use opioid drugs intravenously, arguing that frequency of use decreased when substituting opioid use with cannabis (Kral et al., 2015). Even when cannabis substitution is not an intentional attempt to lessen illicit drug use, there may be indirect positive effects such as reduced cravings and withdrawal symptoms (Goncalves & Nappo, 2015; Wrenger et al., 2014). A study by Lau and colleagues (2015) aimed to understand participant decision-making processes when using cannabis as a harm reduction tool for illicit drugs, alcohol, and pharmaceuticals (Lau et al., 2015). Unlike many other studies, the authors sought out participant perspectives and experiences, suggesting that not only is cannabis substitution an effective harm reduction method in the case of all three substances, but that self-determination is paramount (Lau et al., 2015).

In addition, research demonstrates decreased prescription medication use, particularly opiates, when using cannabis as a substitute (Boehnke et al., 2016; Corroon et al., 2017; Denduluri et al., 2021; Reiman et al., 2017). Peters (2013) found that individuals using medical cannabis reported an increased ability to wean from prescription opioids with some participants preferring cannabis over opioid based medications due to its pain-relieving properties (Peters, 2013). Unfortunately, most research has drawn on male participant experiences involved with medical cannabis rather than recreational cannabis, given Canada's relatively recent legalization. An in-depth understanding of cannabis substitution as a harm reduction strategy may provide insight into strategies that aim to minimize risks of other drug use and misuse (Lau et al., 2015). Further research is needed on cannabis substitution beliefs and practices and potential harm reduction benefits from a gendered framework, that centres the lived experiences of women who consume cannabis (Lau et al., 2015).

2.5 Concluding Reflections on the Available Literature

Upon reviewing the literature surrounding cannabis, it is evident that the research is male-dominated, deficit-focused, and relies heavily on a positivist framework. Very few studies explore the perceived benefits that cannabis use has in the lives of women, particularly those who are marginalized. The lived experiences and voices of women who consume cannabis, especially those occupying marginalized axes of identity, are largely absent in both research and within the broader cannabis industry (Greene, 2018). Positioning women's voices at the centre of this research will enable us to explore these important issues with an aim of creating new knowledge that can inform social work, allied professional policies, and practices to serving women (Greene, 2018). Designing gender-specific health and social programs and policy at the intersection of cannabis and gender, requires that women's needs, and perceptions be incorporated into the evidence as a legitimate source of knowledge (Stengel, 2014).

The substantive gaps in the literature raise important questions about how cannabis legalization will benefit women who identify with particular social identities, particularly those who bump up against stigmatizing practices and policies that regard their cannabis consumption as problematic (El Marroun et al., 2009; Passey et al., 2014). Also of interest, is how these women are perceived, represented, and treated regarding their cannabis consumption through existing social work and allied health and social care practices (Greene, 2018). Without an intersectional analysis of how the experiences of our identity impact decisions around cannabis consumption, our ability to address the complexity of risk behaviour within the context of people's lives is limited.

Chapter 3: Theoretical Framework and Methodologies

The current study is grounded in the theory of intersectional feminism. To situate this research project, the broader context of critical feminist theories will first be discussed. I will then speak to the evolution of intersectional feminism, why this framework is best suited for this research project, and the epistemological and ontological views that underpin it. Lastly, I will discuss the methodology of Feminist Participatory Arts-based Research (FPAR) and the way it was used throughout my thesis.

3.1 Critical Feminist Theories

Critical feminist theories encompass a broad range of knowledge. Feminist theories were initially a site to critically interrogate gender roles and end sexist oppression, recognizing that the concept of gender is both socially constructed and organized hierarchically in society (Cailoa et al., 2014; Grasswick, 2023; Hesse-Biber & Leavy, 2007). Critical feminist theories examine the social, political, and economic forces of women's lives, and consider how these factors shape women's unique perspectives and experiences (Caiola, et al., 2014; Hankivsky, 2012). Since their development over the past few decades, critical feminist theories have expanded beyond gender-based power and inequality, to examine other, intersecting variables of one's social identity (such as race, class, sexual orientation, ability, etc.), while simultaneously considering the influence of structural forces, social relationships, and power differentials (Collins, 2000; Grasswick, 2023; hooks, 1984). Today, critical feminist theories no longer operate on a sole focus of gender, and rather, consider multiple axes of oppression (Grasswick, 2023; hooks, 1984). Critical feminist theories can support individuals to see themselves and their oppressive social systems more clearly, reflecting feminisms key slogan, 'the personal is political' (Freire, 2018/1970; Maguire, 1987).

3.2 Intersectionality

Situated within a critical feminist theory, is the concept of intersectionality, a framework aimed at addressing the narrowly constructed feminist theories in which the experiences of white women of privilege dominated (Grasswick, 2023). Intersectionality brings forth a consideration of the complexities that accompany unequal social, political, and economic power distributions (Caiola et al., 2014). It challenges the idea of gender as the primary dimension of inequity; rather, it asserts that multiple dimensions can and do shape social inequality (Caiola, et al., 2014; Hankivsky, 2012). As an approach to analysis, intersectional feminism considers how particular identities and conditions are located within structures of power, that both overlap and co-exist, to understand experiences of both oppression and privilege (Caiola, et al., 2014; Morali & Grzanka, 2017). Within the context of cannabis consumption, an intersectional feminist lens strengthens considerations of how other aspects of one's identity influence their perspectives, experiences, and motives surrounding cannabis use, and how this translates to their disclosure (or lack thereof) to healthcare and social service providers. An intersectional approach offers a more comprehensive understanding of the multiple aspects of one's social identity that shape their lives by challenging single identity politics, rejecting the homogeneity of experiences, and expressing the limitations to separating experiences of oppression, as they are often experienced simultaneously (Collins, 2000; Combahee River Collective, 1974; hooks, 1984).

Like all women, the women in this study occupy various social positions based on their identities, none of which can be examined in isolation. A multi-dimensional analysis, as claimed by intersectionality, would seek to understand participant experiences beyond gender alone, and instead consider the complexity of how multiple aspects of their identity overlap and intersect to create unique experiences and perspectives regarding their cannabis consumption. Moreover, an

intersectional approach to this research would highlight the ways in which the women's social conditions are implicated within institutions such as health care, child welfare, and social services, as well as broader structures, including not just patriarchy, but racism, heteronormativity, ableism, classism. An intersectional approach to understanding women's experiences with consuming cannabis provides the intellectual tools required for examining the injustices experienced by women who are marginalized among multiple axes of social positioning and offers a complexity of inquiry that matches the complexity of social forces shaping those inequities (Caiola, et al., 2014).

Intersectionality must be understood through the concept's evolution, and the accompanying historical and contemporary marginalization of intellectual contributions from women of colour (Collins, 2000; Morali & Grzanka, 2017). Before the concept of intersectionality was popularized, there is extensive history of its use as an analytic and political tool beyond North American contexts (Hancock, 2007; Hankivsky, 2014). Its origins have been located among Black feminists, Chicana and other Latina feminists, Indigenous feminists, and Asian American feminists (Collins, 2000). Evidence of intersectional theorizing originated in the 1970's as Black feminist scholars and activists sought to address the limitations of the mainstream women's liberation movement through the development of a more comprehensive understanding of the multiple aspects of one's social identity that shape their lives (Collins, 2000; Combahee River Collective, 1974; hooks, 1984). Black and racialized feminists and social justice advocates challenged single identity politics, particularly the narrow focus on gender in feminist movements and on race in civil rights movements (Morali & Grzanka, 2017). In their statement, the Combahee River Collective refer to their commitment to struggle "against racial, sexual, heterosexual, and class oppression, and see as (their) particular task, the development of

an integrated analysis and practice based upon the fact that the major systems of oppression are interlocking" (The Combahee River Collective, 1974, p.1). Black feminists and advocates rejected the homogeneity of experiences and expressed the limitations to separating experiences of race, class, and sex oppression, since they are inextricably linked and often experienced simultaneously (The Combahee River Collective, 1974).

Despite this early theorizing, the term 'intersectionality' was not coined until later, by legal scholar and rights advocate, Kimberle Crenshaw (Crenshaw 1989; Crenshaw 1991). Crenshaw used the term to conceptualize an analysis that accounted for the discrete set of experiences that accompany multiple oppressions in a way that could not be accurately reflected by a single-axis framework (Crenshaw, 1989; Crenshaw 1991). She used the term to describe how Black women's experiences of the unique combination of racism and sexism were obscured by treating race and sex discrimination as separate matters in United States law and in feminist and antiracist activism (Crenshaw, 1989). Crenshaw described how earlier feminist efforts politicized experiences of racism and sexism as mutually exclusive, neglecting the complexities that surface when considering both dimensions in tandem, explaining how experiences of Black women are often left out of discourses of both feminism and antiracism, marginalizing them within both spheres (Crenshaw, 1989). Patricia Hill Collins, expanded on intersectionality to address the systemic aspects of intersectionality, describing it as a structural 'matrix of domination' in which multiple forces of oppression and privilege are mutually dependent and situated within cultural and historical contexts (Collins, 2000). Collins' intersectional theorizing challenged universalism by acknowledging inherent diversity, describing how social roles are embedded in the social context from which they arise (Caiola, et al., 2014; Collins, 2000).

Today, intersectional feminist theory conceptualizes identities as shifting and multiple, offering an alternative to previous static conceptualizations, while aiming to capture the complexity and multiplicity of axes of oppression (Caiola, et al., 2014; Carbin & Edenheim, 2013). Intersectionality is a framework to help one understand how systems of power are not mutually exclusive, but rather, co-exist, requiring a fulsome analysis that scrutinizes not just experiences of marginalization, but makes visible, experiences of privilege as well (Morali & Grzanka, 2017). In many ways, intersectionality is an explanatory conceptual framework and an effort to address social inequality based on intersecting social constructions, manifested at both the individual and population levels and a means by which to promote social justice (Morali & Grzanka, 2017; Mullings & Schulz, 2006).

Intersectional feminism has informed my thesis by rejecting the reduction of the women into one social category with shared experiences and characteristics, and instead, emphasizing the difference and diversity that result from the intersecting experiences of multiple positionalities. These experiences ultimately inform women's decisions-making processes, including their perceptions of cannabis use and disclosure, and the complexity of these intersections must be considered to allow for a more fulsome, and critical analysis. Further, an intersectional feminist lens promotes an appreciation for the women's experiences within a larger social, legal, and political context by attempting to untangle and interrogate the intersection of identities within structures of oppression and discrimination (Caiola et al., 2014; Crenshaw, 1989). This was a necessary step for the women in this study who have complex histories of involvement with structures and the processes of power. Central to intersectionality, is the exploration of experiences that are shaped and perpetuated by hierarchical structures and power differentials that benefit dominant groups and in turn, marginalize subordinate groups

(Hankivsky, 2014; Weber, 2006). As such, an intersectional feminist lens was well-suited to investigate the experiences of the women and provide a more nuanced and complex understanding of identity beyond category binaries, and the implications this has on their experiences with cannabis use and disclosure (Nash, 2008).

3.3 Epistemology and Ontology

I was especially drawn to feminist theory as a conceptual framework for this project, primarily due to its epistemological stance. Feminist theories, and specifically, intersectional feminism, originated as a response to androcentric biases in research methods and theories, whereby the male perspective of the social world was presented as the human experience (Maguire, 1987). Knowledge production, therefore, became monopolized by specific individuals, within specialized and regulated research industries, and within the field of natural sciences (Maguire, 1987; Neuman, 1997). As a result, women's experiences have historically, and continue to be, relegated to the periphery. Feminist theory challenges this bias by centring the lived experience of women, and hence, sharing the creation of social knowledge. As mentioned, this goes beyond the inclusion of the voices of women, to include those experiencing various forms of oppression as well, privileging the voices of the women at the margins and placing greater value on their knowing than those situated in more privileged positions. This approach is particularly relevant to the current study, since cannabis use too, is normalized for both men, and women occupying privileged positions in society (ie. white, middle-class). By centring the voices of women who occupy more marginalized positions in Canadian society, greater insights may be gained surrounding their motives for use and their manifestation within broader institutions and structures.

Moreover, feminist theorizing rejects the positivist paradigm that argues that there is one single and objective reality (Hesse-Biber & Leavy, 2007; Neuman, 1997). Positivism recognizes only observable phenomena and is uninterested in the origins of such information, neglecting the critical aspects of the human condition that cannot be measured or observed (Maguire, 1987; Mason, 2002). Instead, intersectional feminism rejects a universal truth by adopting a relativist approach, making claim that truths are subjective and multiple and illustrating how we come to know our own experiences through the experiences we share with one another (Longino, 2002; Mason, 2002; Nelson, 1990; Neuman, 1997). Social reality is socially constructed and subjective; experiences are far too complex and nuanced, and therefore, cannot be easily reduced to measurable variables (Maguire, 1987; Neuman, 2003). This stance aligns with my views as a researcher as it emphasizes the multiple meanings that can be attributed to a single phenomenon, all of which are significantly influenced by beliefs, identities, experiences, values, culture, ideology, and positionality.

3.4 Methodology

i) Feminist Participatory Arts-Based Research (FPAR)

I have drawn on principles of Feminist Participatory Arts-based Research (FPAR) as an overarching methodological tool to inform this project. This approach to research is rooted within a critical feminist framework that centres the lived experience and participation of women in research orientated towards social change. FPAR is both a conceptual and methodological framework in which knowledge is co-produced through participant engagement in a research process that is explicitly action-oriented (Salmon et al., 2010; Kesby, 2008). FPAR combines feminist theories with principles of participatory action research (PAR), generating a space for

meaning making and knowledge production at both personal and collective levels (Goessling, 2024; Cahill, 2007).

Lived experience is taken as the starting point for investigation, knowledge produced through collaboration is highly valued, and through the process, new subjectivities, and other possibilities of being in the world surface (Cameron & Gibson, 2005; Fine et al., 2001). In my thesis, this approach was integrated into both the art-making process as well as the sharing circles of the body mapping workshops, as the women shared their personal stories and actively participated in the art-making process to reflect their experiences and perceptions about cannabis. The creation of new knowledge and meaning are evidenced as the women in this study related to one another's stories, allowing each participant to build and expand on their own experiences, creating a shared space which the broader topics of cannabis use are constructed. Through this collective participatory process, a critical consciousness was created amongst the women, as they recognized that some of their shared experiences move beyond the individual level and were impacted by power imbalances, systems, and structures. FPAR provides a space for participants to investigate their own everyday lives and concerns, and collectively identify aspects of shared individual experiences that have social and political implications (Cahill et al, 2010; hooks, 1995).

FPAR encourages participants to move beyond shared experiences towards the creation of common meanings, to then forge collective action together as they work towards new understandings (Park, 2001; Frisby et al., 2005; Frisby et al., 2009). In this context, action refers to the production of new, practical knowledge that is produced through a process of inquiry (Reason & Bradbury, 2001). While the current project does not directly involve social change 'action' as is asserted by the principles of Participatory Action Research (PAR), the production

of new, practical knowledge vis-a vis the body mapping workshops remains useful to the women in the everyday context of their lives and is achieved in participation with one another (Reason & Bradbury, 2001). It is not just the development of new practical knowledge, but the ability to create knowledge, that leads to emancipation which becomes the 'action' for the women in this study (Reason & Bradbury, 2001). In fact, the feminist practice of consciousness-raising can be a form of action as the practices and structures of domination are directly challenged through the process of collective inquiry (Maguire, 1987).

For many years, women worldwide have used the arts to develop new knowledge, pose problems, and share their stories and experiences (Clover, 2011). While there is considerable variation among arts-based participatory research due to diverse participants, forms of representation, and the range of descriptions, interpretations, and meanings derived through the process, arts-based methodologies offer many benefits to feminist research (Finley, 2012). Using arts-based methodologies with women through FPAR, is a useful strategy to promote dialogue and explore the nuances of lived experience as they have the potential to deepen and share aspects of the human condition (Greene, 2018). An arts-based approach to this research project elicits the "creative intelligence of the women, develops knowledge through artistically expressive forms, and generate the kind of empathy, curiosity and attention that renders 'action' possible" (Clover, 2011; Finley, 2008; Foster, 2007; as cited in Greene, 2018, p. 3). Using art as a vehicle to share the narratives of women who consume cannabis, encourage their participation and engagement with one another, and promote action-oriented social change, aligns with an intersectional feminist theoretical framework (Greene, 2018).

Chapter 4: Methods

Within this section, I offer a review of the history of body mapping, the method used throughout my thesis. I reflect on the alignment of body mapping as a method, within research committed to mobilizing an intersectional feminist framework. Following this, I discuss the process for recruitment, consent, confidentiality, and compensation. The final section of this chapter explores how this research was mobilized through a trauma-informed lens, that was responsive to the intersecting identities and unique needs of the participants in this study.

4.1 Body Mapping: A History

The first documented use of body maps can be found in Mac Cormack and Draper's (1987) work that investigated fertility rates in rural Jamaica, but arguably, people have been exploring ways to visually represent themselves since the beginning of humanity (Mac Cormack & Draper, 1987; de Jager et al., 2016). Body mapping was subsequently developed as both a therapeutic and artistic process by artist, Jane Solomon, and clinical psychologist, Jonathan Morgan (Solomon, 2007). Solomon and Morgan were both from South Africa, and the body mapping process was originally created as an advocacy strategy for the 'Long Life Project' to bring attention to the issue of HIV/AIDS in Cape Town South Africa and to counteract stigma and fear by recognizing personal stories (Solomon, 2007). The method evolved from the Memory Box Project, a therapeutic approach for women with HIV/AIDS to record their stories and provide a keepsake for their loved ones in a handmade memory box as preparation for death (de Jager et al., 2016; Gastaldo et al., 2012). The technique was adapted to create body maps that reflected on individuals' experiences of living with HIV/AIDS, incorporating participant narratives into the process (Gastaldo et al., 2012). Body mapping has since become a research tool for all kinds of storytelling, supporting individuals to depict their journeys through both narrative and art

(Solomon, 2007). Body mapping as a research method has been used to explore a variety of phenomena related to the body, health, and social processes/issues such as adolescent sexuality (Mwaluko, 2002), eating disorders among women experiencing chronic pain (Brett-MacLean, 2009), employment among racialized groups (Wilson, 2011), women who have undergone forced sterilization (Stevens & Le Roux, 2011), the effects of agricultural labour on the bodies of children (Gamlin, 2011), domestic violence and healing (Lu & Yuen, 2012), the criminalization of HIV and AIDS (Greene et al., 2021), and experiences of immigration (Gastaldo et al., 2012) to name a few. Body mapping is a research method that has therapeutic, artistic, and political roots.

4.2 Body Mapping: A Method

Body mapping is a specific arts-based method involving the process of creating a life-sized image of one's body that includes shapes, images, colours, and symbols to visually represent their life story (Gastaldo, 2012). Body mapping involves tracing around a person's body to create a life-sized outline that is then drawn, painted, and written upon in a contemplative and creative process that assists the maker in reflecting upon, and expressing, their lived and embodied life experiences that represent multiple aspects of their life (Boydell, 2021)

Along with developing the body mapping method, Solomon (2002) also created a facilitators guide, outlining the process and sequence of artmaking exercises. For the purposes of this study, the facilitators guide was adapted to reflect participants' lived experience with consuming cannabis and their interactions with health and social service providers (Appendix A). The adapted facilitators guide included sixteen prompting exercises which involved drawing, painting, visualization, talking in groups, sharing, and reflecting, through which art was used to tell life's stories and promote self-exploration (Greene, 2018). The exercises prompted

participants towards the artmaking component of their body map, contributing to an understanding of the lived experiences of women, trans, and gender diverse individuals who consume cannabis (Greene, 2023). Within this project, the body maps were used to guide group discussions into experiences of cannabis consumption and were complimented by sharing circles as participants provided a narrative to the description of the art created on their body maps. The workshops took place in a group setting where "participants supported and inspired each other as they reflected on their own lives, personal journeys, relationships, and experiences relating to cannabis use" (Greene, 2023, p.3).

Solomon's (2002) body mapping guidelines include three elements: a visual body-map a 'testimonio' or short first-person narrative; and a key to interpret the symbols and slogans on the body-map (Appendix B). The visual body map is the life-size artwork produced through the process (Solomon, 2002). A testimonio is a brief first-person narrative about the participant after the completion of the body map, providing a broad description of their life and experiences with cannabis consumption, providing context to their story conveyed in the body map (Gastaldo et al., 2012: Solomon, 2002). Finally, the body map key describes each element of the map and connects images and symbols with their corresponding exercise prompts (Gastaldo et al., 2012: Solomon, 2002).

4.3 Workshop Program

The body-mapping method developed by Solomon (2002) involves several arts-based, reflective group workshops held over numerous days or sometimes weeks (de Jager et al., 2016; Solomon, 2002). In this study, workshops occurred over a four-day period with a semi-structured plan based on the adapted facilitator's guide. As we got to know the group and their individual needs,

the number of activities planned each day was tailored. An outline of the workshops is as follows:

i) Day One: Opening Ceremony 2pm to 7pm

The research team gathered to prepare the space and art materials. Body map paper was pre-cut and rolled out. Participants were welcomed by the team at which point the letter of information was reviewed and discussed and participant consent forms (Appendix C) were signed. A demographic questionnaire (Appendix D) was completed with assistance from the research team as needed. Participants were given an opportunity to ask questions and/or clarify the process of what they could expect over our four days together. The history and purpose of the body mapping method was introduced as well as a general overview of the Women, Art, and Cannabis Study. The group of women then established shared guidelines and expectations for the course of the workshop, generating a list of considerations to create a safe and comfortable workshop space. This included considerations around taking lots of breaks, limiting noise during art making, and maintaining group confidentiality by not sharing what was said outside of the body mapping workshops.

Participants were then oriented to the art supplies, demonstrating their use, techniques, and how they appear on the body mapping paper. We began by spending time discussing colour, including the meanings we associate to particular colours and co-developed a colour wheel, with words and associations written beside various colours. This remained on display for the duration of the body mapping workshop. Following the colour wheel creation, we began with **Exercise 1**, 'Body Tracing' with a partner. During this exercise, participants follow the outline of their body and create a shape on their paper with which to work for the duration of the process. A second outline is drawn, with a variation to the first, representing their support figure which will become

relevant in future exercises. Participants then began **Exercise 2**, 'Highlighting Your Body Shape', using a favourite colour or one of meaning. At this point, the body maps were left to dry overnight while the group ordered in dinner. We continued to build rapport and learn about one another as we shared a meal before ending the evening.

ii) Day Two: Artmaking and Sharing Circles 9:30 am to 4pm

Day two began with a catered breakfast. We shared a meal together and continued to get to know one another. The session was opened by explaining the outline of the daily agenda, ensuring participants knew what to expect and could ask any remaining questions. Following this, we opened the day with an affirmation card reading in which participants pulled affirmation cards, and shared aspects of themselves in a light-hearted manner.

We began the body mapping workshop with **Exercise 3**, 'Drawing Where You Come From', **Exercise 4**, Exploring the Future', and **Exercise 5**, 'Drawing Life's Distractions and Obstacles' before participating in a sharing circle where colours, symbols, and meanings of each body map were described by participants. We then broke for lunch in which participants selected their meal choice from a restaurant chosen by the group. Following lunch and a 30-minute break, participants continued with **Exercise 6**, 'Strengths', **Exercise 7**, 'Finding a Symbol to Show Using Cannabis', and **Exercise 8**, 'Painting Your Support Shadow' which ended our days artmaking. The group engaged in another sharing circle to reflect on the afternoon's exercises. Multiple breaks were offered throughout the duration of the day's activities, along with plenty of snacks and refreshments. The research team became aware of time limits and at this point, decided to remove specific exercises from the following day's agenda. This was a direct response to participant needs as they required more breaks than we had anticipated and were taking more time with the artmaking processes than we had scheduled for.

iii) Day Three: Artmaking and Sharing Circles Continued 9:30 am to 4pm

Day three began with another breakfast, with participants selecting their meal in advance. Another opening session was used to ground the day's events, this time structured around a colour wheel exercise where participants selected a colour card of their choice and its meaning shared with the group. The group began with **Exercise 9** 'Support Systems' and **Exercise 10a and 10b**, 'Power Point and Power Symbol'. After a short break, the group reconvened to engage in a brainstorming session about the connections between cannabis and wellness, creating a list throughout the process. We discussed various elements of wellness including physical wellness, emotional wellness, spiritual wellness, sexual wellness, and reproductive wellness and how cannabis facilitates and/or obstructs these components of one's wellness. Participants were prompted to depict their experiences with each or any element of wellness on their body maps, some choosing to represent one or two elements, and others representing them all. We completed the morning with a sharing circle where participants gave testimony to their body map, explaining their choice of colours and symbols.

We then took a break for lunch and shared a meal together and informal conversation. After lunch, the group returned to complete **Exercise 12**, 'Health and Social Services for Women, Trans, and Gender Diverse People who use Cannabis', **Exercise 13**, 'Disclosing Cannabis Use', and **Exercise 15,** 'Creating a Personal Vision/Message for Health and Social Services for Women, Trans, and Gender Diverse People who use Cannabis', before closing the day's artmaking with a final sharing circle. In response to time constraints, **Exercise 14,** 'Impacts of Disclosure in a Context of Legalization' was omitted altogether.

iv) Day Four: Gallery and Celebration 9:30 am to 12:30pm

On the final day, the research team arrived early to arrange participant body maps into a gallery-style arrangement, so that upon their arrival, participants were presented with a mounted display of their artwork. A final meal was provided to the group as we welcomed participants to the final day of the workshop. We engaged in **Exercise 16,** 'Art Gallery and Honouring Participants', an opportunity for participants to receive feedback from others about their lives, their special qualities, and their body map as a way of honouring their contributions. Blank cards were distributed to the group, with instructions to comment on "what they see" when looking at and enjoying each other's body map. Once everyone had a chance to view the gallery and reflect on the body maps, the participants and the research team each took turns reading the words written on the card and in doing so, honouring each individual, their artistic creation, and the inspirations that were expressed through each body map.

There were many tears shed during this final exercise and we left with tremendous gratitude for the experience that we had all shared with one another. This final sharing was not audio-recorded but rather, a celebration of the work of each participant. It was not part of the data collection activities.

4.4 Body Mapping: A Method to Mobilize Intersectional Feminist Theory in Research Praxis

Intersectionality offers a lens to understand how social positionings impact and differentiate women's' experiences while also considering how particular identities are influenced by structural forces, unequal social relationships, and power imbalances (Caiola et al., 2014; Crenshaw, 1989; Greene, 2018). An intersectional approach to understanding women's experiences with cannabis consumption provides the tools to examine, confront, and disrupt these influences for women who are marginalized among multiple axes of social positioning (Greene, 2018).

As a method, body mapping aligns with a feminist participatory art-based research approach as it encourages women to confront dominant social norms and expectations assigned to their bodies and experiences (Greene, 2018). Through the process of body mapping, participants were able to critically examine the meaning of their unique experiences and tell their own story about their lives, experiences, and visions for social change (Gastaldo et al., 2012).

Gaunlett & Holzwarth (2006) describe the methodology as one that "enables people to communicate in a meaningful way about their identities and experiences… through creatively making things themselves, and then reflecting upon what they have made (Gaunlett & Holzwarth, 2006, p. 82). Aligned with intersectional feminism, body-mapping has its roots in political activism, privileging and making visible otherwise oppressed or obscured perspectives (Gastaldo et al., 2012). In cases where the phenomenon in question is associated with stigma, as remains the case with cannabis consumption particularly within certain groups of people, body mapping facilitates participants reclaiming or creating a preferred perspective, thus bringing into question negative assumptions inherent in dominant narratives or ways of seeing (de Jager et al., 2016). Body mapping is a mode of participatory research and awareness raising with the potential to engage and enable its participants to communicate creatively through a deeper, more reflexive process with varying degrees of a social justice agenda (de Jager et al., 2016; Gastaldo et al., 2012).

Body mapping is a strengths-based methodology that positions participants in a positive manner (Gastaldo et al., 2012). The process, particularly in conjunction with an intersectional feminist underpinning, highlights participant's strengths and expertise and works to balance power in the research-participant relationship. This is particularly relevant for women who have

traditionally been excluded from knowledge co-production and whose voices and perspectives have been silenced.

When researching with communities who face barriers to participation, it is important to note that body mapping is also a flexible process, where exercises are not contingent upon one another and therefore, the process can easily continue if an exercise is not completed, for instance, as a result of participant absence or discomfort with a specific prompt. This proved to be the case in both workshops where participants left the workshop for a break and did not return for the remainder of the day's workshop activities. In such circumstances, facilitators would either work with participants to catch them up on the missed artwork individually or bypass several exercises altogether. In a methodological context, flexibility also refers to the manner in which participants portray their story, and because body mapping is comprised of the three data components, there is variation that occurs in the ways participants choose to express their narratives and experiences.

Similar to other creative research methods, body mapping allows for a deeper and more reflective engagement since the process occurs often over several days (Gaunlett & Holzwarth, 2006). By having the workshops occur of the course of a few sessions, participant engagement is lengthened, and issues are contemplated in a different way than a brief interview might allow. This resonates with the narrative therapy practice of "loitering with intent" in which the process of producing artwork typically takes longer than a verbal interview, encouraging participants to linger longer, reflecting more deeply on the research topic (White, 2007; White & Epston, 1990). This is particularly relevant for participants of this study, since the legalization of cannabis is relatively recent, and they, therefore, may still have reservations with speaking candidly about their experiences with consumption. Further, it was challenging for participants to

verbally express themselves at times, and so, having alternative means of communicating their ideas, experiences, meanings, and feelings amplified their voices and produced quality data in the process (Gastaldo et al., 2012). As stated by Gaunlett & Holzwarth (2006), the method offers "a positive challenge to the taken-for-granted idea that you can explore the social world [by] just asking people questions, in language (Gaunlett & Holzwarth, 2006, p. 83-84). Finally, body mapping is an ethically appropriate method for data generation given that body maps help "maintain anonymity by not exposing the individual, while at the same time making participants visible as full human beings engaged in society, by showing their hidden trajectories through art" (Gastaldo et al., 2012, p. 13).

4.5 Recruitment

Participants were recruited from within the YWCA Hamilton, a multi-service organization that provides a low barrier overnight drop-in program and transitional living program for women, trans and non-binary people experiencing homelessness.

As an initial step, an informal gathering was hosted at the YWCA Hamilton, which was referred to as 'Coffee and Conversations'. This was an opportunity for the research team to meet with the women and gender diverse people who access YWCA Hamilton, share a meal together, and provide information about the nature of the study, answering questions and/or concerns from attendees. Following the session, recruitment posters (Appendix E) were placed around the building for a two-week period. A screening questionnaire (Appendix F) was conducted by the research coordinator at the time that participants contacted them to express interest in participating in the study. The screening process provided information to prospective participants about the four-day body mapping workshop. Following the completion of the screening process, information was shared with members of the research team who made the final decision

regarding participation. Requirements for participation include self-identification as woman (trans-inclusive) or non-binary, ability to speak and comprehend English, and consumption of cannabis in some form during the past year (i.e., smoking, vaping, ingesting consumables, use of oils, etc.). Additionally, participants had to be able to commit to attend the four-day workshop held at YWCA Hamilton.

4.6 Consent

The Letter of Information (Appendix C) was read to each participant during the initial pre-screening process. This was then reviewed a second time collectively, prior to the start of the workshop. All participants were offered the opportunity to ask questions before providing written informed consent (Appendix C) for their participation in the four-day body mapping workshop. Participation was voluntary, and individuals had the ability to withdraw from the research study at any point without consequence or impact to the services and/or resources they were receiving, nor were they required to reimburse any honorariums they had received. Participants were offered a signed copy of their consent form. Upon completion of each workshop, consent related to the photographing of participants' body map was reviewed again to ensure they agreed to share images of their body map.

4.7 Confidentiality

The protection, privacy and security of participant information was approached with great care. Participants discussed the importance of maintaining one another's confidentiality during the first day of the workshop when we worked to collectively establish expectations of one another during the process. Participants taking part in the body mapping workshops knew one another's identities because of their pre-established relationships formed through accessing services at YWCA Hamilton. However, they had the opportunity to use pseudonyms throughout the

workshops if they chose. Pseudonyms were used for *all* participants in all dissemination activities with a unique code linking participant names and contact information to the data. During audio-recorded portions of the workshops, participants were made aware of this prior to beginning recordings. All audio recordings were transcribed by myself during my capacity as an undergraduate student researcher. Photographs of the body maps were taken at the end of each workshop, ensuring that there was no identifying information in the images. Information was stored on an encrypted storage software (MacDrive), accessible to the research team only.

4.8 Compensation

Finally, to acknowledge and appreciate the participants' valuable contributions of knowledge, time, and energy, the women involved in the study were provided with a $250 cash honorarium at the end of the four-day workshop. Meals, snacks, and refreshments were provided throughout the course of the four-day workshops. Additionally, participants were presented with a welcome gift bag which included chocolates, a notebook, pens, slippers, and body lotion. During the data sharing phase discussed in section 4.11 of this chapter, participants were presented with a framed image of their body map, and an additional honorarium of $25 in cash. All incentives were made possible through funding from the Social Sciences and Humanities Research Council Insights Grant (#997740) for the Women, Art, and Cannabis Research Study.

4.9 A Trauma-Informed Approach to the Method

The research team was committed to working and researching with participants from a trauma-informed lens. While the team did not inquire into past trauma specifically, there always exists the potential for discomfort to arise in research contexts that ask participants to share aspects of their lived experiences and histories (Alessi & Kahn, 2023). In anticipation of this possibility,

there were several practical, methodic considerations that were incorporated throughout the workshops to be discussed.

i) Co-Located Supports

As a research team with history of working with diverse populations in a variety of settings, we were able to anticipate potential harms, and prepared by having supports co-located on site. A community support person was present during the workshops and in addition, many participants had pre-established service user-provider relationships with YWCA advocates. Further, the YWCA Hamilton has staff onsite 24/7 had any of the participants required more immediate support outside of the workshop hours. A list of appropriate referrals for community resources was made available to all participants, in case they had a desire to speak to a support service following their participation in the workshop.

ii) Location

The choice of location for both four-day workshops was intentional and thoughtful. Workshops were conducted at the YWCA Hamilton, 75 MacNab Street South. Many participants were either currently residing in the Transitional Living Program (TLP), staying at Carole Anne's Place, or had some experience of accessing services and/or supports through the YWCA Hamilton. This familiarity with the community, location, on-site staff, and services was a consideration thought to contribute to participant safety since a welcoming physical environment allows participants to "feel comfortable sharing their stories without fear of losing their dignity or being endangered" (Alessi & Kahn, 2023, p. 18). Further, the space was in a neighbourhood accessible by public transportation.

iii) Research Team

The research team was thoughtfully comprised of individuals who had prior involvement and connection to the organization's programming. This uniquely positioned the team to understand some of the nuanced experiences of participants, while promoting trust and greater levels of engagement (Kerstetter, 2012). Moreover, the research team's knowledge of participants allowed them to anticipate their needs, accommodate with flexible timing and pacing during the workshops, and ensure that the process was accessible to a variety of participation needs. This familiarity and comfort with the research team engaged participants in a profound way that evoked meaningful reflection, which to some degree, may not have otherwise been as prevalent. Members of the research team demonstrated respect, enabling participants to develop trust with the research team and one another (Alessi & Kahn, 2023). Relational safety was further developed amongst participants and the research team by demonstrating predictability, consistency, transparency, and acceptance within the research process itself and within our relationships (Alessi & Kahn, 2023). Participants were well-informed and reminded of the daily activities, received predictable expectations for the day, experienced consistency amongst workshop times and location, and were provided with a space free of judgement for participants to express themselves and/or concerns about the body mapping process more specifically.

4.10 Analysis

This project analyzed data in the form of narrative data, collected during the sharing circles along with visual data, their accompanying body maps. A reflexive thematic analysis was used to analyze the narrative data, a method aimed at developing, analyzing, and interpretating patterns of qualitative data (Braun & Clarke, 2006). Reflexive thematic analysis is an approach to qualitative data analysis outlined by Braun & Clarke (2006) that is both easily accessible and theoretically flexible (Braun & Clarke, 2006; Braun & Clarke, 2012). Since thematic analyses

offer a range of different possible outcomes, there is no clear process by how exactly to go about doing it, nor are there discussions about what assumptions may have informed such an analysis (Braun & Clarke, 2006). A reflexive thematic analysis, on the other hand, attempts to demarcate a process to identify and generate theme-based narratives. As the name suggests, reflexivity is at its core, the process of critically interrogating and reflecting on one's role as a researcher and examining how this impacts data analysis (Braun & Clarke, 2006).

In a reflexive thematic analysis, the subjectivity of the researcher is valued, harnessed, and perceived to be an asset, allowing for a unique exploration of the data that reflects the complexity of the human perspective and highlights the researcher's active role in knowledge production (Braun & Clark, 2019). This subjectivity suggests that themes are not necessarily 'discovered' within the data, but rather, are generated through a process of the researcher's interpretive analysis and meaning making that is located at the intersection of the dataset, the theoretical assumptions of the analysis, and the skills of the researcher (Braun & Clarke, 2019). As such, themes are not necessarily replicated across researchers, and attempts at providing "reliable" codes and/or themes are discouraged (Bryne, 2022).

Much like Braun and Clarke's narrative analysis, the interpretation of visual images is also not neutral. My visual analysis of the body maps was guided by Gillian Rose's critical approach to visual analysis, which encourages insight into aspects of the participants by thinking about the social conditions and effects of visual objects, while also considering power relations (Rose, 2001; Rose, 2007). My analysis of the body maps required me to thoughtfully look at the images while acknowledging how they offer very particular visions of social categories such as class, gender, race, sexuality, ability, and other aspects of identity (Rose, 2001).

Braun & Clarke (2006; 2012; 2019) have identified six phases that make up the process of a reflexive thematic analysis, each requiring critical reflection on behalf of the researcher (Braun & Clarke, 2006; Braun & Clarke, 2012; Braun & Clarke, 2012). While the phases are organized sequentially, the authors advise that the analytical process is not linear in nature, but rather iterative, which may require the researchers to move back and forth through the phases as needed, leading to new interpretations throughout the process (Braun & Clarke, 2020). Incorporated within each phase, are components of Rose's critical approach to visual analysis. These phases are to be discussed herein.

i) Phase 1: Familiarization with Data

This phase entails the reading and re-reading of the transcripts, allowing myself to become intimately familiar with the dataset. Since I manually transcribed the body mapping workshops, I was able to immerse myself into the data early on which informed the early stages of my analysis. Workshops were transcribed orthographically – a verbatim account of all verbal and non-verbal utterances. Braun and Clarke (2006) recommend engaging with the data in an 'active' way to encourage an initial search for meaning and patterns (Braun & Clarke, 2006).

An important part of familiarizing myself with the data also involved reviewing the images of the body maps that were created, and how they connected to the narratives provided by the women.

ii) Phase 2: Generating Initial Codes

Once familiar with the visual and narrative data, I developed an initial outline of salient ideas, made note of what made them interesting, and organized these ideas into groups. This phase made up the initial codes from the dataset. Some initial codes that I generated included gender-based and sexual violence; childhood abuse and neglect; mental health; addiction; wellness; pain

management; reproductive health; sexual health; trauma; and grief and loss. I performed this phase manually, using colour codes to differentiate between reoccurring ideas/codes.

iii) Phase 3: Searching for Themes

Phase three involved sorting the codes identified above into potential themes which entailed re-defining and combining codes into broader themes. This required me to again, re-read the transcripts and revisit the accompanying visual images of the body maps. At this point, I sat with the images with more intent and curiosity, considering the artist behind each image and how social differences may have been implicated throughout the imagery (Rose, 2001). While I did combine codes, for example, 'sexual and gender-based violence', 'childhood abuse and neglect', and 'grief and loss', were grouped into the broader theme of 'trauma', the initial codes remained as sub-themes and are uniquely discussed in the Findings chapter to follow.

iv) Phase 4: Reviewing Themes

Once themes were developed, they were further refined, and discarded when it became clear that there was not enough data to support them (Gough & Madill, 2012). The data was re-read with each theme in mind to ensure it followed a coherent pattern (Braun & Clarke, 2006). Some themes were re-worked, for instance, 'mental health' and 'wellness' were themes that were reconfigured as 'emotional wellness' which encapsulated both ideas. Other codes were discarded, as was the case with 'reproductive health' and 'pain management'. At this stage, there became clear and identifiable distinctions between themes (Braun & Clarke, 2006). My transcripts were re-read with my new themes in mind and the images of the body maps were once again reviewed, to determine whether they aligned with the dataset, and to review any additional data that may have been overlooked under previous codes (Braun & Clarke, 2006).

v) Phase 5: Defining and Naming Themes

Once the themes had been mapped out, the next phase of the process required me to define and further refine the themes, "identifying the 'essence' of what each theme is about" (Braun & Clarke, 2006, p. 92). I succinctly named and described the scope of each theme, limiting definitions to just a few short sentences ensuring that the reader would be able to make clear sense of what the theme encompassed (Braun & Clarke, 2006).

vi) Phase 6: Producing the Report

The final stage entailed a final analysis and write up that compellingly illustrated the story to be told (Braun & Clarke, 2006). Here, I utilized participant narratives and artwork to tell a complicated story about my interpretation of the dataset. The themes helped support the broader, overall story that I was attempting to illustrate. This the basis of both Chapter 5: Findings, and Chapter 6: Discussion.

Characterized by flexibility and researcher subjectivity, Braun & Clarke's reflexive thematic analysis and Rose's critical approach to visual analyses are organic and iterative approaches offering rich and detailed, yet complex and subjective accounts of data (Braun & Clarke, 2006; Rose, 2001). Although my analyses relied more heavily on Braun and Clarke's approach which speaks primarily to qualitative data, Rose's critical approach to visual analysis was thoughtfully integrated when applicable throughout each of the six phases of analysis. Engaging in and applying these analyses of my dataset, allowed me to explicitly interrogate how my social location, history, and research practice directly affected the interpretive process (Gough & Madill, 2012). It required time and effort to reflect on my potential motivations and goals as a researcher, but in doing so, added depth to the findings and situated the research within its relevant social context (Gough & Madill, 2012).

4.11 Returning to the Community

An important ethical consideration when doing research with communities, is returning the research in a respectful, meaningful, and accessible way to the participants (Boilevin et al., 2019). A common critique of researchers is their tendency to vanish from the community following the completion of a study, only to later 'share' the research results via a publication that is not accessible to the participants (Boilevin, et al., 2019).

I was committed to reconnecting with research participants to share the data following the initial workshops. I informed the women of an opportunity to meet with me in the community to share the findings and seek their feedback regarding their individual body map summaries. A room was booked at the YWCA Hamilton location where the original workshops had taken place and I remained on site for participants to drop by within a designated window of time on two separate occasions: April 25th and May 14th, 2024. I was able to connect with four of the eight participants. I verbally shared a summary of the major themes that emerged throughout the research, along with a printed first-person 'testimonio', allowing them to review their narratives and the context within which their words and stories were grounded. Participants were provided with a framed image of their body map and a copy of their 'testimonio'. An honorarium of $25 was provided for their time and energy to meet with me, and this was in no way contingent upon their approval of the data. All four participants that I met with approved their 'testimonio' and expressed their enjoyment in reconnecting.

Chapter 5: Findings

The narrative and arts-based data presented in this section outlines the prominent themes that emerged throughout the body mapping workshops using a reflexive thematic analysis. This section will begin with biographies of the participants. Biographies were compiled using data gathered from the demographic survey (Appendix D) and pseudonyms are used. The findings will then explore the theme of cannabis use as a response to trauma, with sub-themes of childhood abuse and neglect; gender-based and sexual violence; and grief and loss. A second major theme to be presented is the role played by cannabis as a harm reduction tool, exploring sub-themes related to cannabis as an alternative to both prescription medication as well as other addictive substances. The final theme to be shared is the participant's use of cannabis to support their emotional wellness.

5.1 Participant Biographies

All participants in both the workshop groups identified as women (inclusive of cis and trans women) and were between the ages of 31 and 60 years of age. All participants received social assistance, and all participants are accessing (or have accessed) housing support services from the YWCA Hamilton. All participants have experiences of homelessness or housing precarity.

i) Fiona

Fiona is a 31-year-old Métis woman and mother. She has a history of incarceration and substance use. At the time of research, she was residing in supportive housing. Fiona's primary source of income is ODSP. She has completed some high school education.

ii) Jessie

Jessie is a 33-year-old Black Caribbean woman, who identifies as gender fluid, trans-gender, and pansexual. At the time of the research, Jessie was experiencing homelessness and was staying

with a friend. Her primary source of income is ODSP. She has completed some college education and is currently employed part-time.

iii) Rose

Rose is a 58-year-old Métis woman. She is heterosexual, single, and of Canadian decent. Rose has experiences with street-involved homelessness and at the time of the research, was living in a gender-specific emergency shelter. ODSP is her primary source of income. She holds some university education.

iv) Joelle

Joelle is a 60-year-old Caucasian, divorced/separated, heterosexual woman. She has experiences with immigrating form the United Kingdom. She has experiences with street level homeless and is currently residing in a gender-specific transitional housing program. Joelle's primary source of income is ODSP. She holds some college-level education.

v) Gia

Gia is a 47-year-old, Indigenous woman, and mother from a country outside Canada. She describes her ancestry as a Pacific Islander of Melanesian nationality and has experience with immigration. She has experience with street-involved homelessness and at the time of research, was residing at a gender-specific emergency shelter. Gia's primary source of income is Ontario Works. She has a college education.

vi) Kelly

Kelly is a 35-year-old Latin American trans-woman refugee with experiences of immigration as a newcomer to Canada. She has a history of substance use and street involved homelessness, and at the time of the research, was residing in a supportive housing unit. Kelly receives ODSP as her primary sources of income and has completed elementary school.

vii) Stephanie

Stephanie is a 50-year-old heterosexual Caucasian woman, and mother who was born in Canada. At the time of research, Stephanie was residing at a gender-specific transitional living program. She received ODSP financial support as her primary incomes source and has completed some college education.

viii) Colleen

Colleen is a 50-year-old single, Caucasian, woman of Irish decent. At the time of research, Colleen was residing in a gender-specific transitional living program. Colleen receives ODSP as her primary source of income and has completed high school education.

5.2 A Response to Trauma

Women, particularly those who occupy marginalized identities, are disproportionately impacted by experiences of trauma and violence (Sabri & Granger, 2018). It is, therefore, not surprising that trauma was a common experience for participants in this study, and something discussed at length during our workshops. Sharing circles and body maps revealed the ways participants use of cannabis as a tool to cope with traumatic experiences. Although participants were not asked about trauma and the impact this has had on their lives, a reoccurring theme centred on participants experiences of trauma, specifically instances of childhood abuse and neglect, gender-based and sexual violence, and grief and loss. These sub-themes are explored below drawing on women's artwork and narratives.

i) Childhood Abuse and Neglect

During the body mapping workshops, participants shared about their exposure to childhood abuse and neglect and connected these experiences to their cannabis consumption. For example, Stephanie, recounted experiences of abandonment as a young child, with her single-parent

mother needing to work three jobs and recalled being left to play alone on the farm. Gun violence was also a prominent occurrence in her community, impacting her experiences growing up. An image of a gun was depicted in her body map when prompted to reflect on her roots and where she came from. A brick wall was used to symbolize the obstacles she has faced during her childhood, and the blockage that these experiences created for her. Stephanie elaborates on the meaning of these images:

> "I came from nature, farm, country, abandonment. My mom was never around because she was working three jobs for me… I grew up in the projects of Toronto, so I saw a lot of violence with guns and couldn't tell people. You head home toward gunshots. I'm terrified of firecrackers 'cause they'd let them off all day, and then you'd know at night, that's when there's going to be a gunshot. It's a diversion…. Guns destroyed my life, my family."

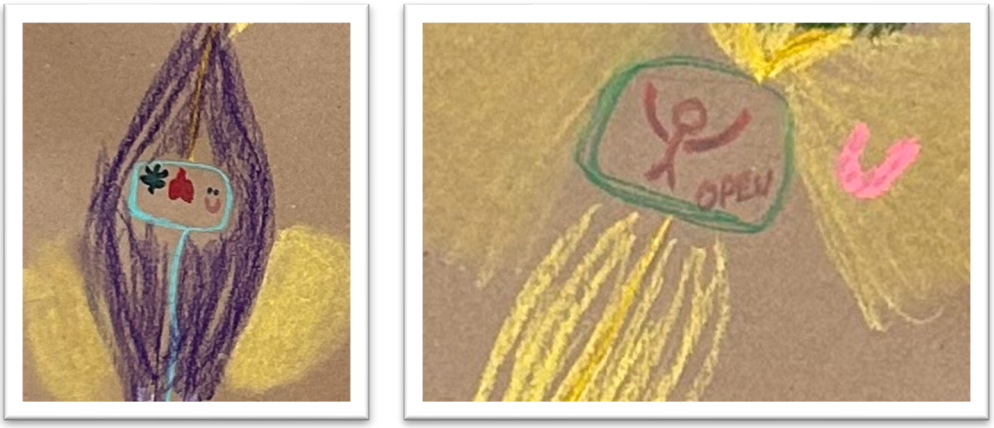
Although not recorded, Stephanie later reflected on the significance of these events, and how her cannabis consumption has been a response to cope with the difficult emotions that accompanied these experiences. Similarly, Rose also shared about the challenges of experiencing abuse and neglect as a young child, during her school age years, *and* into adulthood. She described her memories of her crib and bedroom as a young child, her negative recollection of school, and her first experiences on her own as a young adult. Rose created and described the detailed images

she had placed on her body map to symbolize her roots and the many obstacles she has encountered:

> "The blocks was being locked in my crib, so I put that brown box with the crib in the middle, 'cause [my step mother] isolated me in the room for the first two years, so I didn't leave the crib. So that was my first major blockage… And then school, I made the connection with school and it being black… 'cause that was all bad. School was extremely bad… It made me want to always kill myself… And then, the red was like, warning about people, society, cause when I got out of school and everything, I was on my own and society, they were always judging me, and they were always, like, making me feel uncomfortable and scared… And then, the other one that gets to me, um, where I feel blue all the time, so it's in a blue box… I've got my hands over my ears cause I'm sick of hearing everything, I don't want to hear anything anymore."

In her awareness of these experiences and the challenges that they created, Rose perceived her consumption of cannabis as a way of coping with the impact of these experiences. Cannabis encouraged a state of acceptance for Rose and allowed her to sit with the discomfort of her past. She goes on to express the ways in which her cannabis consumption is a liberating and calming experience for her. She describes an image on her body map that starts off dark and ghostly,

explaining how her cannabis use brought her more in alignment with her spiritual self, symbolized by a cloudy image moving into brightness:



> "But then I got smoking weed, and… everything seemed more serene, more peaceful. There's… the weed plant and the lungs because it felt like I could breathe again… I could finally relax. And then the happy face, 'cause I was able to… just feel happy. And then I got up to the one where I can feel more open now, I'm starting to be more open to people… The blue all around me was… being comforted by my spirituality… In school, there was no God, so it was kind of like, ghostly, and then… I got more spiritual, that's why this is cloudy and that's not. And then that went into feeling really good… and that went into the… brightness. I felt like I wasn't living in the darkness anymore."

It is evident from the women's narratives that their experiences of childhood trauma have had a lasting impact on their lives. For both Stephanie and Rose, cannabis has been a strategy that mitigates their uncomfortable memories of such events and encourages them to be more present in their daily lives.

ii) Gender-based and Sexual Violence

Some women disclosed experiences of sexual trauma and gender-based violence during the body mapping workshops. Disclosures of violence ranged from speaking about these experiences during the art-making process or in unrecorded one-on-one conversations, while others shared their stories widely with the group in the sharing circles. One woman in particular, Kelly, spoke

about her experience as a trans woman, who was sexually assaulted as a child. Kelly described the way in which cannabis has allowed her to move beyond this experience and continue intimacy with her partner:

> "If I'm not high, I'm not okay to having sex. Sometimes you don't trying to think about your bad experience, but your body has memories. So they start to check in, you know… When I'm high, I feel like… it's going to be okay. [It's] helping me, you know, to feel more comfortable. Because of my trauma about um, my PTSD and everything, I realized if I don't smoke, I'm not ready to have sex… I realize when I smoke weed, I'm looking more for my partner to be, you know, intimate."

She used an image of 'do not enter' sign to represent how cannabis contributes positively to her emotional health, describing how her trauma acts as a sexual inhibitor and consuming cannabis releases these inhibitions. Later, Kelly again uses a different version of a 'do not enter' sign to symbolize her sexual health, explaining how cannabis use increases her comfort with sex and intimacy.

Rose shared a similar narrative she has heard expressed by her peers.

> "A lot of people I met too that have had sexual trauma; they won't go near sex without being high."

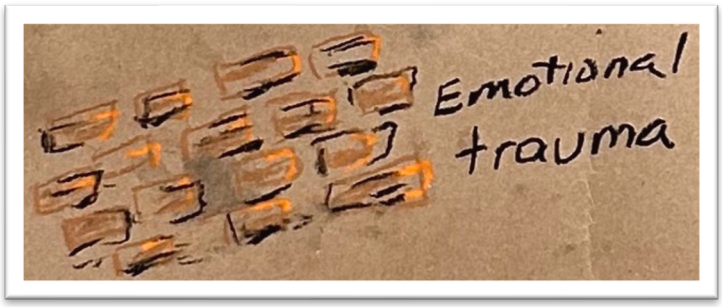
During artmaking, Rose reveals more about her own experiences with using cannabis as a tool to cope with her discomfort around sex and intimacy:

> "The sexual health I put the… yellow again there, um, because it… kind of helps me to feel more peaceful and not so scared at that area, you know. It's like it's more calm… It makes that area like, below the waist and stuff, feel like, not so scary, and not so, you know, harsh kind of thing. It kind of makes it feel just smooth and part of my body that I can accept. I also did the green on the belt there, 'cause it helps me feel free-er… it opens that area up… I know it's a good place because it produces life and everything… and it's essential to being me. But without the weed… it's closed off, it's not a part of me at all… It helps take away my inhibitions and I can relax a bit… I convince myself that this is part of the good feeling."

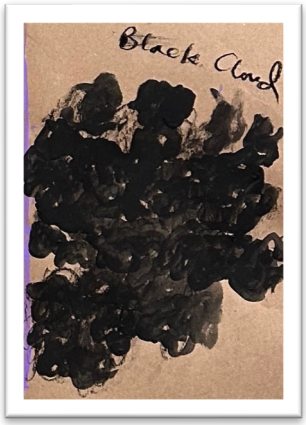
On a psychological level, the women's experiences of sexual trauma have been a barrier to their sexual intimacy. Cannabis has provided them with a heightened awareness, helping them to remain present with their partner, not back in the memory of their trauma. For Kelly and Rose, cannabis has promoted a sense of safety by reducing their hyperarousal symptoms, and potentially encouraging the exploration of pleasure than can accompany sex.

iii) Grief and Loss

Finally, discussions of grief and loss also emerged as a sub-theme of trauma, with several participants sharing stories about lost friends and family members, reinforcing the role that cannabis consumption plays as a coping mechanism in their lives. When asked about her life's obstacles and challenges, participant, Gia, uses the image of a brick wall to symbolize the emotional trauma she has experienced:



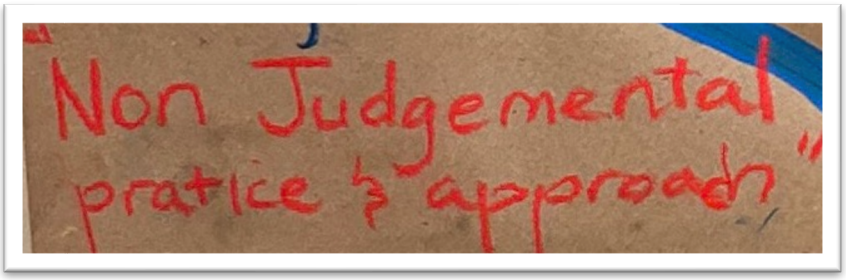
Gia shares about her daughter's death; this is depicted by both the flame and the black cloud that she creates taking up a very large portion of her body map. Also depicted on Gia's body map is her daughter's name, date of birth and death, along with the message "till we meet again xoxo". To protect the identity of Gia, components of this image have been blurred:



> "The social workers that I had involved in my case were obviously the child protective agents and immediately looked at cannabis negatively even though it personally, I felt like it helped me and sustained me to carry on. She [the social worker] represented the black cloud in the picture. It just felt like a roadblock. That explains the cloud right outside the shadow, right there, cause it… I feel like because

> of a lot of decisions from the social workers point of view, uh, we lost our sister, my first born, and my future, my pride and joy. As a result there was death in our family. They wrote me off as a drug addict."

Gia explained how the stigma of cannabis use and the judgement from social service providers led to a closed-off relationship with her worker, reinforcing nondisclosure in other areas of her life in addition to those surrounding her cannabis use. She emphasizes the importance of transparency in service provider-user relationships and writes the phrase "non-judgemental practice & approach". This is her perception about how support should be delivered from health and social service providers:



> "My being able to talk freely about anything that's deep inside me, I have to say, I can speak freely if the entity or the organization or the person is stemming from non-judgmental practices and approach. Because when you start judging me, how can I speak something when I'm thinking you're thinking negative. So the non-judgmental approach and practice I believe was something… a very key factor that was left out. As a result, my family faced death. A loss of a family member."

Despite this tragedy, Gia speaks at length about the importance of her cannabis use as a distraction that shifts her emotions away from her grief, allowing her to focus on the days tasks and remain future-oriented. She creates an image of a waterfall on her body map to represent the loss of her daughter but also her ability to endure the immense grief she has experienced and continue with her life's trajectory:

> "I chose waterfall because of the serenity… Water is as much important to being alive as sun and plants and animals. I think water is a big key factor for life. When a baby's born it's in water… [It] is a continuity, it… meanders and links. There's no breakage. It's something that holds everything together… Flowing water to me is something, um, positive, where life can be in… And in our lives, I think a lot of trauma and bad things have happened in the past, and as humans, we tend to linger on that note. But when you smoke weed, it's like you forget or… it just becomes, ah, just a moment, you know… And I feel like there's a lot of positive and I feel like now, if I want to go out into the world and be calm, or do something, or re-skill, I can. And it's all based… it's all due to, and because of, marijuana."

Jessie also spoke about the loss of a close friend, symbolized by the orange support shadow seen in the background of her body map. She shares how consuming cannabis provides comfort in times when her emotions feel heavy and overwhelmed by her grief and loss:

> "I think when you experience certain forms of loss and grief, that moves me very deep… I would sing at the library, at the studio, and um, emotions get really intense, and like, really powerful… Like, really hefty emotions. So I get really deep in it and… I would cry. My friend Jason, he used to always come and… we used to always come and like, smoking a joint afterwards, it was so comforting, and just like, I felt supported, and I felt like he was my orange shadow at that time."

These shared narratives relating to abuse, grief, loss, and experiences of violence highlight the ways consuming cannabis promotes a sense of resiliency by lessening the discomfort and anguish that accompanies traumatizing experiences. In this way, cannabis can be seen as a coping mechanism that encourages individuals to remain future-oriented when confronted with varying experiences of trauma.

5.3 Harm Reduction: An Alternative

Throughout the body mapping workshops, participants described the ways in which cannabis was used as a method of harm reduction. There are many negative health, social, and legal impacts associated with drug use, and harm reduction as an approach is a practice aimed at minimizing the negative impacts of such use (National Harm Reduction Coalition, 2024). Some women spoke about the role played by cannabis as an alternative to other substances that they

perceived as more harmful, such as crack-cocaine, cocaine, crystal methamphetamine, and fentanyl. Others spoke about cannabis as an alternative to pharmaceutical medications.

i) An Alternative to Illicit Drug Use

Throughout the body mapping workshops, participants described the ways in which cannabis is used as a harm reduction tool, to reduce or stop their use of illicit substances as well as prescription medication. Many of the women who participated identified that their cannabis use stemmed out of their desire to wean themselves from substances that they perceived as more harmful and addictive, with some participants indicating that regular cannabis consumption has prevented their relapse and/or desire to use other substances. For example, Kelly, spoke of her abstinence from what she described as more addictive substances since she began using cannabis as a substitute. She creates an image of bracelets on her body map to symbolize her hope for her future, since she perceives the properties of cannabis as far less harmful than other substances. The bracelets are drawn in yellow, a significant colour for Kelly since in her home country, yellow means there is light coming into your family:

> "I have three years sober for crack, crystal meth, and… cocaine… Yeah, it's helping you to stay away from other drugs because you know, I used cocaine, crack, and crystal meth at the same time, and I don't feel like I want to use other drugs when I have the weed because it makes me feel happy. You know, it's not funny at all to have paranoia… I don't want to come back there. It's not like other drugs… Because the other drugs make you anxious, and this one, no… It's like magic for me because

> I don't feel like you have to do other drugs. [The bracelets] means hope for me, because… it's not an addictive thing... It's makes you feel good, you lose all your fears, and you can be yourself. It's… yellow colour, in my country it means when a new baby's coming… there's coming a light in your family so that's why the yellow means a lot for me (laughing)."

Gia voices similar feelings about cannabis as a substitute for other, harsher substances which she recognizes, would have taken her down a troublesome path. She attributes her authenticity and where she is today to her cannabis use:

> "I'm still me because of marijuana. If I didn't have that, I would have lost myself, you know. And it helps me a lot for… let's say this other drug use around you or this influence to go try something… Not only does it get you *very* high than most other things, it could be the best option for you to lean towards when you're trying to wean yourself off something that's bad for you… And, if not for weed, I would have gone beyond other places that's really bad for me. And using drugs… that would have put me in a *very* bad situation. So I use weed as an option, and a better option for me to not, say, do crack cocaine, or other things like, um, crystal meth… I think it actually saved me from going down a bad path… I use it to wean myself off other things and that really, for me, it's something that now I can have a future. I have a future because of marijuana."

Gia draws a sun as her symbol for cannabis to represent the positive, life-giving energy that she receives from consuming it, illustrating how in many ways, cannabis has saved her life:

> "I represented marijuana in the form of sun because… smoking weed… it gets me to a place where I cannot really linger on the negativity, but think, uh, positive, and have sort of like an upbeat, um, positive energy. And I believe, uh, the sun rays, with

> photosynthesis, and then bringing the THC in the uh, weed, all that, um, I feel like the human body can really metabolize that sort of, the medicinal purposes correctly, so, it really works for me."

Similarly, Fiona shares the ways that she perceives cannabis as a harm reduction tool, acting as a substitute for fentanyl. She later represents this idea with the image of an orange hula hoop on her body map to symbolize the continuity of support she receives from her health and social service providers, family, and friends:

> "My people (supports) are accepting. They accept it (cannabis). It's less harmful of a drug than what I would normally be putting in my body. So they're more comfortable with me smoking weed over any other drug. Yeah, cause I'm safe and we know that I'm not going to get sick."

ii) An Alternative to Pharmaceuticals

Further group discussions elaborated on the role of cannabis as a substitution to prescription medications, addressing both mental health challenges and physical pain. In this way, participants perceived cannabis as medicinal, with the ability to address and lessen their symptoms and hence, eliminate the need for other medically prescribed pharmaceuticals.

a) Mental Health Symptoms

In discussions about medication more broadly, Fiona describes her desire to avoid prescription medication, drawing a more literal image of a pills and a bottle to represent her obstacles in life:

> "I drew some medication, like I didn't know what kind of colours to make it, so I just picked a colour 'cause I don't want to be medicated. I want to be, you know, myself and not be judged for being myself and feeling the way I feel."

Rose uses the image of a stethoscope to depict her personal vision for health and social service providers regarding women who use cannabis. Accompanying this image is a light bulb and exclamation points, suggesting an increased awareness of the benefits of cannabis by health care practitioners:

> "It's a stethoscope and that's representing the doctors. And they're always questioning like… How come you just… use weed? Where's your meds? And, then they go wow, it's wow, that's like a lightbulb up here. The lightbulb comes on. It's like, wow, that's amazing. And then they kind of get it. So that's the exclamation point, its amazing."

Rose goes on to recount her experiences with the side-effects of prescription medications and how cannabis has been better suited to addressing her mental health symptoms:

> "And then I end up thinking, you know what, I need it. I'm okay with it. It's my meds… It upsets me though when I was on all the prescribed medications… It was making me sicker and not helping me, and I was having an unproductive life which was costing everybody so much… Ever since I've been using cannabis instead of all the prescription drugs… there's no medical trauma all the time. There's no medical emergency all the time. Because I'm not on all the prescription drugs… The doctors have all said too that the only thing that works for me is the cannabis and they know that the other prescriptions never helped"

Rose's narrative and accompanying imagery illustrates how for her, cannabis is better suited to addressing her mental health symptoms than prescription medication. Also reflected in her statement, is the importance of her self-determination in her decisions surrounding her care from health and social service providers. Gia also explains her personal preference to consuming cannabis over pharmaceuticals:

> "I don't really like medication, sorry, I don't choose to do medication, so uh, I chose marijuana to use and self-medicate myself before it was legal… I feel like because it's a plant, my body, and… my stomach can metabolize correctly, instead of, a processed man-made chemical pill… A plant becomes the go-to option and the only option. So, that's the savior for me"

Kelly echoes the perception of cannabis as another medication, sharing a similar story:

> "It's another medication… So, when I talked to my doctor and they explained to me everything, there was nothing wrong with that. So, I'm just thinking it's another medication. And it's better because I stopped to take my anxiety pills and my depression pills, and I feel better. When I was on the pills, I was always sleepy. Always. Always."

She then draws an image of a maple leaf to symbolize the support she has received regarding her cannabis use since coming to Canada:

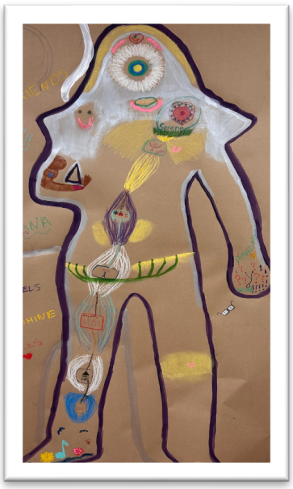
> "I feel a good support, that's why I put the maple leaf, because, you know, when I came… here to Canada, I got all the support… I don't have it over there in my country. So…I have all the support that I need… And I don't feel that people is judging me or something else."

b) Physical Pain

Beyond cannabis as an alternative to mental health medication, participants also expressed its role as an alternative to pain medication, alleviating various forms of physical discomfort. Rose shares how her diagnosis of Multiple Sclerosis has led to chronic pain throughout her body, reporting that cannabis is the only way to mitigate this pain:

> "With me, it takes away my pain, uh, with my MS and everything. I've had a lot of injuries and stuff and I'm supposed to be, um, going to a chronic pain clinic but I don't go cause all I do is smoke my weed… For me I'm supposedly supposed to be in pain all the time and I'm never in pain."

She depicts this with a warm yellow shading that can be seen throughout the entirety of her body map at her sites of pain:



> "It feels like a warm band aid kind of thing on the spots that really hurt without my weed. And so, like, I put my knee's really bad, but when I have my weed it feels like it's just warmth, and just soothing… And my broken foot, there. And then I put it by my stomach because I have problems eating without weed… It feels like such an essential tool for physical pain."

Kelly shares a similar sentiment of cannabis as an alternative to prescription pain management, expressing her struggle with ongoing physical pain that never really seems to subside:

> "Even I have a spine fracture, and it helps me with my pain. Because the doctors say I am not able to go for surgery so I'm in pain 24 hours. Everything for me right now is hard to do it, but when I'm high, I do everything. And I don't feel the pain in my back."

Kelly and Rose expressed how the only effective strategy for managing their pain, was cannabis, describing it as an essential tool in their daily lives.

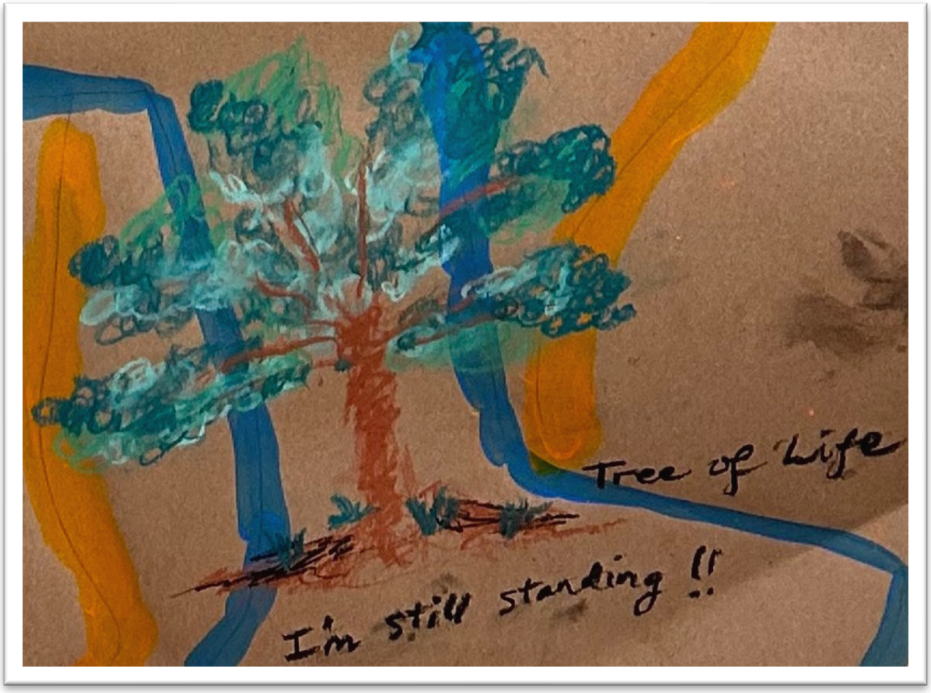
Fiona too speaks about her chronic pain, representing the ways in which cannabis impacts her physical health with the image of a nerve coming from the pain in her hip. To the side, she draws the word 'pain' overlapped by a 'prohibited' sign. She also describes her choice of colours:

> "So I drew, um, a hip bone… And I drew a nerve coming out of like, where I feel like the pain is coming from… I drew black… lines around, like, the outside of the red to symbolize, like, the pain. That it's… constantly there. But then when I smoke weed, I forget… that I even have like, the pain."

Gia relates to this theme of pain management and uses her experience with poverty to elaborate on the stories of others. She describes how as a single mother she has had to endure physical pain and discomfort daily in order to provide for her family:

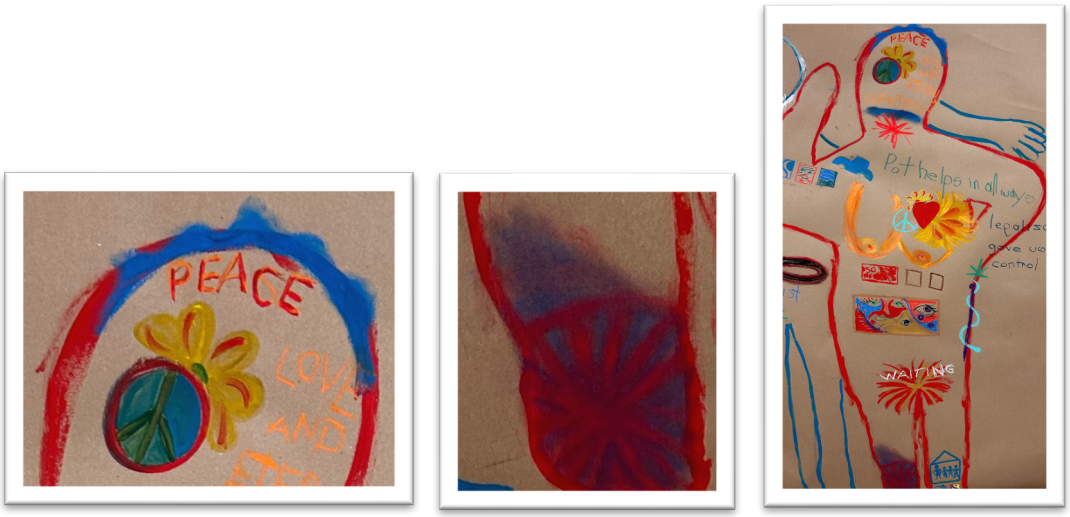
> "As a single mom, it's been really hard trying to carry things and walk. No car, you're on foot and you have to go to foodbanks. It's a lot of strain on your muscle and body so marijuana helps a lot to, um, offset the pains... That's extreme pain level in your leg, your thigh… your foot pains… everywhere. So weed, marijuana… it did a lot for me, to enable me to go ahead and problem solve when it came to physically exerting myself"

Gia uses the image of a tree of life to represent how cannabis supports her physical well-being, describing how it has allowed her to endure over time in the face of physical strain and hardship. She placed this image at the foot of her body map where her pain radiates from, along with the phrase "I'm still standing!!":



> "I placed the image of the tree of life right on my feet, uh, because I'm still standing. That's what marijuana did to me. It… it literally was the option, the go-to option, in order for me to have a future. It's a lot of strain and stress physically. Your feet, I have foot pain. Marijuana took me through my day of problem solving, uh, very easily, so tomorrow I can get up and do it over again. And over again. And over again."

Joelle, who identified as having a physical disability and used an assistive devise for support, described how cannabis alleviated her pain as well. She uses a blueish purple colour near her head and foot, the areas where she experiences the most notable pain, and chooses this colour to represent the soothing effect offered by cannabis:



> "Well, in terms of, uh, physical, I put that up in my head because it helps with headaches and that sort of thing… And down here again… The red is the pain, and the purple-blue is the soothing effect. It's like a blanket."

The women's stories and images demonstrate their calculated decisions to use cannabis in place of both prescribed pharmaceuticals and other illicit drugs. Accompanying these narratives, is the notion that cannabis offers safer, more beneficial outcomes and speaks to the theme of cannabis as a harm reduction tactic, minimizing the short-term and long-term impacts and side effects of other substances.

5.4 Emotional Wellness

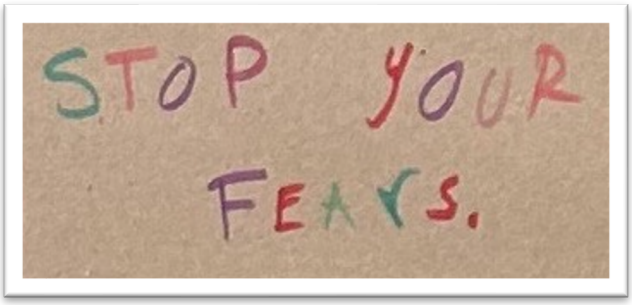
The final theme that emerged from the body mapping workshops was the prominent role that cannabis played in contributing to the emotional wellness of the participants. Women's narratives and body maps highlight the role that cannabis has played in promoting and sustaining their emotional health and well-being. Many participants spoke at length about the psychological benefits associated with cannabis, describing positive thoughts and emotions, feelings of relief, improved mental health, and increased resilience. For example, Jessie describes how her consumption of cannabis makes her feel, using the images of a sun and happy face along with the words: 'joy' and 'stress fading':

> "It makes me feel bright… It brings me joy, and it makes me feel like the stress is fading away. Um, so it's a pure alleviation."

Similarly, Rose explained the role cannabis plays in contributing to her emotional wellness, portraying this feeling by a whiteness that clouds away her problems, and is visible in a large, upper portion of her body map:

> "The weed thing makes me extremely, extremely happy. And it makes me feel calm, and peaceful and just like, I'm relaxing, and I'm relieved. And I'm… and I'm just feeling like, wow, everything is just like, all the problems are gone. I'm high, I can… That's why it's all white all around, cause it's just, all the problems are gone. They're gone for that time when you're high and you're just resting… And the anxiety is gone, and you can just rest and be happy."

Kelly also explained how cannabis supports her emotional health by mitigating her anxious symptoms. She depicted her personal power symbol on her body map by creating the image of a sword because, to Kelly, the sword represents the feeling of fighting alone against her anxiety and fears. Using cannabis gives her the ability to socialize, allowing her to feel accepted:



> "Emotionally, it (cannabis) helped me because I think when I smoke, you know, when you're trans, you're always being scared to being accepted. So when I smoke this thing, I don't know, it makes me feel that I have the power and I don't care for the world, it's just me. And when I do this thing, I have this courage to socialize more with people… It helps me with my PTSD and my anxiety because it makes me feel like I don't have to be hyper-vigilant always. So when I smoke weed, I feel more relaxed."

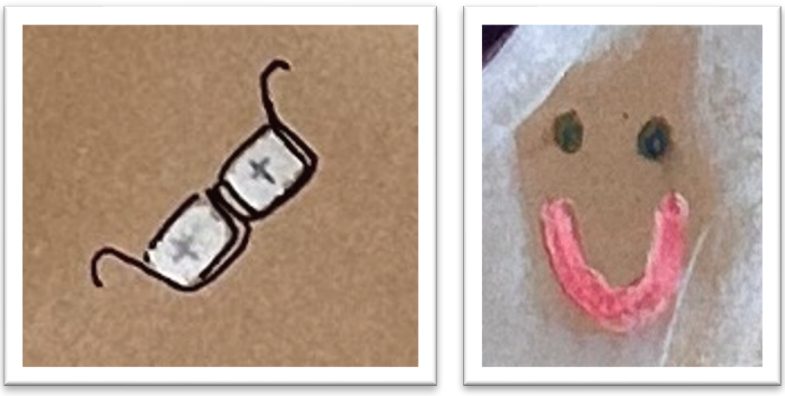
For Kelly, consuming cannabis gave her the confidence to engage socially with others, an activity that was previously more challenging for her. Cannabis helped to lessen the stress and hyper-arousal symptoms that she typically experienced so that she could feel more relaxed in social settings.

Fiona speaks about the obstacles presented by her mental health at times, symbolized by images of tear drops and a stop sign located within the purple sash that falls across the chest of her body map. She described her decision to consume cannabis when her emotions are unsettled, and her anxiety begins to worsen. She chose to represent this feeling on her body map by creating the image of a lung to symbolize the calming effect that is has for her, offering her the ability to breathe again:

> "I have teardrops on my sash because I'm so emotional all the time... I want to be, you know, myself and not be judged for being myself and feeling the way I feel. And then like, I don't remember why I drew the stop sign, but like, I think I drew it because people are always stopping me from… getting anywhere I want to go. And I'm stopping myself."

> "I'll take it (cannabis) if I'm… in a mood. I'll smoke some weed to calm down… It makes you feel leveled out… [I drew] a lung that's blue… because I take a deep breath, uh, before I have to go out because I get like, really bad anxiety. Uh, so I drew, um, upwards arrows in orange, like almost as if it's the air going up, uh, pushing up. And then I'm spiraling upwards, and then I get stuck in my head."

Rose parallels the same affect that cannabis has in mitigating her anxious thoughts. She draws a pair of sunglasses on her body map to represent the feeling of having to mask her authentic self despite the happy feelings she receives from her cannabis use, symbolized by a smiley face:



> "I know that if I have my weed, then everything's okay… With my social anxieties, I usually never ever would go out in public without being stoned because if I did, I

> would just be too anxious. And too much anxiety to even leave the house. But if I can get stoned, hey, I'll go anywhere. You know, I'll talk to anybody, I'll speak to anybody, but if I don't have weed, don't come near me, you might not see me, and if you do see me, it won't be good."

Gia creates an image of flames in her brain to represent her thoughts and emotions because flames are akin to radiation and heat from the sun. She likens this to the life that the sun provides, suggesting that when you feel more positive, you are given life. Gia tells her own story about how cannabis supports her emotional well-being by channeling the negative emotions into positive ones and she does so with intent and conviction:

> "(Cannabis) puts me in a happy mood. Like, our lives are so challenging. Maybe having not enough money you could feel like, sad, or society might be looking at you negatively, like, 'oh, they don't have too much money'… For me as well, I get harassed a lot, so um… which is negative. Marijuana puts me at the mental state of um, 'hey, it's okay, tomorrow's another day, don't worry, be happy'. So yeah, it just has the… makes you have happy feelings. Even though… even though you're being put down, or… emotionally, if you're in a bad relationship whether its physical or verbal abuse, you come to take weed, and then it's like, oh, that's just like, you can go through another day. It helps you to, um, go beyond and past the negativity. Puts you in the positive."

These experiences indicate that while these women occupy marginalized, and traditionally less powerful positions in Canadian society, they possess the self-determination and empowerment to

make meaningful and profound decisions in a way that supports their mental health and resiliency. A final a note from one participant, Rose, who created the concluding image of a flexing bicep wearing a pink bracelet:

> "It makes women feel strong. I put the arm… the big strong arm with the pink bracelet and that, um, because it makes us feel strong. And makes us feel happy. And if it makes us feel strong and happy, then that's good."

The women's narratives describe cannabis' role in both reducing anxious symptoms and maintaining a positive outlook. More profoundly, however, the women demonstrate thoughtful decision-making surrounding their use that reflects the benefits of cannabis and more broadly, enhances their overall emotional wellbeing.

Chapter 6: Discussion

In this section, I will critically analyze the participant insights that surfaced through my findings using an intersectional feminist lens, making connections to the broader literature. The discussion will reflect the three main themes presented in the findings section relating to women's experiences with consuming cannabis: (1) cannabis as a response to trauma; (2) cannabis as a harm reduction tool; and (3) cannabis to support emotional wellness. I will then explore what implications this has on women's health care and social service practice and policy. Finally, I will address the strengths and limitations of the study.

6.1 Cannabis as a Response to Trauma

A theme that became apparent throughout both body mapping workshops was the common experience of trauma among participants. This is not surprising given that individuals from historically marginalized groups often experience trauma disproportionately (Bassir et al., 2023). While the women spoke to an array of traumatic experiences across the lifespan, they collectively voiced decisions to consume cannabis to subdue the discomfort that accompanies such experiences. For the women, using cannabis reduced their emotional pain so that they could go about their day and remain productive. Accounts further indicated that cannabis enabled them to mitigate chronic stress associated with every day survival struggles. For instance, Gia's story about her continuous trips to the foodbank on foot with her children and how cannabis use made this possible. This is understandable given the broader context of structural inequality impacting the women's lives, including homelessness, poverty, childcare, and mental health challenges (Nelson, 2021). In this way, the women's motives for cannabis use reflect their coping beyond the experience of trauma, but include coping with the effects of social marginalization, which in many ways, could be positioned as another form of trauma (Nelson, 2021).

The existing literature regarding trauma and cannabis has not been fully investigated. While many studies indicate a correlation between cannabis and trauma, it remains unknown as to whether individuals who experience trauma are more likely to use substances, including cannabis, as a coping response, or if individuals who use cannabis are also exposed to other risk factors that make them more susceptible to experiences of trauma. For the purposes of this study, however, this was not the intent. Rather, the findings of the current study suggest that women are consuming cannabis due to its protective attributes, regardless of the underlying mechanism at work. The findings support the idea that trauma exposed individuals are likely to report motivations for use that centre on improving specific trauma-related symptoms, such as coping with anxious thoughts, improving distress tolerance, greater attention and concentration, and managing negative feelings, another theme identified across the literature (Brammer et al.,2022; Short et al., 2022; Walukevich-Dienst et al., 2019, as cited in Bassir et al., 2023; Bonn-Miller et al., 2014). This implies that it is not the trauma exposure itself that relates to cannabis use, but rather, the consequences of the experience (Farrelly et al., 2022). However, where the current study differs, is that decisions to consume cannabis go beyond mitigating trauma symptoms alone, to implicate other aspects of their identity in their motives for and disclosure of cannabis use. The women speak to the interconnected impacts of gender, race, class, and other positionalities that significantly shape their perceptions (Nelson, 2021). This became evident through the women's narratives that told complex stories about their cannabis use motives that were a result of many interconnected experiences and overlapping aspects of their identities.

Taken together, the experiences articulated by the women align with the self-medication theory that surfaces across the literature on cannabis and trauma (Baker et al., 2004; Hicks et al., 2022; Simpson et al., 2014). The theory suggests that individuals use substances to reduce and

relieve their painful feelings and emotions (Khantizan, 1987). The women's cannabis use quieted their interfering symptoms and negative psychological states associated with their experiences of trauma, permitting them to endure in the face of such trauma.

6.2 Implications

The association between cannabis and trauma has important implications for health and social care providers. Understanding the prevalence of cannabis use and its valuable role in the lives of trauma-exposed individuals is relevant to screening and assessment practices in a variety of health settings (Browne et al., 2018). Having an awareness of one's use and the underlying motives, is important for service providers if they are to offer person-centred and trauma informed care in a way that meets the individual's needs. It also presents important considerations when developing treatment plans for both physical and mental health related conditions and overall, better positions service-providers to offer nuanced care that is coordinated and tailored to the needs of the individual. There may also be value in supporting individuals with the development of alternative coping strategies and skills, or perhaps, more appropriately, additional coping strategies and skills. Approaches such as counselling, art therapy, community involvement, mindfulness, and/or group therapy, may compliment the strategy of cannabis consumption, offering a more holistic approach to coping with trauma.

The findings also bring to light the prevalence of trauma, particularly among individuals with experiences of marginalization, as well as the various points of encounter that are possible across women's lifespans. This informs the way that practitioners provide care and emphasizes the importance of a trauma-informed approach in all fields of social work and allied-health care practice. If women are using cannabis to manage symptoms following numerous trauma exposures across their lifetime, then addressing this pattern and in a gender-sensitive manner

may be valuable, particularly since women are already at a heightened risk for other traumas, such as gender-based and sexual violence (Browne et al., 2018).

Future research examining the impact of cannabis use on certain subgroups of individuals may provide deeper insights as well as more detailed explanations for use among vulnerable populations. Further, research that explores the need for gender-sensitive-decision support for those contemplating changes in their cannabis use may provide direction for developing tailored information to support decision-making in a variety of settings (Bottorff et al., 2011).

6.3 Cannabis as a Harm Reduction Tool

The second major theme that emerged from the body mapping workshops was the role of cannabis as a harm reduction tool to reduce and/or refrain from illicit drug and prescription medication use. Harm reduction is the practice of reducing the negative health, social, and legal impacts associated with drug use (National Harm Reduction Coalition, 2024). Harm reduction is grounded in a justice and human rights framework, promoting safe drug use rather than abstinence (Harm Reduction International, 2024). As an approach, harm reduction in the field of substance use contends that some degree of drug use is inevitable as many individuals will be unwilling or unable to completely abstain from use, and therefore, reducing the negative consequences is the primary objective (Logan & Marlatt, 2010).

The women narratively and visually expressed the ways in which consuming cannabis was used as a tool to limit their use of illicit, and presumably more harmful and addictive, substances. Some women disclosed their prior use of substances such as crack-cocaine, cocaine, crystal methamphetamine, and fentanyl, and described how they considered cannabis a safer alternative because of the less adverse effects. They described how their use of cannabis allowed them to remain their authentic selves unlike the times when they were using other illicit

substances. Although not explicitly indicated by the women in this study, cannabis has the potential to achieve abstinence from more dangerous substances themselves *and* eliminate/reduce more harmful routes of administration, such as injection use, while managing painful withdrawal symptoms in the process of weening off such substances.

Also expressed by the women, were their preferences to consume cannabis as an alternative to prescription medication, especially for managing chronic pain and mental health symptoms. Common reasons for substitution are improved symptom management and fewer adverse side effects indicating that the benefits are twofold. While the findings of the current study are consistent with previous findings that cannabis is being used to manage pain (Reiman et al., 2017), its use to treat mental health conditions is a relatively recent claim across the literature (Browne et al, 2018; Farrelly et al., 2022; Walsh et al., 2017), suggesting that this may be a trend emerging within the realm of medical cannabis (Lucas et al., 2019). Side effects of prescription medication can be significant, often impacting one's daily functioning. Decreasing or eliminating their use can dramatically improve one's quality of life. There may be a broadening of cannabis' therapeutic applications since Canada's recent legalization (Lucas et al., 2019). This more widespread cannabis use for medicinal purposes will demand further research to "assess the long-term health implications of chronic daily medical use, inform therapeutic considerations by patients and health care providers, and develop evidence-based treatment guidelines (Lucas et al., 2019, p. 6).

The women's narratives not only highlight the benefits of cannabis as a harm reduction strategy, but also amplify their self-determination, the right to decide which treatment or substance is most effective and least harmful for them (Lau et al., 2015; Reimen, 2009). In this

way, the adverse health, social, and legal harms are mitigated, but more profoundly, women are empowered to make meaningful decisions about their use and well-being.

Participant preferences to use cannabis as a substitute to illicit drugs and prescription medication may also reflect inadequate treatment and/or barriers to professional care within the health care system, particularly among marginalized populations who have been historically excluded from such systems (Ivsins & Yake, 2020; Paul et al., 2020). Many individuals indicate challenges to accessing substance use services, including the reluctance of providers to provide opioid replacement therapy, as well as other logistical barriers such as geographic location, access to public transit, eligibility criteria, and mandatory appointment scheduling, among others (Paul et al., 2020). This creates an environment of mistrust with healthcare and other related systems and such barriers lead many to the conclusion that "addressing substance use-related harms, as well as ongoing mental and physical health issues, is something that is best accomplished independently" (Paul et al., 2020, p. 10).

While there are risks inherent in any drug use, participant experiences confirm what is said in the literature regarding cannabis substitution as an effective method of reducing harms associated with both illicit drugs and pharmaceuticals (Duhart et al., 2024; Larnder et al., 2022; Lau et al., 2015). Cannabis products may be a promising strategy for combatting harms associated with other long-term substance and prescription medications use.

6.4 Implications

These findings provide insights that have the potential to inform public health initiatives in a way that considers and addresses the unique and complex needs of women. Until recently, most of the research surrounding the medical use of cannabis has been male dominated, with very little attention being paid to the experiences and patterns of use among women. Growing research,

along with the findings presented in this thesis, indicate that women are using cannabis as an alternative treatment option for various symptoms and conditions (Brabete et al., 2023). The International Cannabis Policy Study (ICPS) which collected data from Canadian respondents between 2019 and 2021, indicates that similar to the current findings, women are significantly more likely to substitute cannabis for prescription medication than men, as they use cannabis to improve mental health symptoms, manage symptoms for medical conditions, and regulate pain (Brabete et al., 2023). This data suggests that more and more women are using cannabis for therapeutic purposes, making deliberate decisions to integrate cannabis into their health and wellness regimes. This has direct implications for women's health initiatives and the need to balance the current understanding of cannabis' 'risks' with the potential role of cannabis in harm reduction and the lived experience of women who use substances (Grafe et al., 2023).

The findings have the potential to better inform health and social service providers about the motives of cannabis use as well as the reasons women may prefer alternative options to other substances and prescription medication, leading to novel harm reduction approaches that reflect this gendered analysis. This could also shift the way in which messaging and information are delivered by service providers, promoting a person-centred approach that meets individuals where they are at, rather than abstinence-based directives. Therefore, designing services and educating/training service providers must incorporate both the potential harms *and* benefits of cannabis use, including its role in limiting or eliminating more harmful forms of substance use (Paul et al., 2020). Doing so would create spaces where meaningful and transparent conversations about cannabis use with health and social care providers can occur, and in the process, aid in reducing stigmatizing practices and surveillance within certain populations (Ivsins & Yake, 2020). It is also essential that health care and social service providers become aware of

the social context in which cannabis use occurs since certain populations demonstrate increased use, including those belonging to marginalized populations (Bayrampour et al., 2019; Mark et al., 2017 as cited in Grafe et al., 2023), which may also act as barriers to seeking treatment (Acevedo et al., 2020). For instance, harm reduction is especially essential during pregnancy, a time when women are likely to encounter stigma, challenges with accessing opiate replacement therapies, and abstinence-based directive from service providers (Grafe et al., 2023).

Especially relevant to public health and safety, the findings bring attention to cannabis' role in reducing both prescription and illicit opioid use, both of which are responsible for the rapid growth in North America's opioid epidemic and the leading cause of accidental death in Canada and the United States (Lau et al., 2015; Lucas et al., 2019). Opioid poisonings also lead to hospitalizations and reactive health care and social service responses. With further research in the area of cannabis substitution, the public health impacts of the current opioid overdose crisis could potentially be mitigated (Lucas et al., 2019).

6.5 Cannabis to Support Emotional Wellness

Finally, emerging from the body mapping workshops was the prominent role that cannabis plays in contributing to the emotional wellness of the women. This reoccurring theme showed up time and again within both workshops and across a wide range of topics, highlighting the ways in which cannabis use is deemed pleasurable and beneficial to the women in this study. The findings point to participant decisions to consume cannabis as a rational and intentional behaviour motivated by the desire for positive experiences (Nelson, 2021). Phrases and words such as joy, happy, calm, peaceful, relieved, strong, relaxed, and power, were used by the women to describe the positive thoughts and emotions, feelings of relief, improved mental health, and increased resilience they receive from consuming cannabis. The findings also speak

to the thoughtful and conscious decision-making process that the women engaged in while making such choices. Since there are inherent risks in all drug use, it appeared as though the women had carefully weighed the social and health harms with the benefits and pleasures of use, indicating that decision-making processes are relative to the individual and context of use.

This theme directly opposes the current conceptualization of cannabis, and other drug use, that is rooted in discourses of pathology, abstinence, and neoliberalism (Moore, 2008). Individuals, institutions, and research are all predominantly concerned with cannabis related 'harms' and even when the 'benefits' of cannabis use *are* discussed, they do not occur as a stand-alone topic and instead, are frequently coupled with 'risks' (Moore, 2008). This dichotomous 'good vs. bad' rhetoric "rarely allows for the separation of drugs and risk, or the co-occurrence of pleasure and safety" (Barratt et al., 2014, as cited in Ivsins & Yake, 2020, p. 8). This binary conceptualization further serves to reinforce power differentials related to cannabis consumption (Haines-Saah et al., 2014), and is especially evident in the acceptance and normalization of use within privileged populations, while framed as deviant or problematic among individuals experiencing oppression and marginalization (Ivsins & Yake, 2020). This rhetoric is understandable given the resources that are at stake in the drug research field (Moore, 2008). Studies on the pleasure of drugs are less profitable than the drug-related harms that have the potential to generate programming and resource funding in attempts to mitigate adverse outcomes associated with use (Moore, 2008). As a result, there is an interest in focusing on, and possibly amplifying, drug-related harms (Moore, 2008). Further, the consequences of drug use are typically presented through a quantitative data analysis which holds more clout in the eyes of government health funding, as opposed to the qualitative research in which pleasure is situated

(Moore, 2008). These power differentials contribute to the "erasing or marginalizing of pleasure in research accounts" (Moore, 2008, p.355).

6.6 Implications

The findings point to the importance of challenging the prevailing discourse that surrounds cannabis use. By integrating the perspectives and experiences of women in this study into health care and social services, the benefits associated with use can be amplified, instead of touting dominant views about harms (Nelson, 2021). Doing so constructs an alternative discourse about cannabis and other drugs (Nelson, 2021). This has the potential to contribute to positive changes in the policy realm that will avoid the damaging effects the current rhetoric has upon individuals who consume cannabis. Further research is also required to understand how cannabis-related pleasure is shaped by intersecting identities and contexts of use (Moore, 2008).

Overall, an important feature of all the findings is the shift away from the risks and harms associated with drug use, towards the positive benefits for those using them. Much of the attention on any positive aspects of substance use has been limited to 'recreational' drug use, only allowing for meaningful conceptions of drug consumption among certain populations (Ivsins & Yake, 2020). Additionally, the findings of this study centre the traditionally silenced voices and lived experiences of women from marginalized positions in Canadian society.

6.7 Strengths

i) Intersectional Feminist Theory

Using an intersectional lens to approach this research project contributed to the rich understanding of the complexity that surrounds women's decisions around cannabis consumption and their disclosure of use to health care and social service providers. By grounding the research in an intersectional feminist framework, the intricacy and multiplicity of their experiences with

cannabis consumption was captured in a way that an exclusive gendered analysis may not have provided. The framework centred the nuanced lived experiences of the individual women while also appreciating these experiences within the larger social, legal, and political context, enriching the level of analysis.

ii) Feminist Participatory Action Research (FPAR)

The methodological framework of FPAR was a powerful means of eliciting participation among the women in which new knowledge and subjectivities were created in the process. This evolution of coming to know through one another was a valuable strategy for the women to develop an awareness and insight that may not have been possible in another research environment and in many ways, this process was more valuable to the participants that the specific outcomes of the study. FPAR provided a space for both individual and broader inquiry that allowed for an action-oriented engagement that was meaningful and liberatory for the women in the study.

iii) Familiarity

The research team included individuals who had prior connections with the community and participants, including myself. This familiarity offered the potential to increase trust, rapport building, and greater levels of engagement during the body mapping workshops (Kerstetter, 2012). Further, these pre-established relationships uniquely positioned the research team to better understand the nuanced experiences of the participants and offer insights which guided our reflexive learning, prompting us to make connections among multiple experiences (Coy, 2005). Without occupying some degree of insider status, we may not have been able to approach participants in such a profound and intimate manner and evoke such meaningful reflection. On the other hand, although it is impossible to know, this familiarity may have also acted as a

limitation, censoring the women's sharing of personal information out of fear that it may impact their access to future services, or simply wanting to compartmentalize aspects of their identities, experiences, and lives.

iv) An Arts-Based Methodology

Finally, the participatory, arts-based nature of the research project was, a major strength, as it promoted a deeper exploration of participant's lived experience. Some scholars claim that language is an insufficient means of describing the social world (Foster, 2007), and question whether language can ever mirror reality since it is not possible to represent life as it is actually lived or experienced (Denzin & Lincoln, 1998). Arts-based research can honour the evocative representation of participants' lived experience and in doing so, can deepen understanding in others, moving closer to a portrayal of the world in all its emotional complexity (Foster, 2007). The women's artwork complemented their narratives and, in some ways, aided in their story-telling process as they elaborated on the images depicted in their body maps, enriching the data beyond narratives alone. Moreover, since reading and writing are not everybody's primary means of communication (Foster, 2007), artistic expression can be a powerful tool for individuals who have challenges expressing themselves through oral or written communication, making it especially useful for those experiencing cognitive, psychological, or safety-related barriers (Sinding & Barnes, 2015). This was especially relevant to the women in this study, many of whom had experiences with such obstacles. In this way, art becomes more accessible than traditional research practices, but it also assumed a form of resistance, since art does not fully comply with expectations of colonial research practices, such as written expression (Sinding & Barnes, 2015). Arts-based research challenges the academic community's claims to positivist knowledge and resists institutionalized ways of discoursing the human experience, by using art

to highlight multiple and diverse ways of understanding and being in the world (Finley, 2012). By collecting and representing data in the form of body maps, the research team contributed to disrupting dominant practices and oppressive systems that typically silence and marginalize individuals (Clover, 2011; Sinding & Barnes, 2015). As feminist theory is positioned, this also has the capacity to contribute to meaningful change at both the individual and society levels (Clover, 2011; Sinding & Barnes, 2015).

6.8 Limitations

Though the findings and implications are promising, the current study is limited in several respects.

i) Analysis

The lack of participant involvement at the data analysis stage may be perceived as a limitation. Ethical practices in community-based research encourage participant involvement in all stages of the research process, with particular attention paid to the analysis phase as this democratizes the process and diversifies the level of analysis. Involvement in data analysis also provides an opportunity for participants to confirm whether the meanings extracted from the data have been interpreted correctly and within the appropriate context. Unfortunately, due to the complexity of the women's lives as well as limited resources required to facilitate such involvement, such as time for adequate training and funding, participant involvement at the analysis phase of research was not possible.

ii) Recruitment

A final limitation to this research study was the recruitment process. Since participants were recruited from within the YWCA Hamilton, this meant that most were already connected with a service provider and were receiving gender-specific supports. Further, an individual who self-selects their participation in a research study is going to offer a different perspective than those

unwilling or unable to engage and commit in the same manner. Therefore, the experiences of the women were less diversified than may have been the case if recruitment was more widespread or had the selection process been different.

Chapter 7: Conclusion

In this thesis, I consider some of the processes and structures that may have contributed to the experiences and perceptions of women who consume cannabis and their impact on decision-making processes. I have brought forth various considerations made by women who participated in the body mapping workshops, calling attention to coping with trauma, mitigating harm, and enhancing emotional wellness as the predominant motives for consumption. I have also highlighted the complexities of these motives and attempted to connect them with one another as well as to the larger societal structures and institutions in which they sit. I have brought forth an analysis of how particular identities overlap and co-exist to understand both experiences of oppression and privilege that inevitably influence women's decision-making processes regarding cannabis use and their decisions that surround disclosure to health and social service providers.

7.1 Personal Reflections

Throughout this process, I continuously reflected on my social positioning as a white, cisgender, heterosexual, middle-class researcher, exploring the experiences of women who are positioned along more marginalized axes of their identities. Aside from our cannabis use, I had very little in common with them and I worried about how this might influence our time together in the body mapping workshops and broader research outcomes of this thesis. My experiences were not the same as theirs; I could not relate to the obstacles, stigma, loss, violence, and trauma that the women had encountered and endured. My social positioning has granted me privilege and, in some ways, protected me from some of these same experiences. This research project has forced me to reflect and acknowledge that my experiences with cannabis are accepted by society; I am not stigmatized and surveilled in the same way. At the same time, I recognize and appreciate the subjectivity that accompanies my identity, incorporating aspects of myself, my experiences, my

values, and my beliefs into this research, illuminating new perspectives as it is situated within *my* social context (Gough & Madill, 2012). This thesis is but one version of truth with the possibility for multiple truths, all valid, authentic, and sincere.

However, even in the face of these differences, across all aspects of this thesis, from start to finish, was our shared experiences as women. Although not all of our struggles were the same, we had all struggled at some point in our lives and our identities as women united many of these experiences that may have otherwise appeared separate. As women, we came to understand, even without sharing the same lived experience. Being a woman is what "connects us, reveling in our differences; this is the process that brings us closer, that gives us a world of shared values, of meaningful community (hooks, 2013, p.197). This is the feeling that resonated deep inside me as I shared this unforgettable experience with such powerful and inspiring women.

7.2 Personal Implications

This thesis has personal implication for me and my future social work practice. As I plan to return to clinical social work practice at the nexus of mental health and perinatal health, I consider how this research will impact my future work. I think about the bi-directional relationship between cannabis consumption and mental health as well as the over-surveillance that dominates the lives of women, especially during pregnancy, breast-feeding and as parents. My hope is that this awareness, coupled with the increased understanding of the prevalence and benefits of use that exists within certain populations will encourage me to consider alternative modalities, approaches, and mindset regarding treatment and care within a clinical setting. In an environment where the 'harms' of cannabis use are highlighted and abstinence-based approach becomes the predominant response, I have the ability, and the power, to begin to deviate from this outlook in a way that reduces judgement, centres the nuanced needs of the individual, de-

pathologizes, reduces harm in the less traditional sense, and shifts the discourse surrounding women who consume cannabis.

There will always remain personal tensions for me between the medical model of care and my direct social work practice. The mental health system, many of the professionals that practice within it, and the knowledge regimes, all adhere to practices embedded within the dominant culture of power (Joseph, 2015). I recognize that my participation is this setting is responsible for reinforcing and perpetuating this prevailing, yet problematic, ideology and to some degree, reflects my complacency in recreating and reinforcing structures of oppression. However, I continuously remind myself that these power differentials will persist regardless of my presence, and that working from within the system has the potential to promote change by taking risks that promote gradual change. By learning to recognize, unmask and challenge power in small, thoughtful, and intentional ways, I am able to resist the aspects of the medical model that create this tension for me both personally and professionally. In discussions about this tension, a professor once said to me, “if not you, then who?” and these words echo true to me and will sit with me throughout my future practice (J. Chaplin, personal communication, 2022).

References

Alessi, E. J., & Kahn, S. (2023). Toward a trauma-informed qualitative research approach: Guidelines for ensuring the safety and promoting the resilience of research participants. *Qualitative Research in Psychology*, *20*(1), 121–154. https://doi.org/10.1080/14780887.2022.2107967

Alhusen, J. L., Lucea, M. B., Bullock, L., & Sharps, P. (2013). Intimate partner violence, substance use, and adverse neonatal outcomes among urban women. *The Journal of Pediatrics*, *163*(2), 471–476. https://doi.org/10.1016/j.jpeds.2013.01.036

Archie, S. R., & Cucullo, L. (2019). Harmful effects of smoking cannabis: A cerebrovascular and neurological erspective. *Frontiers in Pharmacology*, *10*, 1481–1481. https://doi.org/10.3389/fphar.2019.01481

Asmussen, F. V., Christensen, A.-S., & Vibeke Dahl, H. (2013). Cannabis use during a life course - integrating cannabis use into everyday life. *Drugs and Alcohol Today*, *13*(1), 44–50. https://doi.org/10.1108/17459261311310844

Astley, S. J., Little, R. E. (1990). Maternal marijuana use during lactation and infant development at one year. *Neurotoxicology and Teratology*, *12*(2), 161–168. https://doi.org/10.1016/0892-0362(90)90129-Z

Azcarate, P. M., Zhang, A. J., Keyhani, S., Steigerwald, S., Ishida, J. H., & Cohen, B. E. (2020). Medical reasons for marijuana use, forms of use, and patient perception of physician attitudes among the US population. *Journal of General Internal Medicine: JGIM*, *35*(7), 1979–1986. https://doi.org/10.1007/s11606-020-05800-7

Baggio, S., Deline, S., Studer, J., Mohler-Kuo, M., Daeppen, J.-B., & Gmel, G. (2014). Routes of administration of cannabis used for nonmedical purposes and associations with patterns of

drug use. *Journal of Adolescent Health*, *54*(2), 235–240. https://doi.org/10.1016/j.jadohealth.2013.08.013

Baron, E. P., Lucas, P., Eades, J., & Hogue, O. (2018). Patterns of medicinal cannabis use, strain analysis, and substitution effect among patients with migraine, headache, arthritis, and chronic pain in a medicinal cannabis cohort. *Journal of Headache and Pain*, *19*(1), 37–28. https://doi.org/10.1186/s10194-018-0862-2

Barratt, M. J., Allen, M., & Lenton, S. (2014). "PMA sounds fun": Negotiating drug discourses online. *Substance Use & Misuse*, *49*(8), 987–998. https://doi.org/10.3109/10826084.2013.852584

Belenky, M. F. (1986). *Women's ways of knowing: The development of self, voice, and mind*. Basic Books.

Bird, C. E., & Rieker, P. P. (1999). Gender matters: An integrated model for understanding men's and women's health. *Social Science & Medicine (1982)*, *48*(6), 745–755. https://doi.org/10.1016/S0277-9536(98)00402-X

Blackstock, C. (2006). *Reconciliation in child welfare: touchstones of hope for indigenous children, youth, and families*. First Nations Child & Family Caring Society of Canada. https://books-scholarsportal-info.libaccess.lib.mcmaster.ca/uri/ebooks/ebooks1/gibson_chrc/2010-08-06/1/10119640

Blake, D. R., Robson, P., Ho, M., Jubb, R.W., McCabe, C.S. (2006). Preliminary assessment of the efficacy, tolerability and safety of a cannabis-based medicine (Sativex) in the treatment of pain caused by rheumatoid arthritis. *Rheumatology (Oxford, England)*, *45*(1), 50–52. https://doi.org/10.1093/rheumatology/kei183

Boehnke, K. F., Litinas, E., & Clauw, D. J. (2016). Medical cannabis use is associated with decreased opiate medication use in a retrospective cross-sectional survey of patients with chronic pain. *The Journal of Pain*, *17*(6), 739–744. https://doi.org/10.1016/j.jpain.2016.03.002

Boilevin, L., Chapman, J., Deane, L., Doerksen, C., Fresz, G. Joe, D., Leech-Crier, N., Marsh, S., McLeod, J., Neufeld, S.D., Pham, S., Shaver, L., Smith, P., Steward, M., Wilson, D., and Winter, P. (2019). *Research 101: A manifesto for ethical research in the downtown eastside.* https://avenue.cllmcmaster.ca/d2l/le/content/584661/viewContent/4385574/View

Bonn-Miller, M. O., Vujanovic, A. A., Feldner, M. T., Bernstein, A., & Zvolensky, M. J. (2007). Posttraumatic stress symptom severity predicts marijuana use coping motives among traumatic event-exposed marijuana users. *Journal of Traumatic Stress*, *20*(4), 577–586. https://doi.org/10.1002/jts.20243

Bottorff, J. L., Bissell, L. J. L., Balneaves, L. G., Oliffe, J. L., Capler, N. R., & Buxton, J. (2013). Perceptions of cannabis as a stigmatized medicine: A qualitative descriptive study. *Harm Reduction Journal*, *10*(1). https://doi.org/10.1186/1477-7517-10-2

Bottorff, J. L., Bissell, L. J. L., Balneaves, L. G., Oliffe, J. L., Kang, H. B. K., Capler, N. R., Buxton, J. A., & O'Brien, R. K. (2011). Health effects of using cannabis for therapeutic purposes: A gender analysis of users' perspectives. *Substance Use & Misuse*, *46*(6), 769–780. https://doi.org/10.3109/10826084.2010.537732

Boyd, S. (2019). Gendered drug policy: Motherisk and the regulation of mothering in Canada. *International Journal of Drug Policy*, *68*, 109–116. https://doi.org/10.1016/j.drugpo.2018.10.007

Boyd, S. C. (2015). *From witches to crack moms: Women, drug law, and policy* (Second edition.). Carolina Academic Press.

Boydell, K. (2021). *Applying body mapping in research: An arts-based method*. Routledge. https://doi.org/10.4324/9780429340260

Boys, A., Marsden, J., & Strang, J. (2001). Understanding reasons for drug use amongst young people: A functional perspective. Health Education Research, 16, 457–469. doi:10.1093/her/16.4.457

Braitstein, P., Kendall, T., Chan, K., Wood, E., Montaner, J. S. G., O'Shaughnessy, M. V., & Hogg, R. S. (2001). Mary-jane and her patients: Sociodemographic and clinical characteristics of HIV-positive individuals using medical marijuana and antiretroviral agents. *AIDS (London)*, *15*(4), 532–533. https://doi.org/10.1097/00002030-200103090-00016

Braun, V. & Clarke, V. (2012). Thematic analysis. In Cooper, H., Camic, P. M., Long, D. L., Panter, A. T., Rindskopf, D., & Sher, K. J. (eds.) *APA Handbook of Research Methods in Psychology*, Research Designs, vol. 2, pp. 57–71. American Psychological Association, Washington.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. In *Qualitative Research in Sport, Exercise and Health* (Vol. 11, Issue 4, pp. 589–597). Routledge. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Brett-Maclean, P. (2009). Body mapping: Embodying the self living with HIV/AIDS. *Canadian Medical Association Journal (CMAJ)*, *180*(7), 740–741. https://doi.org/10.1503/cmaj.090357

Bridgeman, M. B., & Abazia, D. T. (2017). Medicinal cannabis: History, pharmacology, and implications for the acute care setting. *P&T (Lawrenceville, N.J.)*, *42*(3), 180–188.

Browne, K. C., Dolan, M., Simpson, T. L., Fortney, J. C., & Lehavot, K. (2018). Regular past year cannabis use in women veterans and associations with sexual trauma. *Addictive Behaviors*, *84*, 144–150. https://doi.org/10.1016/j.addbeh.2018.04.007

Bruce, D., Grove, T. J., Foster, E., & Shattell, M. (2021). Gender differences in medical cannabis use: Symptoms treated, physician support for use, and prescription medication discontinuation. *Journal of Women's Health (Larchmont, N.Y. 2002)*, *30*(6), 857–863. https://doi.org/10.1089/jwh.2020.8437

Bruni, N., Pepa, C. D., Oliaro-Bosso, S., Pessione, E., Gastaldi, D., & Dosio, F. (2018). Cannabinoid delivery systems for pain and inflammation treatment. *Molecules (Basel, Switzerland)*, *23*(10), 2478-. https://doi.org/10.3390/molecules23102478

Brzuzy, S., Ault, A., & Segal, E. A. (1997). Conducting qualitative interviews with women survivors of trauma. *Affilia*, *12*(1), 76–83. https://doi.org/10.1177/088610999701200105

Budney, A. J., Novy, P. L., & Hughes, J. R. (1999). Marijuana withdrawal among adults seeking treatment for marijuana dependence. *Addiction (Abingdon, England)*, *94*(9), 1311–1322. https://doi.org/10.1046/j.1360-0443.1999.94913114.x

Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality and Quantity*, *56*(3), 1391–1412. https://doi.org/10.1007/s11135-021-01182-y

Cahill, C. (2007). The personal is political: Developing new subjectivities through participatory action research. *Gender, Place and Culture*, *14*(3), 267–292. https://doi.org/10.1080/09663690701324904

Cahill, C., Quijada Cerecer, D. A., & Bradley, M. (2010). "Dreaming of. . . ": Reflections on participatory action research as a feminist praxis of critical hope. *Affilia - Journal of Women and Social Work*, *25*(4), 406–416. https://doi.org/10.1177/0886109910384576

Caiola, C., Docherty, S. L., Relf, M., & Barroso, J. (2014). Using an intersectional approach to study the impact of social determinants of health for African American mothers living with HIV. *Advances in Nursing Science*, *37*(4), 287–298. https://doi.org/10.1097/ANS.0000000000000046

Caiola, C., Docherty, S. L., Relf, M., & Barroso, J. (2014). Using an intersectional approach to study the impact of social determinants of health for African American mothers living with HIV. *Advances in Nursing Science*, *37*(4), 287–298. https://doi.org/10.1097/ANS.0000000000000046

Cameron, E. C. (2023). *Stigma, Female Identity, and Cannabis Use for Women with Chronic Pain*. ProQuest Dissertations & Theses. http://libaccess.mcmaster.ca/login?url=https://www.proquest.com/dissertations-theses/stigma-female-identity-cannabis-use-women-with/docview/2728138975/se-2

Cameron, J., & Gibson, K. (2005). Participatory action research in a poststructuralist vein. *Geoforum*, *36*(3), 315–331. https://doi.org/10.1016/j.geoforum.2004.06.006

Campbell, N. D. (Nancy D., & Ettorre, E. (2011). *Gendering addiction: The politics of drug treatment in a neurochemical world* (1st ed. 2011.). Palgrave Macmillan UK. https://doi.org/10.1057/9780230314245

Canadian Center on Substance Use and Addiction (2024). Cannabis: Demographic trends for cannabis use. https://www.ccsa.ca/cannabis

Carbin, M., & Edenheim, S. (2013). The intersectional turn in feminist theory: A dream of a common language? *European Journal of Women's Studies*, 20(3), 233–248. https://doi.org/10.1177/1350506813484723

Carter, J. J., Lahousse, S., Roper, N., & Monte, S. (2007). Ethanol Inhibition of Aspartyl-(asparaginyl)-β-Hydroxylase: Relevance to Impaired Neuronal Migration in Fetal Alcohol Syndrome. *The FASEB Journal*, *21*(5), A75–A75. https://doi.org/10.1096/fasebj.21.5.A75-b

Centre for Addiction and Mental Health (CAMH) (2023). *Understanding substance abuse problems and addiction.* https://moodle8.camhx.ca/moodle/mod/book/view.php?id=113&chapterid=217

Clark, A. J., Ware, M., Yazer, E., Murray, T. J., & Lynch, M. E. (2004). Patterns of cannabis use among patients with multiple sclerosis. *Neurology*, *62*(11), 2098–2100. https://doi.org/10.1212/01.WNL.0000127707.07621.72

Clover, D. (2011). Successes and challenges of feminist arts-based participatory methodologies with homeless/street-involved women in Victoria. *Action Research*, *9*(1), 12–26. https://doi.org/10.1177/1476750310396950

Clover, D. (2011). Successes and challenges of feminist arts-based participatory methodologies with homeless/street-involved women in Victoria. *Action Research*, *9*(1), 12–26. https://doi.org/10.1177/1476750310396950

Collective, C.R. (1977). The Combahee River Collective Statement. https://avenue.cllmcmaster.ca/d2l/le/content/589350/viewContent/4501646/View

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment.* New York, NY: Routledge. (Original work published 1990).

Conner, S. N., Bedell, V., Lipsey, K., Macones, G. A., Cahill, A. G., & Tuuli, M. G. (2016). Maternal marijuana use and adverse neonatal outcomes: A systematic review and meta-analysis. *Obstetrics and Gynecology (New York. 1953)*, *128*(4), 713–723. https://doi.org/10.1097/AOG.0000000000001649

Coomber, R., Oliver, M., & Morris, C. (2003). Using cannabis therapeutically in the UK: A qualitative analysis. *Journal of Drug Issues*, *33*(2), 325–356. https://doi.org/10.1177/002204260303300204

Corroon, J., Mischley, L., & Sexton, M. (2017). Cannabis as a substitute for prescription drugs: A cross-sectional study. *Journal of Pain Research*, 10, 989-998. https://doi.org/10.2147/jpr.s134330

Corsi, D. J., Donelle, J., Sucha, E., Hawken, S., Hsu, H., El-Chaâr, D., Bisnaire, L., Fell, D., Wen, S. W., & Walker, M. (2020). Maternal cannabis use in pregnancy and child neurodevelopmental outcomes. *Nature Medicine*, *26*(10), 1536–1540. https://doi.org/10.1038/s41591-020-1002-5

Corsi, D. J., Hsu, H., Weiss, D., Fell, D. B., & Walker, M. (2019). Trends and correlates of cannabis use in pregnancy: A population-based study in Ontario, Canada from 2012 to

2017. *Canadian Journal of Public Health*, 110(1), 76–84. https://doi.org/10.17269/s41997-018-0148-0

Coy, M. (2006). This morning I'm a researcher, this afternoon I'm an outreach worker: Ethical dilemmas in practitioner research. *International Journal of Social Research Methodology, 9(5)*, 419–431. https://doi.org/10.1080/13645570601076785

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. University of Chicago Legal Forum, pp. 139-167.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. University of Chicago Legal Forum, 1, 139–168.

Crenshaw, K. (1991). *Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color*. In Source: Stanford Law Review (Vol. 43, Issue 6). https://about.jstor.org/terms

Crume, T. L., Juhl, A. L., Brooks-Russell, A., Hall, K. E., Wymore, E., & Borgelt, L. M. (2018). Cannabis use during the perinatal period in a state with legalized recreational and medical marijuana: The association between maternal characteristics, breastfeeding patterns, and neonatal outcomes. *The Journal of Pediatrics*, *197*, 90–96. https://doi.org/10.1016/j.jpeds.2018.02.005

Curran, V. H., Brignell, C., Fletcher, S., Middleton, P., & Henry, J. (2002). Cognitive and subjective dose-response effects of acute oral Δ9-tetrahydrocannabinol (THC) in infrequent cannabis users. *Psychopharmacologia*, *164*(1), 61–70.

Cuttler, C., Mischley, L. K., & Sexton, M. (2016). Sex differences in cannabis use and effects: A cross-sectional survey of cannabis users. *Cannabis and Cannabinoid Research*, *1*(1), 166–175. https://doi.org/10.1089/can.2016.0010

Davis, D. (2019). Obstetric racism: The racial politics of pregnancy, labor, and birthing. *Medical Anthropology*, 38(7), 560–573. https://doi.org/10.1080/01459740.2018.1549389

Davis, K. & Yonkers, K. (2012). Making lemonade out of lemons: A case report and literature review of external pressure as an intervention with pregnant and parenting substance-using women. *Journal of Clinical Psychiatry*, 73(1), 51–56. https://doi.org/10.4088/JCP.11cr07363

de Jager, A., Tewson, A., Ludlow, B., & Boydell, K. (2016). Embodied ways of storying the self: A systematic review of body-mapping. *Forum, Qualitative Social Research*, *17*(2). https://doi.org/10.17169/fqs-17.2.2526

Denduluri, S. K., Woolson, S. T., Indelli, P. F., Mariano, E. R., Harris, A. H. S., & Giori, N. J. (2021). Cannabinoid and opioid use among total joint arthroplasty patients: A 6-year, single-institution study. *Orthopedics (Thorofare, N.J.)*, *44*(1), E101–E106. https://doi.org/10.3928/01477447-20200928-02

Dreher M. (2002). Crack heads and roots daughters: The therapeutic use of cannabis in Jamaica. *Journal of Cannabis Therapeutics*, *2*(3–4), 121–133. https://doi.org/10.1300/J175v02n03_08

Duff, C., & Erickson, P. G. (2014). Cannabis, risk and normalisation: Evidence from a Canadian study of socially integrated, adult cannabis users. *Health, Risk and Society*, *16*(3), 210–226. https://doi.org/10.1080/13698575.2014.911823

Duhart Clarke, S. E., Victor, G., Lynch, P., Suen, L. W., & Ray, B. (2024). Cannabis donation as a harm reduction strategy: A case study. *Harm Reduction Journal*, *21*(1). https://doi.org/10.1186/s12954-024-00974-3

Duran, M., Pérez, E., Abanades, S., Vidal, X., Saura, C., Majem, M., Arriola, E., Rabanal, M., Pastor, A., Farré, M., Rams, N., Laporte, J., & Capellà, D. (2010). Preliminary efficacy and safety of an oromucosal standardized cannabis extract in chemotherapy-induced nausea and vomiting. *British Journal of Clinical Pharmacology*, *70*(5), 656–663. https://doi.org/10.1111/j.1365-2125.2010.03743.x

El Marroun, H., Tiemeier, H., Steegers, E. A. P., Jaddoe, V. W. V., Hofman, A., Verhulst, F. C., van den Brink, W., & Huizink, A. C. (2009). Intrauterine cannabis exposure affects fetal growth trajectories: The generation R study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *48*(12), 1173–1181. https://doi.org/10.1097/CHI.0b013e3181bfa8ee

Elliott, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., & Reed, B.G. (2005). Trauma-informed or trauma- denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology* 33, 461–77. doi:10.1002/jcop.20063.

Farrelly, K. N., Romero-Sanchiz, P., Mahu, T., Barrett, S. P., Collins, P., Rasic, D., & Stewart, S. H. (2022). Posttraumatic stress disorder symptoms and coping motives are independently associated with cannabis craving elicited by trauma cues. *Journal of Traumatic Stress*, *35*(1), 178–185. https://doi.org/10.1002/jts.22715

Fattore, L. (2013). Considering gender in cannabinoid research: A step towards personalized treatment of marijuana addicts. *Drug Testing and Analysis*, *5*(1), 57–61. https://doi.org/10.1002/dta.1401

Fergusson, D., Horwood, J. L., & Northstone, K. (2002). Maternal use of cannabis and pregnancy outcome. *BJOG: An International Journal of Obstetrics and Gynaecology*, 109(1), 21–27. https://doi.org/10.1111/j.1471-0528.2002.01020.x

Finley S. in Knowles, J., & Cole, A. (2012). Handbook of the Arts in Qualitative Research: Perspectives, Methodologies, Examples, and Issues. In *Handbook of the Arts in Qualitative Research: Perspectives, Methodologies, Examples, and Issues*. SAGE Publications, Inc. https://doi.org/10.4135/9781452226545

Finley S. in Knowles, J., & Cole, A. (2012). Handbook of the Arts in Qualitative Research: Perspectives, Methodologies, Examples, and Issues. In *Handbook of the Arts in Qualitative Research: Perspectives, Methodologies, Examples, and Issues*. SAGE Publications, Inc. https://doi.org/10.4135/9781452226545

Finley, S. (2008). Chapter 6: Arts-based research. In J. Gary Knowles, Ardra L. Cole (Eds.), *Handbook of the arts in qualitative research: Perspectives, methodologies, examples, and issues.* Sage Publications.

Fischer, B., Robinson, T., Bullen, C., Curran, V., Jutras-Aswad, D., Medina-Mora, M. E., Pacula, R. L., Rehm, J., Room, R., Brink, W. van den, & Hall, W. (2022). Lower-risk cannabis use guidelines (LRCUG) for reducing health harms from non-medical cannabis use: A comprehensive evidence and recommendations update. *The International Journal of Drug Policy*, *99*, 103381–103381. https://doi.org/10.1016/j.drugpo.2021.103381

Foster, V. (2007). "Ways of knowing and showing": Imagination and representation in feminist participatory social research. *Journal of Social Work Practice*, *21*(3), 361–376. https://doi.org/10.1080/02650530701553732

Freire, P. (2018). *Pedagogy of the oppressed: 50th anniversary edition.* (Myra Bergman Ramos, Trans.). Bloomsbury Academic (Original work published 1970).

Friedman, S., Heneghan, A., & Rosenthal, M. (2009). Characteristics of women who do not seek prenatal care and implications for prevention. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *38*(2), 174–181. https://doi.org/10.1111/j.1552-6909.2009.01004.x

Frisby, W., Maguire, P., & Reid, C. (2009). The "f" word has everything to do with it: How feminist theories inform action research. *Action Research*, *7*(1), 13–29. https://doi.org/10.1177/1476750308099595

Frisby, W., Reid, C. J., Millar, S., & Hoeber, L. (2005). Putting "participatory" into participatory forms of action research. In *Research and Reviews Journal of Sport Management* (Vol. 19).

Gamlin, J. B. (2011). "My eyes are red from looking and looking": Mexican working children's perspectives of how tobacco labour affects their bodies. *Vulnerable Children and Youth Studies*, 6, 339–345. doi:10.1080/17450128.2011.635222

Gastaldo, D., Magalhães, L., Carrasco, C., & Davy, C. (2012). Body-map storytelling as research methodological considerations for telling the stories of undocumented workers through body mapping. https://avenue.cllmcmaster.ca/d2l/le/content/551630/viewContent/4258564/View

Gastaldo, D., Magalhães, L., Carrasco, C., & Davy, C. (2012). Body-map storytelling as research methodological considerations for telling the stories of undocumented workers through body mapping. https://avenue.cllmcmaster.ca/d2l/le/content/551630/viewContent/4258564/View

Gauntlett, D., & Holzwarth, P. (2006). Creative and visual methods for exploring identities. *Visual Studies (Abingdon, England)*, *21*(1), 82–91. https://doi.org/10.1080/14725860600613261

Goessling, K. P. (2024). Learning from feminist participatory action research: A framework for responsive and generative research practices with young people. *Action Research*. https://doi.org/10.1177/14767503241228502

Goffman, E. (1963). *Stigma; Notes on the management of spoiled identity*. Prentice-Hall.

Gonçalves, J. R., & Nappo, S. A. (2015). Factors that lead to the use of crack cocaine in combination with marijuana in Brazil: A qualitative study. *BMC Public Health*, *15*(1), 706–706. https://doi.org/10.1186/s12889-015-2063-0

Gough, B., & Madill, A. (2012). Subjectivity in psychological science: From problem to prospect. *Psychological Methods*, *17*(3), 374–384. https://doi.org/10.1037/a0029313

Gough, B., & Madill, A. (2012). Subjectivity in psychological science: From problem to prospect. *Psychological Methods*, *17*(3), 374–384. https://doi.org/10.1037/a0029313

Government of Canada (2014). Canadian alcohol and drug use monitoring survey: Summary of results for 2012. https://www.canada.ca/en/health-canada/services/health-concerns/drug-prevention-treatment/drug-alcohol-use-statistics/canadian-alcohol-drug-use-monitoring-survey-summary-results-2012.html

Government of Canada (2021). Cannabis legalization and regulation. https://www.justice.gc.ca/eng/cj-jp/cannabis/

Government of Canada (2024, January 12). Cannabis use (non-medical) in Canada: Key findings on non-medical cannabis use of cannabis in Canada in 2023. https://health-infobase.canada.ca/cannabis/

Government of Canada (2024). Social determinants of health and health inequalities. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Grasswick, H. (2021). Feminist epistemology. In *The Oxford Handbook of Feminist Epistemology*. https://doi.org/10.1093/oxfordhb/9780190628925.013.15.

Grasswick, H. (2021). Feminist epistemology. In *The Oxford Handbook of Feminist Epistemology*. https://doi.org/10.1093/oxfordhb/9780190628925.013.15.

Graves, L. E., Robert, M., Allen, V. M., Dama, S., Gabrys, R. L., Tanguay, R. L., Turner, S. D., Green, C. R., & Cook, J. L. (2022). Guideline no. 425b: Cannabis use throughout women's lifespans – part 2: Pregnancy, the postnatal period, and breastfeeding. *Journal of Obstetrics and Gynaecology Canada*, *44*(4), 436-444.e1. https://doi.org/10.1016/j.jogc.2022.01.013

Gray, T. R., Eiden, R. D., Leonard, K. E., Connors, G. J., Shisler, S., & Huestis, M. A. (2010). Identifying prenatal cannabis exposure and effects of concurrent tobacco exposure on neonatal growth. *Clinical Chemistry (Baltimore, Md.)*, *56*(9), 1442–1450. https://doi.org/10.1373/clinchem.2010.147876

Greaves, L., & Hemsing, N. (2020). Sex and gender interactions on the use and impact of recreational cannabis. *International Journal of Environmental Research and Public Health*, *17*(2), 509-. https://doi.org/10.3390/ijerph17020509

Greene, S. (February 28, 2023). *Women, art and cannabis body mapping facilitators guide*. Version 28-Feb-23.

Greene, S. (October 12, 2018). *Women, art and cannabis: Insight grants*. Social Sciences and Humanities Research Council of Canada, Application for a Grant: 997740.

Greene, S. (October 12, 2018). *Women, art and cannabis: Insight grants*. Social Sciences and Humanities Research Council of Canada, Application for a Grant: 997740.

Greene, S. (October 12, 2018). *Women, art and cannabis: Insight grants*. Social Sciences and Humanities Research Council of Canada, Application for a Grant: 997740.

Greene, S., O'Brien-Teengs, D., Whitebird, W., & Ion, A. (2014). How HIV positive aboriginal women (PAW) talk about their mothering experiences with child and family services in Ontario. *Journal of Public Child Welfare*, 8(5), 467–490. https://doi.org/10.1080/15548732.2014.948253

Greene, S., Vaccaro, M., Bernier, A., Griffith, G., Ion, A., Maurice, R., Gabel, C., & Blake, M. (2023). "Digging in": Stigma and surveillance in the lives of pregnant and breastfeeding mothers who consume cannabis. *Critical Public Health*, *33*(5), 697–708. https://doi.org/10.1080/09581596.2023.2262739

Guy, B., & Arthur, B. (2022). Feminism and participatory research: Exploring intersectionality, relationships, and voice in participatory research from a feminist perspective. In D. Burns,

Haight, S. C., King, B. A., Bombard, J. M., Coy, K. C., Ferré, C. D., Grant, A. M., & Ko, J. Y. (2021). Frequency of cannabis use during pregnancy and adverse infant outcomes, by cigarette smoking status – 8 PRAMS states, 2017. *Drug and Alcohol Dependence*, *220*. https://doi.org/10.1016/j.drugalcdep.2021.108507

Haines-Saah, R. J., Johnson, J. L., Repta, R., Ostry, A., Young, M. L., Shoveller, J., Sawatzky, R., Greaves, L., & Ratner, P. A. (2014). The privileged normalization of marijuana use - an analysis of Canadian newspaper reporting, 1997-2007. *Critical Public Health*, *24*(1), 47–61. https://doi.org/10.1080/09581596.2013.771812

Haines-Saah, R. J., Johnson, J. L., Repta, R., Ostry, A., Young, M. L., Shoveller, J., Sawatzky, R., Greaves, L., & Ratner, P. A. (2014). The privileged normalization of marijuana use - an analysis of Canadian newspaper reporting, 1997-2007. *Critical Public Health*, *24*(1), 47–61. https://doi.org/10.1080/09581596.2013.771812

Haines, R. J., Johnson, J. L., Carter, C. I., Arora, K. (2009). "I couldn't say, I'm not a girl"-Adolescents talk about gender and marijuana use. *Social Science & Medicine (1982)*, *68*(11), 2029–2036. https://doi.org/10.1016/j.socscimed.2009.03.003

Hall, W., & Degenhardt, L. (2009). Adverse health effects of non-medical cannabis use. *The Lancet (British Edition)*, *374*(9698), 1383–1391. https://doi.org/10.1016/S0140-6736(09)61037-0

Hall, W., & Degenhardt, L. (2014). The adverse health effects of chronic cannabis use. *Drug Testing and Analysis*, *6*(1–2), 39–45. https://doi.org/10.1002/dta.1506

Hancock, A.-M. (2007). When multiplication doesn't equal quick addition: Examining intersectionality as a research paradigm. *Perspectives on Politics*, *5*(1), 63–79. https://doi.org/10.1017/S1537592707070065

Hancox, R. J., Poulton, R., Ely, M., Welch, D., Taylor, D. R., McLachlan, C. R., Greene, J. M., Moffitt, T. E., Caspi, A., & Sears, M. R. (2010). Effects of cannabis on lung function: A population-based cohort study. *The European Respiratory Journal*, *35*(1), 42–47. https://doi.org/10.1183/09031936.00065009

Handbook of action research: Participative inquiry and practice (pp.81-90). London: Sage.

Haney, M. (2005). The marijuana withdrawal syndrome: Diagnosis and treatment. *Current Psychiatry Reports*, *7*(5), 360–366. https://doi.org/10.1007/s11920-005-0036-1

Hankivsky, O. (2012). Women's health, men's health, and gender and health: Implications of intersectionality. *Social Science and Medicine*, *74*(11), 1712–1720. https://doi.org/10.1016/j.socscimed.2011.11.029

Harm Reduction International (2022). What is harm reduction? https://hri.global/what-is-harm-reduction/

Hayatbakhsh, M., Flenady, V., Gibbons, K., Kingsbury, A., Hurrion, E., Mamun, A., & Najman, J. (2012). Birth outcomes associated with cannabis use before and during pregnancy. *Pediatric Research*, 71(2), 215–219. https://doi.org/10.1038/pr.2011.25

Health Canada (2024). Cannabis for medical purposes under the cannabis act: Information and improvements. https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/medical-use-cannabis.html

Health Canada. (2022). Taking stock of progress: Cannabis legalization and regulation in Canada. https://www.canada.ca/en/health-canada/programs/engaging-cannabis-legalization-regulation-canada-taking-stock-progress/document.html

Hendricks, P. S., Delucchi, K. L., Humfleet, G.L., & Hall, S. M. (2011). Alcohol and marijuana use in the context of tobacco dependence treatment: Impact on outcome and mediation of effect. *Nicotine & Tobacco Research*, *14*(8), 942–951. https://doi.org/10.1093/ntr/ntr312

Hernandez-Avila, C. A., Rounsaville, B. J., & Kranzler, H. R. (2004). Opioid, cannabis and alcohol-dependent women show more rapid progression to substance abuse treatment. *Drug and Alcohol Dependence*, *74*(3), 265–272. https://doi.org/10.1016/j.drugalcdep.2004.02.001

Hesse-Biber, S. N., & Leavy, P. L. (2007). *Feminist Research Practice*. SAGE Publications, Inc. https://doi.org/10.4135/9781412984270

Hicks, D. L., Resko, S. M., Ellis, J. D., Agius, E., & Early, T. J. (2022). Driving after cannabis use among young adults in Michigan. *Cannabis and Cannabinoid Research*, *7*(1), 100–106. https://doi.org/10.1089/can.2020.0096

Hoffmann, D. E., & Tarzian, A. J. (2003). The girl who cried pain: A bias against women in the treatment of pain. *The Journal of Law, Medicine & Ethics*, *28*(s4), 13–27. https://doi.org/10.1111/j.1748-720X.2001.tb00037.x

Holland, C. L., Rubio, D., Rodriguez, K. L., Kraemer, K. L., Day, N., Arnold, R. M., & Chang, J. C. (2016). Obstetric health care providers' counseling responses to pregnant patient disclosures of marijuana use. *Obstetrics and Gynecology*, 127(4), 681. https://doi.org/10.1097/aog.0000000000001343

hooks, b. (1984/2000). *Feminist theory: From margin to center.* South End Press.

Ivsins, A., & Yake, K. (2020). Looking beyond harm: Meaning and purpose of substance use in the lives of marginalized people who use drugs. *Drugs: Education, Prevention and Policy*, *27*(1), 27–36. https://doi.org/10.1080/09687637.2018.1497145

J. Howard, & S. M. Ospina (Eds.), In *The SAGE Handbook of Participatory Research and Inquiry*. SAGE Publications Ltd. https://doi.org/10.4135/9781529769432

Joseph, A. J. (2015). Beyond intersectionalities of identity or interlocking analyses of difference: Confluence and the problematic of "anti"-oppression. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, Vol. 4(1), 15-39. https://intersectionalities.mun.ca/index.php/IJ/article/view/1407/1226

Kandel, D. B., Yamaguchi, K., & Klein, L. C. (2006). Testing the gateway hypothesis. *Addiction (Abingdon, England)*, *101*(4), 470–472. https://doi.org/10.1111/j.1360-0443.2006.01426.x

Keethakumar, A., Mehra, V. M., Khanlou, N., & Tamim, H. (2021). Cannabis use and patterns among middle and older aged Canadians prior to legalization: A sex-specific analysis of the Canadian tobacco, alcohol and drugs survey. *BMC Public Health*, *21*(1), 26–14. https://doi.org/10.1186/s12889-020-10074-z

Kerstetter, K. (2012). Insider, outsider, or somewhere between: The impact of researchers' identities on the community-based research process. *Journal of Rural Social Sciences* (Vol. 27, Issue 2). https://egrove.olemiss.edu/cgi/viewcontent.cgi?article=1434&context=jrss

Kerstetter, K. (2012). Insider, outsider, or somewhere between: The impact of researchers' identities on the community-based research process. *Journal of Rural Social Sciences*, *27*(2), 99–117. http://libaccess.mcmaster.ca/login?url=https://www.proquest.com/scholarly-journals/insider-outsider-somewhere-between-impact/docview/1287032003/se-2

Kesby, D. (2008). Exploring the power of action learning. *Knowledge Management Review*, *11*(5), 26.

Khan, S. S., Secades-Villa, R., Okuda, M., Wang, S., Pérez-Fuentes, G., Kerridge, B. T., & Blanco, C. (2013). Gender differences in cannabis use disorders: Results from the national epidemiologic survey of alcohol and related conditions. *Drug and Alcohol Dependence*, *130*(1–3), 101–108. https://doi.org/10.1016/j.drugalcdep.2012.10.015

Khantzian, E. J. (1987). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. In *The Cocaine Crisis* (pp. 65–74). Springer US. https://doi.org/10.1007/978-1-4613-1837-8_7

King, G. R., Ernst, T., Deng, W., Stenger, A., Gonzales, R. M. K., Nakama, H., & Chang, L. (2011). Altered brain activation during visuomotor integration in chronic active cannabis

users: Relationship to cortisol levels. *The Journal of Neuroscience*, *31*(49), 17923–17931. https://doi.org/10.1523/JNEUROSCI.4148-11.2011

Kirmayer, L. J., Gone, J. P., & Moses, J. (2014). Rethinking historical trauma. *Transcultural Psychiatry* 51:299–319. doi:10.1177/1363461514536358

Kitchigina, V. F. (2021). Cannabinoids, the endocannabinoid system, and cognitive functions: Enemies or friends? *Neuroscience and Behavioral Physiology*, *51*(7), 893–914. https://doi.org/10.1007/s11055-021-01148-5

Ko, J. Y., Tong, V. T., Bombard, J. M., Hayes, D. K., Davy, J., & Perham-Hester, K. A. (2018). Marijuana use during and after pregnancy and association of prenatal use on birth outcomes: A population-based study. *Drug and Alcohol Dependence*, *187*, 72–78. https://doi.org/10.1016/j.drugalcdep.2018.02.017

Kozak, T. (2017). Supply, secrecy, and surveillance: Experiences of women who use cannabis for pleasure. MacSphere: McMaster University Libraries Institutional Repository. https://macsphere.mcmaster.ca/handle/11375/22332

Kozak, T., Ion, A., & Greene, S. (2022). Reimagining research with pregnant women and parents who consume cannabis in the era of legalization: The value of integrating intersectional feminist and participatory action approaches. *Cannabis and Cannabinoid Research*, *7*(1), 11–15. https://doi.org/10.1089/can.2020.0086

Kral, A. H., Wenger, L., Novak, S. P., Chu, D., Corsi, K. F., Coffa, D., Shapiro, B., & Bluthenthal, R. N. (2015). Is cannabis use associated with less opioid use among people who inject drugs? *Drug and Alcohol Dependence*, *153*, 236–241. https://doi.org/10.1016/j.drugalcdep.2015.05.014

Krieger, N. (2003). Genders, sexes, and health: What are the connections—and why does it matter? *International Journal of Epidemiology,* 32(4), 652-657. https://doi.org/10.1093/ije/dyg156

Lammert, S., Harrison, K., Tosun, N., & Allen, S. (2018). Menstrual cycle in women who co-use marijuana and tobacco. *Journal of Addiction Medicine*, *12*(3), 207–211. https://doi.org/10.1097/ADM.0000000000000387

Larnder, A., Saatchi, A., Borden, S. A., Moa, B., Gill, C. G., Wallace, B., & Hore, D. (2022). Variability in the unregulated opioid market in the context of extreme rates of overdose. *Drug and Alcohol Dependence*, *235*, 109427–109427. https://doi.org/10.1016/j.drugalcdep.2022.109427

Lau, N., Sales, P., Averill, S., Murphy, F., Sato, S., & Murphy, S. (2015). Responsible and controlled use: Older cannabis users and harm reduction. *International Journal of Drug Policy*, 26(8), 709-718. https://doi.org/10.1016/j.drugpo.2015.03.008

Levenson, J. (2017). Trauma-informed social work practice. *Social Work* 62:105–13. doi:10.1093/sw/swx001.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27(1), 363-385. https://doi.org/10.1146/annurev.soc.27.1.363

Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *The Lancet (British Edition)*, *367*(9509), 528–529. https://doi.org/10.1016/S0140-6736(06)68184-1

Longino, H. E. (2002). *The Fate of Knowledge*. Princeton: Princeton University Press. https://doi-org.libaccess.lib.mcmaster.ca/10.1515/9780691187013

Lu, L., & Yuen, F. (2012). Journey women: Art therapy in a decolonizing framework of practice. *The Arts in Psychotherapy,* 39, 192-200. https://doi.org/10.1016/j.aip.2011.12.007

MacCormack, C. P., & Draper, A. (1987). Social and cognitive aspects of female sexuality in Jamaica. In *The Cultural Construction of Sexuality* (1st ed., pp. 143–165). Routledge. https://doi.org/10.4324/9781315002392-6

Macrory, F., & Boyd, S. C. (2007). Developing primary and secondary services for drug and alcohol dependent mothers. *Seminars in Fetal & Neonatal Medicine*, *12*(2), 119–126. https://doi.org/10.1016/j.siny.2007.01.005

Maguire, P. (1987). *Doing participatory research: A feminist approach*. Center for International Education, School of Education, University of Massachusetts.

Marcellus, L. (2004). Feminist ethics must inform practice: Interventions with perinatal substance users. *Health Care for Women International*, *25*(8), 730–742. https://doi.org/10.1080/07399330490475584

Marchei, E., Escuder, D., Pallas, C. R., Garcia-Algar, O., Gómez, A., Friguls, B., Pellegrini, M., & Pichini, S. (2011). Simultaneous analysis of frequently used licit and illicit psychoactive drugs in breast milk by liquid chromatography tandem mass spectrometry. *Journal of Pharmaceutical and Biomedical Analysis*, *55*(2), 309–316. https://doi.org/10.1016/j.jpba.2011.01.028

Marconi, A., Di Forti, M., Lewis, C. M., Murray, R. M., & Vassos, E. (2016). Meta-analysis of the association between the level of cannabis use and risk of psychosis. *Schizophrenia Bulletin*, *42*(5), 1262–1269. https://doi.org/10.1093/schbul/sbw003

Mason, J. (2002). *Qualitative Researching*, 2nd Edition. London: Sage Publications. http://www.sxf.uevora.pt/wp-content/uploads/2013/03/Mason_2002.pdf

Massey, S. H., Mroczek, D. K., Reiss, D., Miller, E. S., Jakubowski, J. A., Graham, E. K., Shisler, S. M., McCallum, M., Huestis, M. A., Ganiban, J. M., Shaw, D. S., Leve, L. D.,

Eiden, R. D., Stroud, L. R., & Neiderhiser, J. M. (2018). Additive drug-specific and sex-specific risks associated with co-use of marijuana and tobacco during pregnancy: Evidence from 3 recent developmental cohorts (2003–2015). *Neurotoxicology and Teratology*, *68*, 97–106. https://doi.org/10.1016/j.ntt.2018.06.002

McNaughton, C. C. (2008). Transitions through homelessness, substance use, and the effect of material marginalization and psychological trauma. *Drugs: Education, Prevention & Policy*, *15*(2), 177–188. https://doi.org/10.1080/09687630701377587

McNaughton, C. C. (2008). Transitions through homelessness, substance use, and the effect of material marginalization and psychological trauma. *Drugs: Education, Prevention and Policy*, 15(2), 177–188. https://doi.org/10.1080/09687630701377587

Mechtler, L. L., Gengo, F. M., & Bargnes, V. H. (2021). Cannabis and migraine: It's complicated. *Current Pain and Headache Reports*, *25*(3), 16–16. https://doi.org/10.1007/s11916-020-00931-2

Metz, T. D., & Stickrath, E. H. (2015). Marijuana use in pregnancy and lactation: A review of the evidence. *American Journal of Obstetrics & Gynecology*, 213(6), 761–778. https://doi.org/10.1016/j.ajog.2015.05.025

Milliken, S. (2024, January 30). *Dual role and the 'space between' Steph guest lecture.* [Lecture notes, PowerPoint Slides]. Avenue2Learn. https://avenue.cllmcmaster.ca/d2l/le/content/584661/viewContent/4552236/View

Mittleman, M. A., Lewis, R. A., Maclure, M., Sherwood, J. B., & Muller, J. E. (2001). Triggering myocardial infarction by marijuana. *Circulation (New York, N.Y.)*, *103*(23), 2805–2809. https://doi.org/10.1161/01.CIR.103.23.2805

Moore, B. A., Augustson, E. M., Moser, R. P., & Budney, A. J. (2005). Respiratory effects of marijuana and tobacco use in a US sample. *Journal of General Internal Medicine: JGIM*, *20*(1), 33–37. https://doi.org/10.1111/j.1525-1497.2004.40081.x

Moore, T. H., Zammit, S., Lingford-Hughes, A., Barnes, T. R., Jones, P. B., Burke, M., & Lewis, G. (2007). Cannabis use and risk of psychotic or affective mental health outcomes: A systematic review. *The Lancet (British Edition)*, *370*(9584), 319–328. https://doi.org/10.1016/S0140-6736(07)61162-3

Moradi, B., & Grzanka, P. R. (2017). Using intersectionality responsibly: Toward critical epistemology, structural analysis, and social justice activism. *Journal of Counseling Psychology*, 64(5), 500–513. https://doi.org/10.1037/cou0000203

Muckle, G., Laflamme, D., Gagnon, J., Boucher, O., Jacobson, J. L., & Jacobson, S. W. (2011). Alcohol, smoking, and drug use among Inuit women of childbearing age during pregnancy and the risk to children. *Alcoholism, Clinical and Experimental Research*, *35*(6), 1081–1091. https://doi.org/10.1111/j.1530-0277.2011.01441.x

Mullings L. & Schulz, A.J. (2006). Intersectionality and health: An introduction. In: Schulz AJ, Mullings L, eds. Gender, Race, Class & Health: Intersectional Approaches, 3-17

Mwaluko, G. M., Mgalla, Z. J., & Morona, D. (2002). The body mapping: A useful tool to understand adolescents' perceptions of sexuality in the AIDS era. Experience from Mwanza, Tanzania. Paper presented at the International Conference on AIDS, Tanesa, Mwanza, Tanzania. Abstract no. WePeE6508 Available from http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102252096.html

Myers, C. D., Riley, J. L., & Robinson, M. E. (2003). Psychosocial contributions to sex-correlated differences in pain. *The Clinical Journal of Pain,* 19(4), 225-232. https://doi.org/10.1097/00002508-200307000-00005

Nakamura, N., Dawe, M., McGuire, F., Rudzinski, K., Jones, W., Rehm, J., & Fischer, B. (2011). Gender differences in cannabis use related characteristics in high frequency using Canadian university students: An exploratory study. *Women's Health and Urban Life*, 10(2), 81-93. https://hdl.handle.net/1807/29998

Nash, J. C. (2008). re-thinking intersectionality. *Feminist Review*, *89*(1), 1–15. https://doi.org/10.1057/fr.2008.4

National Harm Reduction Coalition (2024). Principles of Harm Reduction. https://harmreduction.org/about-us/principles-of-harm-reduction/

Nelson, E. E. (2021). "I take it to relax... and chill": Perspectives on cannabis use from marginalized Nigerian young adults. *Addiction Research & Theory*, *29*(6), 490–499. https://doi.org/10.1080/16066359.2021.1895125

Nelson, L. H. (1990). *Who knows: From Quine to a feminist empiricism.* Temple University Press.

Neuman, L. (1997). Chapter 4. The meanings of methodology. In Neuman, W. L. *Social Research Methods: Qualitative and Quantitative Approaches* (pp. 60–87). Allyn & Bacon.

Oleson, E. B., & Cheer, J. F. (2012). A brain on cannabinoids: The role of dopamine release in reward seeking. *Cold Spring Harbor Perspectives in Medicine*, *2*(8), a012229–a012229. https://doi.org/10.1101/cshperspect.a012229

Onaemo, V. N., Fawehinmi, T. O., & D'Arcy, C. (2021). Comorbid cannabis use disorder with major depression and generalized anxiety disorder: A systematic review with meta-analysis

of nationally representative epidemiological surveys. *Journal of Affective Disorders*, *281*, 467–475. https://doi.org/10.1016/j.jad.2020.12.043

Park, P. (2001). Knowledge and participatory research. In P. Reason & H. Bradbury (Eds.),

Parker, H. (2005). Normalization as a barometer: Recreational drug use and the consumption of leisure by younger Britons. *Addiction Research & Theory*, *13*(3), 205–215. https://doi.org/10.1080/16066350500053703

Passey, M. E., Sanson-Fisher, R. W., D'Este, C. A., & Stirling, J. M. (2014). Tobacco, alcohol and cannabis use during pregnancy: Clustering of risks. *Drug and Alcohol Dependence*, *134*(1), 44–50. https://doi.org/10.1016/j.drugalcdep.2013.09.008

Patel, S., & Hillard, C. J. (2009). Role of endocannabinoid signaling in anxiety and depression. In *Behavioral Neurobiology of the Endocannabinoid System* (Vol. 1, pp. 347–371). Springer Berlin Heidelberg. https://doi.org/10.1007/978-3-540-88955-7_14

Paul, B., Thulien, M., Knight, R., Milloy, M. J., Howard, B., Nelson, S., & Fast, D. (2020). "Something that actually works": Cannabis use among young people in the context of street entrenchment. *PloS One*, *15*(7), e0236243–e0236243. https://doi.org/10.1371/journal.pone.0236243

Paul, B., Thulien, M., Knight, R., Milloy, M. J., Howard, B., Nelson, S., & Fast, D. (2020). "Something that actually works": Cannabis use among young people in the context of street entrenchment. PLoS ONE, 15(7 July). https://doi.org/10.1371/journal.pone.0236243

Peters, D. C. (2013). Patients and caregivers report using medical marijuana to decrease prescription narcotics use. *Humboldt Journal of Social Relations*, *1*(35), 24–40. https://doi.org/10.55671/0160-4341.1185

Poole, N., & Isaac, B. (2001). *Apprehensions: Barriers to treatment for substance-using mothers.* British Columbia Centre of Excellence for Women's Health.

Potts, K., & Brown, L. (2005). Becoming an anti-oppressive researcher. In *Research as Resistance: Critical, Indigenous and Anti-oppressive Approaches*, ed. L. Brown and S. Strega, 255–86. Toronto: Canadian Scholars' Press/Women's Press.

Prentiss, D., Power, R., Balmas, G., Tzuang, G., & Israelski, D. M. (2004). Patterns of marijuana use among patients with HIV/AIDS followed in a public health care setting. *Journal of Acquired Immune Deficiency Syndromes (1999)*, *35*(1), 38–45. https://doi.org/10.1097/00126334-200401010-00005

Public Health Ontario. (2018, November). Evidence brief: Health effects of cannabis exposure in pregnancy and breastfeeding. https://www.publichealthontario.ca/-/media/documents/E/2018/eb-cannabis-pregnancy-breastfeeding.pdf

Reason, P. (1998). Three approaches to participative inquiry, in *Strategies of Qualitative Inquiry*, eds N. K. Denzin & Y. S. Lincoln, Sage.

Reason, P., & Bradbury, H. (2001). *Handbook of action research: Participative inquiry and practice*. London: Sage.

Reid, C. (2004). *Advancing Women's Social Justice Agendas: A Feminist Action Research Framework. International Journal of Qualitative Methods*, *3*(3), 1–15. https://doi.org/10.1177/160940690400300301

Reid, C. & Frisby, W. (2008). Continuing the journey: Articulating dimensions of feminist Participatory Action Research. In Peter Reason and Hilary Bradbury, eds., Handbook of Action Research: Participative Inquiry and Practice, 2nd ed., 93-105. London: Sage.

Reiman, A., Welty, M., & Solomon, P. (2017). Cannabis as a substitute for opioid-based pain medication: Patient self-report. *Cannabis and Cannabinoid Research*, 2(1), 160-166. https://doi.org/10.1089/can.2017.0012

Rose, G. (2001). *Visual methodologies: An introduction to the interpretation of visual materials*. Sage.

Rose, G. (2007). *Visual methodologies: An introduction to the interpretation of visual materials* (2nd ed.). Sage.

Rossi, S., Bernardi, G., & Centonze, D. (2010). The endocannabinoid system in the inflammatory and neurodegenerative processes of multiple sclerosis and of amyotrophic lateral sclerosis. *Experimental Neurology*, *224*(1), 92–102. https://doi.org/10.1016/j.expneurol.2010.03.030

Ryan, S. A., Ammerman, S. D., O'Connor, M. E., Patrick, S. W., Plumb, J., Quigley, J., & Walker-Harding, L. R. (2018). Marijuana use during pregnancy and breastfeeding: Implications for neonatal and childhood outcomes. *Pediatrics (Evanston)*, *142*(3), 1-. https://doi.org/10.1542/peds.2018-1889

Sachs, J., McGlade, E., & Yurgelun-Todd, D. (2015). Safety and toxicology of cannabinoids. *Neurotherapeutics*, *12*(4), 735–746. https://doi.org/10.1007/s13311-015-0380-8

Salmon, A., Browne, A. J., & Pederson, A. (2010). "Now we call it research": Participatory health research involving marginalized women who use drugs. *Nursing Inquiry*, *17*(4), 336–345. https://doi.org/10.1111/j.1440-1800.2010.00507.x

Scott, K. A., & Davis, D. (2021). Obstetric racism: Naming and identifying a way out of Black women's adverse medical experiences. *American Anthropologist*, *123*(3), 681–684. https://doi.org/10.1111/aman.13559

Sherman, B. J., McRae-Clark, A. L., Baker, N. L., Sonne, S. C., Killeen, T. K., Cloud, K., & Gray, K. M. (2017). Gender differences among treatment-seeking adults with cannabis use disorder: Clinical profiles of women and men enrolled in the achieving cannabis cessation—evaluating N-acetylcysteine treatment (ACCENT) study. *American Journal on Addictions*, *26*(2), 136–144. https://doi.org/10.1111/ajad.12503

Sholler, D. J., Strickland, J. C., Spindle, T. R., Weerts, E. M., & Vandrey, R. (2021). Sex differences in the acute effects of oral and vaporized cannabis among healthy adults. *Addiction Biology*, *26*(4), e12968-n/a. https://doi.org/10.1111/adb.12968

Simpson, T. L., Stappenbeck, C. A., Luterek, J. A., Lehavot, K., & Kaysen, D. L. (2014). Drinking motives moderate daily relationships between PTSD symptoms and alcohol use. *Journal of Abnormal Psychology*, 123(1), 237. http://dx.doi.org/10.1037/a0035193

Sinding, C. & Barnes, H. (2015). How art works; hopes, claims and possibilities for social justice. In C. Sinding and H. Barnes (Eds). *Social Work Artfully,* Pp. 27-42. Waterloo: Wilfrid Laurier University Press. https://avenue.cllmcmaster.ca/d2l/le/content/551630/viewContent/4258562/View

Sinding, C. & Barnes, H. (2015). How art works; hopes, claims and possibilities for social justice. In C. Sinding and H. Barnes (Eds). *Social Work Artfully,* Pp. 27-42. Waterloo: Wilfrid Laurier University Press. https://avenue.cllmcmaster.ca/d2l/le/content/551630/viewContent/4258562/View

Slavin, M., Barach, E., Farmer, S., Luba, R., & Earleywine, M. (2017). Cannabis and symptoms of PMS and PMDD. *Addiction Research & Theory*, *25*(5), 383–389. https://doi.org/10.1080/16066359.2017.1294165

Solomon, J. (2002). "Living with X": A body mapping journey in time of HIV and AIDS. Facilitator's Guide. Psychosocial Wellbeing Series. Johannesburg: REPSSI. http://www.repssi.org/index.php?option=com_content&view=article&id=46&Itemid=37

Solomon, J. (2007). *Living with X: A body mapping journey in the time of HIV and AIDS, facilitator's guide.* Johannesburg: REPPSI. Print manual.

Solowij, N (1998). *Cannabis and Cognitive Functioning*. Cambridge University Press.

Stengel, C. (2014). The risk of being "too honest": Drug use, stigma and pregnancy. *Health, Risk and Society* 16(1), 36–50. https://doi.org/10.1080/13698575.2013.868408

Stevens, M., & Le Roux, N. (2011). A human rights violation: The forced sterilization of HIV positive women. Nursing Update, 35(3), 32-35.

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social Science & Medicine (1982)*, *67*(3), 351–357. https://doi.org/10.1016/j.socscimed.2008.03.023

Sznitman, S. R., Vulfsons, S., Meiri, D., & Weinstein, G. (2020). Medical cannabis and insomnia in older adults with chronic pain: A cross-sectional study. *BMJ Supportive & Palliative Care*, *10*(4), 415–420. https://doi.org/10.1136/bmjspcare-2019-001938

Tait, R. J., Caldicott, D., Mountain, D., Hill, S. L., & Lenton, S. (2016). A systematic review of adverse events arising from the use of synthetic cannabinoids and their associated treatment. *Clinical Toxicology, 54*(1), 1–13. https://doi.org/10.3109/15563650.2015.1110590

Tashkin, D. P., Simmons, M. S., & Tseng, C.-H. (2012). Impact of changes in regular use of marijuana and/or tobacco on chronic bronchitis. *Chronic Obstructive Pulmonary Disease*, *9*(4), 367–374. https://doi.org/10.3109/15412555.2012.671868

Tennes, K., Avitable, N., Blackard, C., Boyles, C., Hassoun, B., Holmes, L., & Kreye, M. (1985). Marijuana: Prenatal and postnatal exposure in the human. *NIDA Research Monograph*, 59, 48–60. https://pubmed.ncbi.nlm.nih.gov/3929132/

Tetrault, J. M., Crothers, K., Moore, B. A., Mehra, R., Concato, J., & Fiellin, D. A. (2007). Effects of marijuana smoking on pulmonary function and respiratory complications: A systematic review. *Archives of Internal Medicine*, 167(3), 221-228. https://doi.org/10.1001/archinte.167.3.221

Tuana, N. (2006). The speculum if ignorance: The women's health movement and epistemologies of ignorance. *Hypatia*, *21*(3), 1–19. https://doi.org/10.1111/j.1527-2001.2006.tb01110.x

Vaccaro, M. (2024). *Emergency reproductive care at YWCA Hamilton: Addressing the needs of pregnant people experiencing homelessness*. Homeless Hub. https://www.homelesshub.ca/blog/emergency-reproductive-care-ywca-hamilton-addressing-needs-pregnant-people-experiencing#:~:text=Emergency%20Reproductive%20Care%20Beds%3A,access%20to%20case%20management%20support

Valleriani, J., Haines-Saah, R., Capler, R., Bluthenthal, R., Socias, M. E., Milloy, M., Kerr, T., & McNeil, R. (2020). The emergence of innovative cannabis distribution projects in the downtown eastside of Vancouver, Canada. *The International Journal of Drug Policy*, *79*, 102737–102737. https://doi.org/10.1016/j.drugpo.2020.102737

van Gelder, M. M. H. J., Reefhuis, J., Caton, A. R., Werler, M. M., Druschel, C. M., & Roeleveld, N. (2010). Characteristics of pregnant illicit drug users and associations

between cannabis use and perinatal outcome in a population-based study. *Drug and Alcohol Dependence*, *109*(1), 243–247. https://doi.org/10.1016/j.drugalcdep.2010.01.007

Verdoux, H., Gindre, C., Sorbara, F., Tournier, M., & Swendsen, J. (2003). Effects of cannabis and psychosis vulnerability in daily life: An experience sampling test study. *Psychological Medicine*, *33*(1), 23–32. https://doi.org/10.1017/S0033291702006384

Volkow, N. D., Compton, W. M., & Wargo, E. M. (2017). The risks of marijuana use during pregnancy. *JAMA: The Journal of the American Medical Association*, *317*(2), 129–130. https://doi.org/10.1001/jama.2016.18612

Waissengrin, B., Urban, D., Leshem, Y., Garty, M., & Wolf, I. (2015). Patterns of use of medical cannabis among Israeli cancer patients: A single institution experience. *Journal of Pain and Symptom Management*, *49*(2), 223–230. https://doi.org/10.1016/j.jpainsymman.2014.05.018

Wallis, D., Coatsworth, J. D., Mennis, J., Riggs, N. R., Zaharakis, N., Russell, M. A., Brown, A. R., Rayburn, S., Radford, A., Hale, C., & Mason, M. J. (2022). Predicting self-medication with cannabis in young adults with hazardous cannabis use. *International Journal of Environmental Research and Public Health*, *19*(3), 1850-. https://doi.org/10.3390/ijerph19031850

Ware, M. A., Adams, H., & Guy, G. W. (2005). The medicinal use of cannabis in the UK: Results of a nationwide survey. *International Journal of Clinical Practice (Esher)*, *59*(3), 291–295. https://doi.org/10.1111/j.1742-1241.2004.00271.x

Weber, L. (2007). Future directions of feminist research: New directions in social policy-The case of women's health. Handbook of Feminist Research: Theory and Praxis. 669-679.

Wenger, L. D., Lopez, A. M., Comfort, M., & Kral, A. H. (2014). The phenomenon of low-frequency heroin injection among street-based urban poor: Drug user strategies and contexts of use. *The International Journal of Drug Policy*, *25*(3), 471–479. https://doi.org/10.1016/j.drugpo.2014.02.015

White, M. (2007). *Maps of narrative practice* (1st ed.). W.W. Norton & Co.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends* (1st ed.). Norton.

Wilson, R. M. (2012). *Working rough, living poor employment and income insecurities faced by racialized groups and their impacts on health*. Access Alliance Multicultural Health and Community Services. https://books-scholarsportal-info.libaccess.lib.mcmaster.ca/uri/ebooks/ebooks0/gibson_cppc-chrc/2012-05-14/1/10534599

Wong, M. M., Craun, E. A., Bravo, A. J., & Pearson, M. R. (2019). Insomnia symptoms, cannabis protective behavioral strategies, and hazardous cannabis use among U.S. college students. *Experimental and Clinical Psychopharmacology*, *27*(4), 309–317. https://doi.org/10.1037/pha0000273

Young-Wolff, K. C., Tucker, L.-Y., Alexeeff, S., Armstrong, M. A., Conway, A., Weisner, C., & Goler, N. (2017). Trends in self-reported and biochemically tested marijuana use among pregnant females in California from 2009-2016. *JAMA: The Journal of the American Medical Association*, *318*(24), 2490–2491. https://doi.org/10.1001/jama.2017.17225

YWCA Hamilton (2024, April). YWCA Housing Services. https://www.ywcahamilton.org/housing/?utm_source=google&utm_medium=search&utm_campaign=YWCA-Hamilton-YWCA-

Hamilton&gad_source=1&gclid=CjwKCAjwnqK1BhBvEiwAi7o0X0aLRB2LLlkfztf1ejJ7e_SHB7A2OSAogplmIpxPyZygORoeX_bV4hoC0tcQAvD_BwE

Zehra, A., Burns, J., Liu, C. K., Manza, P., Wiers, C. E., Volkow, N. D., & Wang, G.-J. (2018). Cannabis addiction and the brain: A review. *Journal of Neuroimmune Pharmacology*, *13*(4), 438–452. https://doi.org/10.1007/s11481-018-9782-9

Zhang, Z. F., Morgenstern, H., Spitz, M. R., Tashkin, D. P., Yu, G. P., Marshall, J. R., Hsu, T. C., & Schantz, S. P. (1999). Marijuana use and increased risk of squamous cell carcinoma of the head and neck. *Cancer Epidemiology, Biomarkers & Prevention*, *8*(12), 1071–1078.

APPENDICES

Appendix A

Women, Art, and Cannabis
Body Mapping Facilitators Guide Version: 08-Feb-23

INTRODUCTORY REMARKS:
The purpose of this guide is to outline the preparatory work and creative exercises that will be included in the Body Mapping workshops for the Women, Art, and Cannabis Study. This guide has been written for facilitators who will plan each workshop and lead participants through a series of artistic exercises in order to create a Body Map. The guide includes information to assist with organizing and opening the workshop, how to present each exercise to participants (e.g., talking script), and materials needed for each workshop. Additional resources have been included in the Appendices at the back of the guide including sample workshop agenda (Appendix A), sample ice breaker / movement activities (Appendix B), a legend to keep track of art exercises (Appendix C), a wellness circle image for group brainstorming activity (Appendix D), and handouts for final exercise (Appendix E). If there are any questions regarding the content of this guide, or the Body Mapping process in general as is being implemented for the Women, Art, and Cannabis Study, please contact: Dr. Saara Greene (Women, Art and Cannabis PI; greenes@mcmaster.ca) or Research Coordinator (Coordinator, [insert email]).

Before you get started – an important note for facilitators:
As the facilitator you are not meant to interpret or assess drawings or drawing styles. The value is in the doing, so please take your time to facilitate the process according to this guide. Listen to the group and do your best to not offer insight into others' artwork or life stories. Let the participants talk about their own experiences when and if they are ready.

As the facilitator, you can show examples on the "test paper" but remember this is not your process. You are not meant to create your own Body Map or to influence the process by making your journey or experience stand out at the daily debriefing sessions. Rather, you are meant to be the anchor. You are there to guide the process, watch for cues among the group, manage the daily debriefing sessions, spend time evaluating the daily exercises with your co-facilitator after the daily exercises have wrapped up, and to promote self-care among the participants.

As an artist-guide, you are also meant to assist with art techniques, art supplies, and general queries where needed. You are there to be confident in the process and to encourage participants to trust you as well as the creative process as they embark on this research journey.

The exercises build on one another, so participants should complete them in sequence. Visualization and discussion are vital in facilitating this process so please follow this guide carefully. Finally, please do not share this guide with others who are not part of the Women, Art, and Cannabis study. A word of caution to review this guide carefully: In the past, well-meaning individuals have thought they were equipped to manage and facilitate the process, however, participants paid dearly for the lack of expertise and understanding of the process.

What is Body Mapping?

Body Mapping is a form of art and narrative therapy used to gain a better understanding of ourselves, our bodies, and the world we live in. Jane Solomon and Jonathan Morgan, both from Cape Town, South Africa, developed the Body Mapping process and the approach will be adapted for the Women, Art, and Cannabis study. It is important to honour and respect Jane and Jonathan's passion, and this process as they have intended it to work. Jane is a South African artist, textile trainer and master trainer and Jonathan, a clinical psychologist, works for the Regional Psychosocial Support Initiative (REPSSI) in southern Africa. REPSSI is a non-profit organization working to lessen the devastating psychosocial impact of poverty, conflict, and HIV among children and youth in Sub Saharan Africa. They considered the Body Mapping facilitator's guide to be a psychosocial training tool for organizations supporting families affected by HIV. Under REPSSI's tutelage, organizations throughout 13 Sub-Saharan African countries have been facilitating Body Mapping opportunities in an effort to help parents living with HIV find ways to talk openly with their children.

Body Mapping was first seen as an advocacy tool to bring attention to the issue of HIV/AIDS in Africa. However, it rapidly became a tool for storytelling, helping people living with HIV to sketch, paint, and put their journeys into words. The Body Mapping process includes drawing, painting, visualization exercises, group discussion, sharing, and reflection. The life-size Body Maps stand tall, vibrant, and proud.

It is helpful to understand that the Body Mapping methodology as developed by Solomon and Morgan and the manual "Living with X" was based on a playful subversion of the term PLWHA (Person living with HIV and AIDS) that was often used in sub- Saharan Africa. They based their title on the idea that there is a subtle and often unnamed pressure for people living with HIV to attach considerable weight to this particular aspect of their identity. They suggested that this pressure is unique to People Living with HIV in a way that is generally less pronounced or even absent, for instance, when compared to people living with other health issues, for example, cancer or diabetes. The original Body Mapping journey outlined in the facilitator's guide contained a sequence of art-making exercises that attempted to shift this pressure and rename the "X" in their lives and return them to being people who are living their lives as everyday people – those with hopes, dreams, challenges, and struggles, more important than the disease contained within their bodies.

Body Mapping and the Women, Art, and Cannabis Project

The Body Mapping exercises used in the Women, Art, and Cannabis Study have been adapted slightly from the original guide created by Solomon and Morgan. The exercises to be included for the Women, Art, and Cannabis Study will contribute to our understanding of the lived experiences of women who use cannabis and their interactions with health and social services.

Our goal for this research is to inform policies and best practices for health and social service providers to better meet the needs of women who choose to use cannabis. The Women, Art, and Cannabis Body Mapping workshops will be done in a group setting where participants will support and inspire each other as they reflect on their own lives, personal journeys, relationships and experiences relating to cannabis use.

Safety Notes:
Body Mapping can be fun, but it can also unleash emotions and memories.
Make sure the group feels safe enough to go through this process before you start.
Take time with the consent forms. Find a quiet, private space to work in that is large enough to accommodate the Body Maps.

Proceed carefully. Inform the group that it is their right to decide what they want to draw on their body maps. They can decide what they want to leave out and what they want to share with the group visually, as well as in the group discussion at the end of each day.
Talk about confidentiality issues before you begin. Everyone in the group needs to give their informed consent and be in control of what happens to their Body Maps following the workshop.
Check with the group whether or not they want their photographs taken or photographs of their Body Maps. Some participants may not even feel comfortable with cameras in the room.
The facilitator must allow time for participants to work alone and to engage with others over the course of the process. There is a fine balance, and the facilitator needs to manage the group accordingly.

Explain to participants that over the course of the workshop, they will be describing their artwork in installments, that is, reflecting at the end of each day what artwork they created during that day. When facilitating group discussions make sure everyone can see the work the participant is willing to talk about. Having their Body Map displayed in the middle of the sharing circle shows respect. Ask participants (as much as possible) to answer the questions asked during each completed exercise up until that point. It is helpful to have each question listed on a flip chart paper for easy reference. Allow participants to talk freely within a given time frame. Don't interrupt and don't try to solve problems by giving your own opinion and/or advice. Don't ask participants or allow other participants to ask probing questions when someone is sharing their story. What a person chooses to share is their choice.

Keep a check on the general health and energy levels of the group. Body Mapping is active and can be tiring. Give those who are feeling tired the option to ask for assistance or take breaks. Ensure that you plan well-timed breaks for the entire group.

Remember that working into the evenings may be welcome by some participants, but not necessarily by everyone. Body Mapping is taxing both emotionally and physically and encouraging self-care is important. At some point, the entire group needs to take a break. Having some of the group remain together late at night while others choose to rest can also lead to some participants feeling left out of a potential bonding experience. Again, it is a fine balance and will be something a facilitator figures out as they get to know the group.

Challenges that may arise and tips on how to deal with them:

Challenge: Participants say they can't draw.
Tip: Don't draw for them. There is no such thing as not being able to create. Everyone should give it a try. Encourage participants to do their best. Present the exercises as a process rather than trying to create a perfect final product.
Participants can choose to represent an idea using colour, symbols, words; they don't have to find a perfect image or drawing to be able to express themselves.
Challenge: Participants don't want to talk about their drawings.
Tip: Let those that feel confident start the dialogue and others will join in when they are ready.
Challenge: Tiredness and lack of energy.
Tip: Get participants to get up, stretch and move around from time to time. They can even sing and dance in between exercises. If participants all agree, they can even choose to play music at quiet volume. Some ideas for ice breaker and stretching activities have been included in this guide (see Appendix) to energize participants and break up the art-making exercises.
Challenge: Participants are overwhelmed by the task(s).
Tip: Give tasks one at a time. Only give the next task when most of the group is finished. Ask for permission from the group early on to move on together. You don't want the slower participants to start feeling disheartened, left behind and left feeling that they will never catch up.

Remember: Body Maps are very evocative and powerful tools. Through them we, as facilitators, lead people to express their feelings. If many of these feelings are difficult or painful ones, to put them out there on a huge piece of paper, amongst a group can potentially re-traumatize the participant. With Body Mapping, the facilitator, co-facilitator, interviewers, and counselor have to work especially hard to ensure the space is as safe as possible. It is important to discuss with participants before they arrive at the workshop, as well as once all participants are together on the first day, what they need in order to feel safe and comfortable. Ideas can be generated as a group, listed on flip chart paper, and posted in the room. It is a good idea to revisit these ideas that participants generate as the workshop progresses to maintain a comfortable and safe space that is conducive to sharing and art-making.

What will you need for a Body Mapping workshop?
It is preferred that the days fall consecutively. Try to never break mid-exercise and always end the day with group sharing so participants do not leave the space feeling uncontained.

Space: You will need a big, well-lit, well-ventilated space with enough floor space to accommodate the participants, their Body Maps, art materials, and refreshments, e.g. ~100 sq ft per Body Map, an ideal room is at least 1000 sq ft. You will need chairs to sit on during group discussions, but these can be stacked out of the way when not in use. If participants are unable to work on the floor, table space should be arranged. Certain folding tables can be set up as easels, or participants can be provided with 1-2 tables on which to lay their Body Map.

Materials needed: Be creative when it comes to sourcing materials. Listed below are the materials that are most recommended. Sometimes art supply stores will give discounts or in-kind donations if you explain what you are using the materials for.

BODY MAPPING MATERIALS:

Per participant per workshop:
6 ft. X 4 ft. pattern card paper (Pattern stock paper from World Sew, Queen West, Toronto)
Note: one Body Map per participant is needed plus a sample paper that will be used to demonstrate the Body Tracing + Support Shadow exercises. The sample paper can also be used by participants to see how the various paint supplies and art materials show up on the stock paper (i.e. the paint may look one way in the container but appear differently once painted on to the paper).
Small notebook / journal – so participants have something where they can reflect, make notes, practice drawing shapes and images throughout the workshop
Handout with a picture of a blank Body Map and support shadow (see Appendix) – this blank picture will be used as a Legend to keep track of where participants draw / place each exercise on their own Body Map. This Legend will be especially useful during the end-of-day sharing circles to stimulate participants' memory for which exercise they drew each symbol / image, etc.

Additional supplies to be shared (available on the art supplies table):
Permanent markers with thick and thin tips (E.g., Sharpies) – enough for each participant to have 1 for tracing their Body Shape
Pencils – enough for each participant to practice drawing images / symbols
3 X Eraser
2 X Sharpener
8 X Paint brush – thick for painting in background
8 X Paintbrush – thin for doing face in brush and ink
8 X Paintbrush – middle size (between thick and thin) for painting
Note: It is important to buy good quality paintbrushes. One good quality brush will probably run around CDN $3-$5. Bigger brushes may be a bit more expensive.
Synthetic bristles are fine. Good brushes can be re-used for many years if cared for properly.
1 X Scissors
1 X large pencil crayons set – water soluble
1 X Large pack of wax crayons
Small containers to mix & store paints in: 30 or so (any food/recycled containers with covers, can also be coffee cups); enough containers are needed for each colour (+ to lighten each colour/mix with white)
Artist palettes or paper plates – some participants may want to create their own artist palette with the paint, especially to mix colours and keep a number of colours close by as they are working on their map. Palettes can be purchased at Dollar Stores, or a disposable paper or plastic plate could be used for this purpose.
5 X Gold felt pens (sparkly liquid-type ones – sold in marker sections of hobby stores)
5 X silver felt pen (sparkly liquid-type ones – sold in marker sections of hobby stores)
5X white felt pen of the same liquid-type as the gold and silver markers
2 X large buckets with handles for water (we mix acrylic paints with water and also use water for dipping/cleaning brushes)
Oil pastels
Charcoals (available in black and white)
Spray fixative (can be hairspray) - to fix pastels and charcoal

Prestick (sticky stuff – basically sticky play-dough stuff for adhering things to walls) – Note: in our experience quite a lot of sticky-tack is needed to adhere the heavy Body Mapping paper to walls – it may need to be used in combination with other materials, e.g., thumb tacks and duct tape, when setting up the Gallery
Masking tape
Duct Tape / Gorilla Tape (for setting up the Gallery, be careful not to rip Body Maps)
1 package of cling wrap (for covering paint containers with no lids)
2 X Rulers
Shower curtains / plastic tablecloths to protect carpet (taped down with masking tape) down) – ensure each participant has at least 1 tablecloth for a floor covering, and to be used to cover the tables where the art supplies are laid out
Rags/old towels/sheets for cleaning
Paper towels
One flip chart, markers and paper
Scrap paper – for doodling and practicing
Cards for final exercise (printed on card stock – each workshop attendee including facilitators are given enough cards as Body Maps produced, including so they can comment on their own)

Acrylic Paints:
Note: Paints should be relatively good quality acrylic paints from a paint/hobby store and not from a Dollar Store. We don't have to get these exact colours, but this list just shows that it's great to have different shades of colours. Colours can also be mixed to create certain colours that participants may want to use.

2 X 500ml Postbox Red
2 X 500ml Royal Blue
1 X 500 ml Turquoise
2 x 500 ml Primrose yellow
2 X 500ml Golden yellow
1 X 500 ml Brown
1 X 500 ml Orange
1 X 500 ml Cerise
1 X 500ml Purple
1 X 500 ml Green
1 X 500 ml Black
6 X 500ml White
1 X 250ml Gold
1 X 250ml Silver

Tuesday May 9th:

3pm – 4pm Before we Begin:

- Welcome / Opening Ceremony (to be integrated throughout opening evening and at a time that is conducive based on the group's travel, arrival at the workshop site, mealtimes, etc.)

- Introductions – facilitation team, participants
- Introduce Body Mapping – history, purpose, show examples (facilitators can refer to the information outlined in this guide about the history of Body Mapping)
- Introduce Women, Art, and Cannabis Study – general overview
- Review/discuss participant consent forms
- Answer all participant questions
- Sign consent forms
- Establish ground rules / shared guidelines for Body Mapping Workshop – all participants to generate list together with facilitators and on-site support person (e.g. not to walk on each other's Body Maps); these are the guidelines and considerations to creating a safe and comfortable workshop space including use of cellphones, etc.

Refreshments

4:15pm Orienting Participants to Art Supplies (10-15 minutes):

Participants may not have had the opportunity to work with all of the art supplies that will be available throughout the workshop or may need a reminder about how to work with the acrylic paint and paint brushes. Take some time (~10-15 minutes) to orient participants to the art supplies that are available, how they appear on the Body Map paper, how different materials may or may not work or blend together, how to mix paint, how to clean the paint brushes, and answer any questions participants might have about the art materials.

Some reminders:
If participants all want to use the same colour, use small containers, lids or artist palettes to share the colours.

Remind participants to wash their brushes before going from one paint colour to another. Colours may become contaminated with other colours and result in murky and dull paints. Demonstrate how to use the paint before beginning. Participants might use the paint too thickly or thinly.

There may be paint smudges or drips, but to avoid this do not lift Body Maps when they are wet.

4:30pm Exercise 1: Body Tracing (20 minutes)
In this exercise, people work with partners to build trust, define their shapes, and begin the process. This is the only time when participants are requested to work together on their papers.

Overview: During this exercise participants follow the outline of the human form and create a shape on their piece of cardboard with which to work throughout the rest of the process. Working with a partner acknowledges that we are not alone. It is also a reminder that participants will support each other in various exercises throughout the remainder of the process.

Materials: One sheet of paper per participant (4ft X 6ftm) and thick, black permanent waterproof markers (one per participant).

Please Read: We are going to use our bodies as a starting point for our artwork. We all exist somewhere in the world. Ultimately our home is the body that we inhabit every day. In this workshop we are going to create a map of the body we live in. You know yourself better than anyone else does. There is no need to feel afraid because we are all creative. Pablo Picasso once said, "Every child is an artist the problem is how to remain an artist when you grow up." With this in mind, remember that art is fun, and a way to express your feelings. Art is about looking, feeling, taking chances and experimenting, and ultimately about making magic. We all have that gift within us. This workshop will include hard work, but it will also be fun. It is important that you focus on the tasks as outlined by the facilitators but that you also enjoy the process. Don't be afraid to make the wrong marks here today because in this workshop there is no such thing as a mistake. When you express your own experience, you are the one who knows best and anything you do will be seen as creative and beautiful.

To deepen our understanding of ourselves we are going to be working with our own experiences. We are all human, but our uniqueness lies in how we all come in different sizes and shapes. Right now, we are going to begin the Body Mapping process by helping each other for this "body tracing" exercise. We are going to work with partners, because it is impossible to trace around our own bodies. You will need to choose someone in the room to trace your body shape onto the paper that will be yours for the duration of this workshop. Please also ensure you have two different coloured markers for this exercise.

First you will ask your partner to lie down on the paper and you can help them find a position that works for you. You will trace your partner's body shape using the black marker, which represents your "support figure." After your "support figure" has been traced, you lie down on the paper and choose how you want to show your shape on the paper; your partner will then trace your body shape using the different colour marker. In this way, your body is being "propped up" and supported by your "support figure," which will come in to play in further exercises.

Instructions: Ask the participants to choose a partner to work with. Demonstrate body tracing: one facilitator will lie down on the piece of paper with as much of their body as possible touching the paper. Using a thick black marker, the other facilitator will slowly and carefully draw around their shape trying to avoid marking their cloths or skin. When the facilitator has traced around the entire body, they will stand up so the group can see the outline on the paper. Participants can be reminded to think about how they want their support shadow to be seen, and that this shadow will come in to play in future exercises.

The other facilitator then lies down on the same piece of paper and the facilitator traces their body. A different colour marker may be used in order to differentiate the two body tracings, which will be helpful when participants highlight their body shape and then pain their support shadow. Participants can be reminded to think about how they want to be seen – e.g. solidly grounded with both feet on the ground, running to get lots done, etc.
After the example is complete, participants then begin. Each participant takes turns tracing both images on their papers.

To claim ownership of their own Body Map, remind participants that their Body Map reflects the figure that they chose, and that this figure is surrounded by the figure of their partner, which will be seen as a supportive shadow and explored further in a later exercise.

5pm Exploring Colours and Shapes (15-20 minutes):
Before giving the instructions for Exercise 2 (Highlighting your body shape), spend some time discussing the group's ideas related to the meaning of colour and shapes. Using the flip chart paper, dab a bit of each colour on the paper and then make notes about participants' responses to what they feel each colour symbolizes. Keep this "colour wheel" up during the duration of the workshop so that participants can use it as a guide and add new colours and meanings as they wish. When participants are struggling to draw something, they can be encouraged to use colour to help represent what they are envisioning.

Following the creation of the "colour wheel," spend some time practicing or thinking about examples of different symbols in order to lead a discussion about the meaning behind many everyday symbols. Draw symbols on the flip chart (e.g. marijuana leaf, heart, gender symbols, sun, tree, etc.) and have participants guess at their literal and potential meanings. Post the flip chart in the room so participants can be reminded of the importance of symbols throughout the workshop. It is important to not gather exhaustive examples of symbols because participants will try to copy what they can see. If you give too many prompts or examples then the imagination can be stifled.

Helpful tips for this exercise: What is a symbol?

- A symbol is a simplified picture or image that has a special meaning
- A symbol may not always look like something you immediately recognize but through association and feeling it portrays a special message
- People from different cultures, people who speak different languages and people who have trouble reading are able to understand the meanings of certain symbols
- Children can understand symbols
- Symbolism is a visual language
- Symbols are used to communicate messages and give directions. For example, traffic signs are symbols found around the world
- Colour can also be used symbolically. (i.e. red for passion, danger and excitement).
- Some symbols may be viewed as sacred to different religions and cultures and should be respected.

5:30pm – DINNER

Day 2 – Breakfast 9:30am

10:00: Welcome

10:15: Exercise 2: Highlighting your body shape (20 minutes)

Before you begin: Once you have created the "colour wheel" with participants continue with the following.

Please Read: We all have a special feeling for one colour or another. A favourite colour might be represented in the clothing that we like to wear or by things that we like to have in our homes. It might be that our favourite colour just makes us feel happy. Now I want you to choose a colour from the assortment of available colours to use for the outline of the tracing figure that represents you. As you are painting over your shape, think about why you have chosen that particular colour and what particular meaning that colour has for you.

Overview: Participants identify the outline of their body shape and highlight it in their favourite colour or a colour of meaning.

Instructions: Facilitator chooses their favourite colour and demonstrates how to paint over the line that outlines his/her shape. Participants then choose a colour and highlight with their paint colour their own body tracing (this tracing is not to be confused with the second outline on the paper).
Participants may get confused as to which line outlines their body shape and which line outlines their partner. Participants can use a different colour marker to show the different tracings. You can also encourage participants to follow the outline of their body with their finger so that they become familiar with their tracing before using paint. Only assist if asked.

This is a good time to remind to participants about not walking on other's papers as each paper represents a person in the room. Also ask participants to be especially careful not to spill paint on each other's work, and to use the tablecloth drop sheets to protect the meeting room floor from spillage.

When working with the rights and lefts of the Body Map (in terms of where to place certain exercises on the Body Maps), have participants pretend that they are lying on their paper facing outwards towards the world.

10:45am Exercise 3: Drawing where you come from (30 minutes – more time given for first exercise)

Overview: This exercise helps to "ground" participants, by focusing on their roots. It is important to spend time exploring one's roots so that the subsequent exercises can fall into place. Discussing and learning about symbols will give participants the tools they need to respond to many of the exercises and throughout the process.

Before you begin: Spend time practicing or thinking about examples of different symbols in order to lead a discussion about the meaning behind many everyday symbols. Paste or draw symbols and have participants guess at their literal and potential meanings. Paste the symbols exercise in the room so participants can be reminded of the importance of symbols throughout the workshop.

Please Read: For this next exercise, I want you to think of where it is that you come from. What comes to your mind when you think of your roots? Is it the village or place where you were born? Is it a symbol to show your culture? Is it a set of symbols to show where is it that you feel you can really connect with your past? For this exercise we will work in the bottom right-hand corner of your Body Map (as if you are laying on your paper looking out at the world). Please feel free with the space and fill it is best you can. As you do this exercise, try to use colour symbolically in your drawing.

Instructions: Participants draw symbol(s) or picture(s) in the bottom right hand corner to show where they come from.

11:15 Exercise 4: What are you moving towards? Exploring the future. (30 minutes)

Overview: This exercise asks participants to think about goals, dreams and personal visions. It can often be difficult to think about one is reaching out to but with the use of symbols and a quiet space to reflect it is a very meaningful exercise. Exploring one's goals gives participants a chance to reflect on the direction of their lives.

Please Read: You have just spent time grounding yourself in your past and reflecting on where it is that you come from. Now I want you to look ahead to the future and the possibilities that it holds. What is your vision, your goal or your dream for yourself?
Where do you see yourself, or where would you like to be in the next five or ten years? What are you striving towards? It can be something material, physical, emotional, or spiritual. Remember that you are on a journey and your body is your vehicle. For this exercise we will work in the opposite top corner of your Body Map as to where you illustrated your past.

Instructions: Participants draw a symbol or collection of symbols (and use colour) in top left hand corner to show what they are working towards, their goals, dreams, etc.

12pm – 1pm LUNCH

1pm Exercise 5: Connector and Drawing life's distractions and obstacles (40 minutes)

Overview: Participants will be asked to connect their past to what they're moving towards. It's a way to link the past to their future. The second half of this exercise gives participants the opportunity to represent the things in their lives that serve as distractions, bumps, challenges, roadblocks, and other diversions that get in the way of reaching their goals. It may be that things like alcohol, gangs, peer pressure, negative relationships, illnesses, financial challenges, etc. keep them from achieving what they really feel they can.

Before you begin: Ensure participants know what you mean by "distractions" and obstacles.

Please Read: As you look at your past and think about what your future holds how do you see these two important parts of your life connecting? What did this journey look like for you? Is it one that is set in stone, mapped out clearly for all to see? Is it challenged with hills and pitfalls, learning experiences and ups and downs? Try to represent what the journey from where you have

come from to where you are going looks like. Life is about navigating the things that are thrown our way. Some things are easy to navigate while others can really influence our decisions and our actions. I want you to think about the things in your life that influence your actions and your decisions. Having said that, I want you to think about the good and the bad and how your obstacles influence the decisions you make in your life. I want you to think about the party scene, about drugs and alcohol and the power it holds in your life. On your Body Map, draw what kind of obstacles are getting in the way of you moving forward towards your goals. You can add these representations within the "connecting" symbol that you used to link your past to your future goals. In the next exercise we will look at strengths.

Instructions: Participants draw a symbol or collection of symbols (and use colour) to show their journey of leaving the past and moving towards the future. Sometimes when people are clear about their forward trajectory, they may choose a straight arrow. For others who have seen ups and downs, challenges, and successes they may draw a road map or a series of hills and valleys. Participants may need time to really think about this exercise in relation to their lives. Participants add depictions of their life obstacles/challenges to the "connector" image they drew.

1:20 Exercise 6: Strengths (20 minutes)

Overview: This exercise asks participants to think about the things that have helped them or are helping them to overcome their obstacles in order to achieve their goals. Here they will focus on personal strength, as well as what resources, supports, and people that are helping them along the way.

Please Read: You've just added your personal and life obstacles to your Body Map. Now I want you to think about what things that have helped you or are helping you to overcome your obstacles in order to allow you to achieve your goals. Think about your personal strength as well as what resources and people you have supporting you as you work to overcome your personal and life hurdles.

Instructions: Participants add depictions of the things that are helping them to overcome their obstacles in the same general area as Exercise 5. The idea of a connector becomes as myriad of symbols and images.

1:40pm Exercise 7: Finding a symbol to show "using cannabis" (30 minutes)

Overview: In this exercise, participants think of a way in which to show how it feels when they use cannabis, and what symbol they would use to represent what cannabis does to and for their body.

Please Read: How does it feel when you use cannabis? This can mean recreationally but it can also mean to treat symptoms of emotional, mental, or physical pain or discomfort. What symbol can you think of to show this feeling? Choose a symbol that you could use to explain how cannabis feels in your mind and body to someone who does not share your embodied experiences, or who does not use cannabis Go ahead and mark a symbol anywhere on your Body Map about what it means and feels like for you to use cannabis.

2pm Break (15 min)

2:15pm. Exercise 8: Painting Your Support Shadow (30 minutes)

Overview: In this exercise participants think about what it means to have support in their lives. With this idea of support in mind, they will paint in the support shadow (the first tracing they did with their partner) that lies outside of their own body figure. After the paint dries, participants will add names, people, places, etc. to their support figure. For this Exercise, participants will use colour symbolically to fill in the support image. Exercise 8 will involve adding text, symbols, etc. to the painted area.

Please Read: I am sure you have been wondering about the second figure or shadow that lies outside of your own body figure. It's been quietly lying on your map since we started the first exercise. This figure acts as the support figure both for this workshop and in life in general. We always have someone or something thing to give us strength in our journey and this support shadow represents that. The shadow's quiet presence is a gentle reminder that even through the tough times we were never alone. For this exercise I want you to think of what it means to feel the support that has given you strength in your life. I want you to think of a colour that represents that support and use it to fill in the shadow figure that lies outside of your body tracing. We will help you so that you don't go over the areas that are your body. As you paint, remind yourself of those people, places, and organizations that have supported you in your life. When the paint is dry, we will do another exercise related to the ideas that you have come up with.

Instructions: Participants choose a colour to represent the support they have known or felt in their lives. Their supports can be individuals (including those who have passed away), groups, pets, organizations or belief systems. Participants paint in the second figure on the Body Map, which is the figure that their partner represented in Exercise 1. Participants only paint the second figure where it does not overlap with their own body tracing. This can be a difficult to understand, but when it is done correctly it serves a great purpose. It shows the second figure to be somewhat like a shadow and allows the participants own body tracing to really stand out. Where possible let participants try to figure it out first or ask other participants for support. Note: The paint must be dry before you can move on to Exercise 8.

End of Day 1 Art-making 3:00 – 4:00

Audio-recorded group discussion (approximately 60 minutes)

Instructions: Remind people to listen fully to each participant. Sometimes we worry about what we are going to say instead of fully engaging with the stories of others. Perhaps let participants know that they will be commenting on the stories told by the Body Maps of others at the end of the workshop. When facilitating group discussions make sure everyone can see the work as each participant talks about their work by having each Body Map displayed in the sharing circle when each artist is speaking (or participants can easily move from one Body Map to the next around the room and would allow for some group movement). Ask participants (as much as possible) to answer the questions asked in the exercises up until that point. It helps to have each exercise

briefly outlined on a piece of flip chart paper for easy reference. Explain to participants that over the four days together, they will be describing their artwork in installments.

Allow participants to talk freely within a given time frame, but keep in mind that 60 minutes has been allotted for this activity and time can be shared equally among participants (e.g., 6-8 minutes per participant, depending on number of participants).

Don't interrupt and don't try to solve problems by giving your own opinion and/or advice. Don't ask participants or allow other participants to ask probing questions when they are sharing their story. What a person chooses to share is their choice.

Day 2 of Art-making

9:30 Breakfast

10:00 Welcome

10:15 Exercise 9: Support systems (20 minutes)

Overview: Participants now add names to the area they painted in Exercise 8.

Please Read: Now that you can see a support shadow around your body tracing, I hope you are reminded that there is always something present in your life that keeps you going. What does the support in your life look like? It can be a symbol, a name, a nickname, someone's initials, something. It may be a beloved pet or the name of an organization. It can be people past and present. Sometimes those who have supported you have passed on, but you still feel their presence in your life. You can also place the names in special places on your support figure. For example, you may feel the support of a loved one in your heart every day. You could then add that person's names near the heart area. Or you may have felt grounded by a friend or by faith and you could add that word or name near your legs or feet. It may be that you are your own support system. You may also get support from the natural or spiritual worlds. If so, feel free to add symbols, such as a cross for religion, to your support figure. I want to remind you that you can use people's real names, but you can also use pseudonyms, nicknames, or initials. You do not have to use identifying characteristics if you don't wish to.

Instructions: Participants use colour to write in the names of people, places, things, organizations, pets, etc. that have supported them. They can use symbols and colour to add meaning to this exercise. Remind participants of the use of symbolism. For example, their connection to nature might be something that provides them with great support. Instead of writing the word nature, they might choose to draw a flower or a tree. Another example could be that they find support from pets both past and present. They might choose to draw a paw print to represent this. This exercise is one that participants can go back to everyday. Often, they will come each day and add a name or two that they have forgotten.

10:45 Exercise 10a and 10b: Power Point and Power Symbol (30 minutes)

Overview: This exercise has two parts and gives participants the opportunity to express how they view their inner strength in relation to the world around them. The two visualization exercises help participants to think about recognizing their own personal, intuitive strength, as well as where, in their bodies, they feel that source of power. Ask participants to sit quietly near their Body Map and let them know that you will be leading them through two visualization exercises. As they hear the words you read, they can work at developing an image or a picture in their mind. Participants can form mental images of ideas that they have and then work towards drawing the images on paper. When doing visualization exercises, use a calm voice and don't rush.

Exercise 10a: The Spot

Please Read: If you feel comfortable, please take a moment and close your eyes as I read this to you. So far, we have drawn around the outlines of our bodies to represent the shape we live within. Our bodily homes contain many different thoughts, memories, emotions and ideas. All of these are important to who we are as unique people living in the world. In your mind, I want you to try to see the shape you have drawn and as you do this travel into your own body. Be reminded that each of us needs a great deal of strength and courage to take on all the responsibilities and challenges that we encounter in our daily lives. Knowing that we all have inner strength, try to determine which part of your body that you draw your power from. It's important to recognize that different people get their power from different parts of their body. For example, your power might be from your shoulders, your thighs, your arms or your heart. It's wherever you feel your strength and your courage when you need it most. Now, as you continue to keep your eyes closed, I want you to scan your body and really feel where it is that your power lies. Scan from head to toe and travel into your bodily home. And once you've identified your place of true strength, I want you to open your eyes, make a pencil mark on that place on your body outline."

Instructions: After reading, have participants use their pencils to make a simple mark on their place of power. Some participants may identify more than one power point, and this is fine. It may be helpful to have participants mark their place of power quickly, so they don't have time to doubt themselves and go with their initial gut feeling. The pencil marks will be erased during the next exercise.

Exercise 10b: A Personal Symbol

Please Read: As you close your eyes again, I want each of you to bring to mind a symbol that represents you. I want you to think of something that says who you are and how you feel about yourself in connection with the world around you. How do you see your personal strength and power? Think of a symbol that people who know you, might associate with you. By looking at the colour, shape and picture of the image they might be able to associate it with you. We know that symbols are meaningful pictures and as you think of your own personal symbol remember that it could be anything at all. It might be something from the natural world; something like a plant, animal, insect, flower, feather, bird, moon or star. It could even be a stone or a shell. Perhaps it is something very simple like that of a shape with distinct lines or curves. Maybe your symbol is the shape or outline of a special object - something that was given to you in the past,

something new or something old, something special that was passed down through your family. Your symbol could represent your religion, what you believe in or a higher power. It could also be something that is used in an event that you regularly take part in. Your symbol could be something special that you wear or something you use for sports and entertainment. It could even be an everyday object that has special meaning for you. Your symbol could be something from your dream world, from your imagination, or a fantasy object. Your symbol is yours to envision so spend some time thinking about it and how it shows who you really are.

[STOP READING and Pause for a few seconds. Count ten breaths before continuing.]

I hope by now you all have a picture in your mind. What does your symbol look like? What shape is it? What colour is it? What does it mean to you? Does this picture or symbol inspire you? How does it show your courage and strength? I want you to remember that a symbol is a simplified picture so when you draw your symbol, I want you to draw only what is important and particular to what you have imagined. Now, when you are ready, I invite you to open your eyes and draw the picture or symbol that came to you during this second visualization exercise. Draw your symbol or picture symbol on to the place that you marked earlier with the pencil. Your personal symbol is meant to be placed on the spot where your feel your strength and your own unique source of power.

Please Read: At this point, we want to remind everyone about confidentiality and the limits to it. While we will do everything in our power to ensure your confidentiality as researchers, we have to remember that this is a group process. While we have all agreed to uphold all participant's confidentiality, we as researchers cannot fully guarantee that everyone will uphold this agreement. Please keep this in mind as you move through the following exercises.

Exercise 11: Experiences of Consuming Cannabis and impact on health and well-being

Brainstorm – 30 min Please read: What is your experience of consuming cannabis? How does it impact your health and well-being? When do you experience it as helpful? When do you experience it as a challenge? How does if impact your overall health? We are going to brainstorm some ideas as a group and create a list of what people think about health and well-being:

There are various elements of wellness including: (USE FLIPCHART)

Physical wellness: What does physical wellness mean for you? What is important for you as it relates to your physical wellness? What comes to mind when you think about physical wellness? It may be an image from your past, present or future.

Emotional wellness: What does mental wellness mean for you? What is important for you as it relates to your mental wellness? What comes to mind when you think about mental wellness? It may be an image from your past, present or future.

Spiritual wellness: What does spiritual wellness mean for you? What is important for you as it relates to your spiritual wellness? What comes to mind when you think about spiritual wellness? It may be an image from your past, present or future.

Sexual wellness: What does sexual wellness mean for you? What comes to mind when you think about your sexual health? What is important for you as it relates to your sexual wellness? Everyone is different – sexual wellness could mean choosing not to have sex, or choosing to have sex, or thinking about who you're having sex with, or having sex on your own. It might also relate to your physical self, for example, pap smears, mammograms, menopause, and other parts and aspects of our bodies that are connected to sexual health.

Reproductive wellness: What does reproductive wellness mean for you? What comes to mind when you think about your reproductive health? What is important for you as it relates to your reproductive wellness? Everyone is different – reproductive wellness could relate to your physical self (e.g. your body parts) or other aspects of yourselves that are connected to your reproductive health and wellness.

11a: For this next exercise, I want you to think about the ways that cannabis supports you as you think about your physical, emotional, spiritual, sexual and reproductive health and wellness. Draw anything that comes to mind using images, colours, or words. Physical health might be really important for you right now, or perhaps it's your emotional health, or perhaps a combination of the different areas of wellness that you reflected on. Draw the symbols to represent how cannabis has been helpful in regard to these experiences in your left leg (when thinking about your body looking up to the sky from the floor).

1b: For this exercise we want you to think about the ways that Cannabis may not support you in your health and wellness. When does cannabis result in challenges to your physical, emotional, spiritual, sexual and reproductive health and wellness? Draw the symbols to represent times and/or areas of your life where cannabis isn't helpful in your right leg (when thinking about your body looking up to the sky from the floor).

LUNCH 12:30 pm – 1:15

1:30pm Exercise 12: Health and Social Services for Women, Trans, and Gender Diverse People who use Cannabis (45 mins)

Overview: In this exercise, participants will think about the health and social services they utilize for different aspects of wellness and how this might relate to, come up against, or impact their use of cannabis.

Please Read: I now want you to think about the people and services you access in regard to your health and wellness. What healthcare or social services are you receiving and how does this relate to, impact, or support your use of cannabis as a woman? Where do you go for healthcare? Where do you go to get support? This exercise is about who provides you with healthcare and support services - where you go to get it, and how it supports or impinges on your wellness. This care might not have anything to do with your use of cannabis. You might be thinking about your

family doctor, an emergency room, or mental health provider. Or you might be thinking about cannabis-specific services such as compassion clubs or clinics. What do you like about these services and the people who provide them? For social services you might think of those you access on your own accord or those you are or have been mandated to work with, such as CAS or other Child Welfare workers. What do you not like about these services and the people who provide them? Think about situations and locations related to your care. Think about the social service and healthcare providers you interact with. How do your experiences of healthcare and social services make you feel? We want you to reflect on the services you access or would like to access in connection with the different areas of your wellness that we've been focusing on throughout this workshop. As a reminder, reflect on Exercise 8 when we asked you to represent your experiences and understanding of wellness on your Body Map. Remind yourself of all the ways you thought about and defined wellness - physical, spiritual, emotional, mental, sexual, and reproductive wellness. How would you represent these experiences and feelings on your Body Map? Think about the colours, shapes, images or words that reflect your experiences.

You will have 60 minutes to draw anything that comes to mind related to the health and social services you use (or don't use) as a woman who uses cannabis. You will place these symbols anywhere on your body map. As we work through the 60 minutes, I will give you a prompt at each 10 minute interval in case you wish to represent all six aspects of wellness on your Body Map for this exercise. And don't forget to use your legend to keep track of where on your Body Map you draw the health and social services, and your experiences of these health services, as a woman who uses cannabis.

Instructions: Participants add their depictions to any area on their Body Map

2:15pm Exercise 13: Disclosing Cannabis Use (20 mins)

Overview: In this exercise participants will think about their reflections, thoughts, and experiences (positive and negative) related to disclosure of cannabis use.

Please Read: We are now going to explore your reflections, thoughts and experiences related to disclosure of cannabis use. Think about a time that you disclosed your use of cannabis. Who did you disclose to? What are some of the tools that you use/used to disclose? How do you frame the conversation? Who supports you around your use of cannabis and who you talk to about it? Why do you disclose your use of cannabis? Maybe you chose to disclose, or maybe you were asked to disclose? Who are you most careful about disclosing to? What has your experience of telling people about your cannabis use been like? Has it been an emancipatory or freeing experience? Or has it been a negative experience? What emotions and feelings have you experienced before and after you have disclosed? Do you have any concerns related to telling people about your use of cannabis? Are there any colours that represent this disclosure for you?

Instructions: Go to your Body Map and draw a symbol / image that represents your experiences and feelings related to disclosing your use of cannabis

2:45 Break

3:00pm Exercise 14: Impacts of Disclosure in a Context of Legalization (20 mins)

Overview: With the passing of the Federal Cannabis Act and Provincial legislation regulating the sale and recreational consumption of cannabis products, the medical and recreational use of cannabis is now legal for adults over 19. In this exercise participants will be asked to reflect of whether they feel legalization of cannabis has empowered them to disclose their use of cannabis more openly to everyone in their lives. Has legalization changed their relationship to cannabis or to others in their lives, including their health care and social service providers (for example, Ontario Works caseworker, ODSP caseworker).

Please Read: We are now going to focus specifically on the legalization of cannabis for both medicinal and recreational purposes and what this means to you. How does it affect your life? What are you certain about regarding the laws related to cannabis production, purchase, and consumption? Or what are you not so certain about? Has the legalization of cannabis allowed you to be more open about your use? To whom (ex: health care providers, social service workers, employers?) Do you feel the legalization of cannabis has lessened or eliminated the stigma associated with its use? Or has it produced new stigmas? If so, do all women experience these stigmas and their impacts in the same way? Why or why not? How would you represent this law and its effects on your life on your Body Map? Think about what symbols you might use to represent clarity, confusion, trust or mistrust based on your understanding of the Cannabis Act and associated laws. On your Body Map, in any of the available space, draw a symbol or image to represent your thoughts and ideas. For example, if the law affects your finances or your relationships that might determine what kind of image or symbol you draw.

3:20pm Exercise 15: Creating a Personal Vision/Message for Health and Social Services for Women who use Cannabis (30 Minutes)

Overview: In this exercise, participants will think about a message, personal vision, or personal slogan they would like to share about what care and support should look like for women who use cannabis.

Please Read: The last exercise explored your interactions with health and social services as a woman who uses cannabis. We also explored your understanding of any interactions or interplay between your cannabis use and your access to care and supportive services, as well as your positive and negative experiences of health and social supports as a woman who uses cannabis. We now want you to think about your hopes, dreams, aspirations, and vision for what care should look like for women who use cannabis in Ontario. What comes to mind when you think of a personal vision for wellness and wellbeing for women using cannabis in Ontario? You might be thinking about your own priorities and areas of wellness that are most important for you, or you might be thinking about an aspect of wellness that you think is important for all women in Ontario. What image or symbols or words come to mind that represents your vision for wellness and the care or services that help you to work towards wellness? Draw an image inside of your own body that represents your personal vision for health, wellness and support for women who use cannabis.

End of Day 2 Art-making 4pm – 5pm

Audio-recorded group discussion (approximately 60 minutes)

Instructions: Remind people to listen fully to each participant. Sometimes we worry about what we are going to say instead of fully engaging with the stories of others. Perhaps let participants know that they will be commenting on the stories told by the Body Maps of others at the end of the workshop. When facilitating group discussions make sure everyone can see the work as each participant talks about their work by having each Body Map displayed in the sharing circle when each artist is speaking (or participants can easily move from one Body Map to the next around the room and would allow for some group movement). Ask participants (as much as possible) to answer the questions asked in the exercises up until that point. It helps to have each exercise briefly outlined on a piece of flip chart paper for easy reference. Explain to participants that over the four days together, they will be describing their artwork in installments. Allow participants to talk freely within a given time frame, but keep in mind that 60 minutes has been allotted for this activity and time can be shared equally among participants (e.g., 6-8 minutes per participant, depending on number of participants). Don't interrupt and don't try to solve problems by giving your own opinion and/or advice. Don't ask participants or allow other participants to ask probing questions when they are sharing their story. What a person chooses to share is their choice.

Please Read: Thank you for trusting us and making today's journey. Each of you will be sharing your story – honour your story – honour yourself. Remember our agreements. This is the time to listen to the stories of others. This is not the time to ask questions or analyze the work other women have done. We will go around the circle and each of you will have a chance to share what you want to with the circle. This will be audio recorded for the research. We ask that you speak clearly into the recorder.

Describe the symbols, the colours, the words you used, and why you chose these. To help you talk about your Body Mapping journey, we have put the exercises on the flipcharts. Please tell us about how you responded to each of the exercises and how you represented these exercises on your Body Map.

Closing the Day (10-15 minutes): Community Support person and Facilitators conclude Day 2.

5:30 Start organizing gallery

DAY 3: Sharing and Gallery

9am – 10am: Set up the Gallery
Facilitators to pack up all art supplies and set-up the Body Map Gallery at the end of Day 2 or in the morning of the final day. Please note that it takes some time to mount each Body Map so it stands tall and proud; facilitators should spend some time in the evening or morning of the last day to set-up the gallery.

10am Opening the Day (10-15 minutes):

Facilitators open the space and welcome participants to final day of the workshop (see list of ice breakers / opening exercises in Appendix).

10:15am – 11:15am Exercise 16: Art Gallery and Honouring Participants (60 minutes)

Instructions: This exercise helps each participant to receive feedback from the others about their lives, their special qualities, and their Body Map. This exercise acts as a final sharing for the group. It often brings out a wonderful group dynamic, where participants are honoured for their special qualities and contributions. This exercise includes the Body Map Gallery, where all Body Maps are placed against a wall or mounted in the art- making space (using tape, sticky-tack, thumbtacks, etc.) for viewing by the group. This is a celebration of the beautiful work created during the workshop. Blank statements printed on card stock (see Appendix) are distributed to each participant and the facilitators so that they can comment on all of the Body Maps in the room as well as their own. Comments should be brief and heartfelt.

Once everyone has a chance to view the Gallery and reflect on the Body Maps, an honour seat will be established, and participants will take turns sitting in the seat next to their own Body Map. The other participants and the facilitator will take turns reading the words they have written on the paper and then the artist will read their own paper based on what they see in their own Body Map. Participants can also be given the opportunity to comment about any other aspects of their Body Map that they might have missed in the other group sharing opportunities. Once a person has sat in the honour seat and heard all of the words of their fellow participants, the papers are gathered and offered to each respective artist to take home. This final sharing is not audio recorded; it is a celebration of the work that each participant has done but is not part of the data collection activities.

Please Read: In a few moments you will be entering the Body Map Gallery where you will be taken on journeys through the lives of [insert # of participants] incredible women. Our last exercise will be honouring the qualities and contributions of each artist. If you see pain, loss or sorrow, know that these are aspects of every woman's life, but please focus on the attributes that show each woman's strengths. This is an exercise to celebrate the beautiful work created during the past two days. Each of you will be given small cards where you can write brief comments about each of the Body Maps. Please keep your comments to a few words. [Now make a written example and read it and post it somewhere in the room]. For example, When I look at the Body Map created by Christina, I see a dynamic woman and a gentle, kind soul. Signed [name of facilitator].

(Do participants need to stretch?)

Closing the Workshop (30-45 minutes)

Facilitators conclude the Gallery and the workshop. Facilitators may choose to gift each participant with a small gift or card to say thank you for participating and sharing. Facilitators review next steps with participants related to the timeline for Women, Art, and Cannabis Study (e.g. other Body Mapping workshops being conducted) and preparation of participant summaries from the transcripts that are generated.

Participants to confirm best way to stay in touch with facilitators in order to facilitate ongoing communication and sharing of participant summaries at a later date.
The Body Maps are wrapped for transport home. Participants may wish to take their Body Map with them, or it may be stored by the facilitators at their respective organizations.

12pm LUNCH

Appendix 1: Ice Breakers / Opening Exercises
The following exercises could be used to open the day, and throughout the day to create opportunities for movement and building connection between participants.

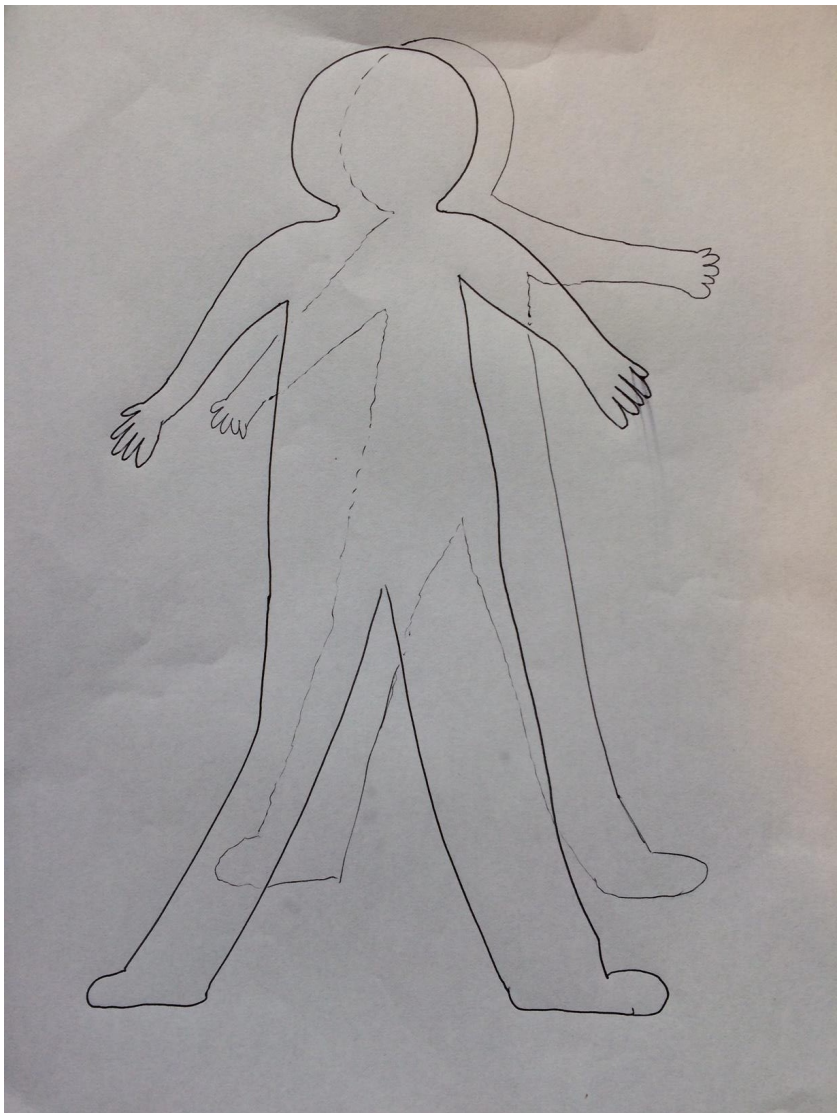
Be Like a Tree:
Facilitator to ask participants to (read text in italics and demonstrate):
Stand grounded on Mother Earth and connect with your roots (participants press their feet into the floor)
Turn over a new leaf (participants take their arms out wide palms face floor, then turn wrists to have their palms facing the sky)
Bend before you break (swing arms like branches swaying in the wind, tip from the hip to create hip/trunk movement)
Reach for your dreams / the stars (reach through the fingertips to the sky)
(Repeat)

Canoe:
Facilitator to ask participants to (read text in italics and demonstrate):
Place one foot ahead of the other, and grab your paddle
Paddle like you're in a canoe, and release air out through your mouth
Change feet and paddle the other side

Be Like an Animal:
Facilitator to ask participants what animal they feel like and act out with sounds. Each person will take a turn in the circle.

Blow Up Your Balloon:
Facilitator to ask participants to (read text in italics and demonstrate):
Pick up your balloon, and blow it up
Tie it off
Keep it in the air (using hands) – up high, and down low
Send your balloon to someone else and call out their name who then tosses to another
Keep it going, have fun
Then, all toss your balloon like a volleyball (volley to people in the circle calling out names)
Then, put your balloon on the floor, stomp and pop it.

Appendix 2: Legend
Please provide each participant with a handout of a Body Map and support shadow tracing – see sample below. This will serve as a legend to keep track of where each participant placed each Exercise on their Body Map. The legend can be used as a reference during the sharing circles.



Appendix 3: Wellness Circle
During the group brainstorming exercise to define and explore the notion of wellness, facilitators may also choose to draw an image (e.g. medicine wheel) to show and explain how the six areas of wellness that are being discussed throughout the workshop are interconnected and overlapping, and not standalone concepts or feelings (see sample below).


Spiritual wellness
mental wellness
Emotional wellness
my wellness
Reproductive &
Sexual wellness
Physical wellness

Appendix 4: Cards Activity

For the last exercise (Art Gallery), each participant and facilitator will receive blank cards (preferably printed on card stock). Each workshop attendee (facilitators + participants + support person) should receive enough cards to provide feedback on each Body Map including participants to comment on their own.

When I look at the Body Map created by… I see	When I look at the Body Map created by… I see
and	and
Signed:	Signed:
When I look at the Body Map created by… I see	When I look at the Body Map created by… I see
and	and
Signed:	Signed:

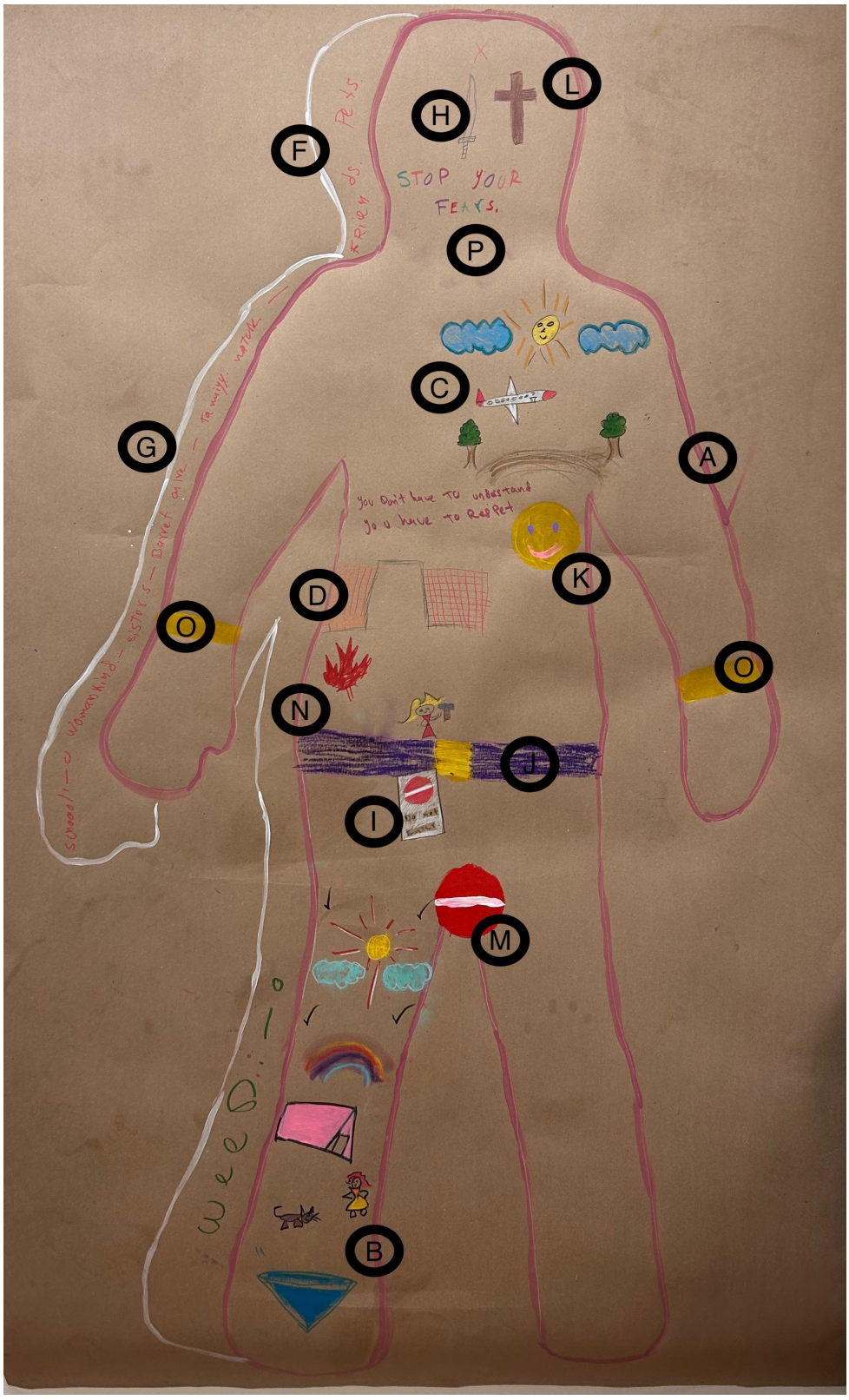
Appendix B

Body Map Key

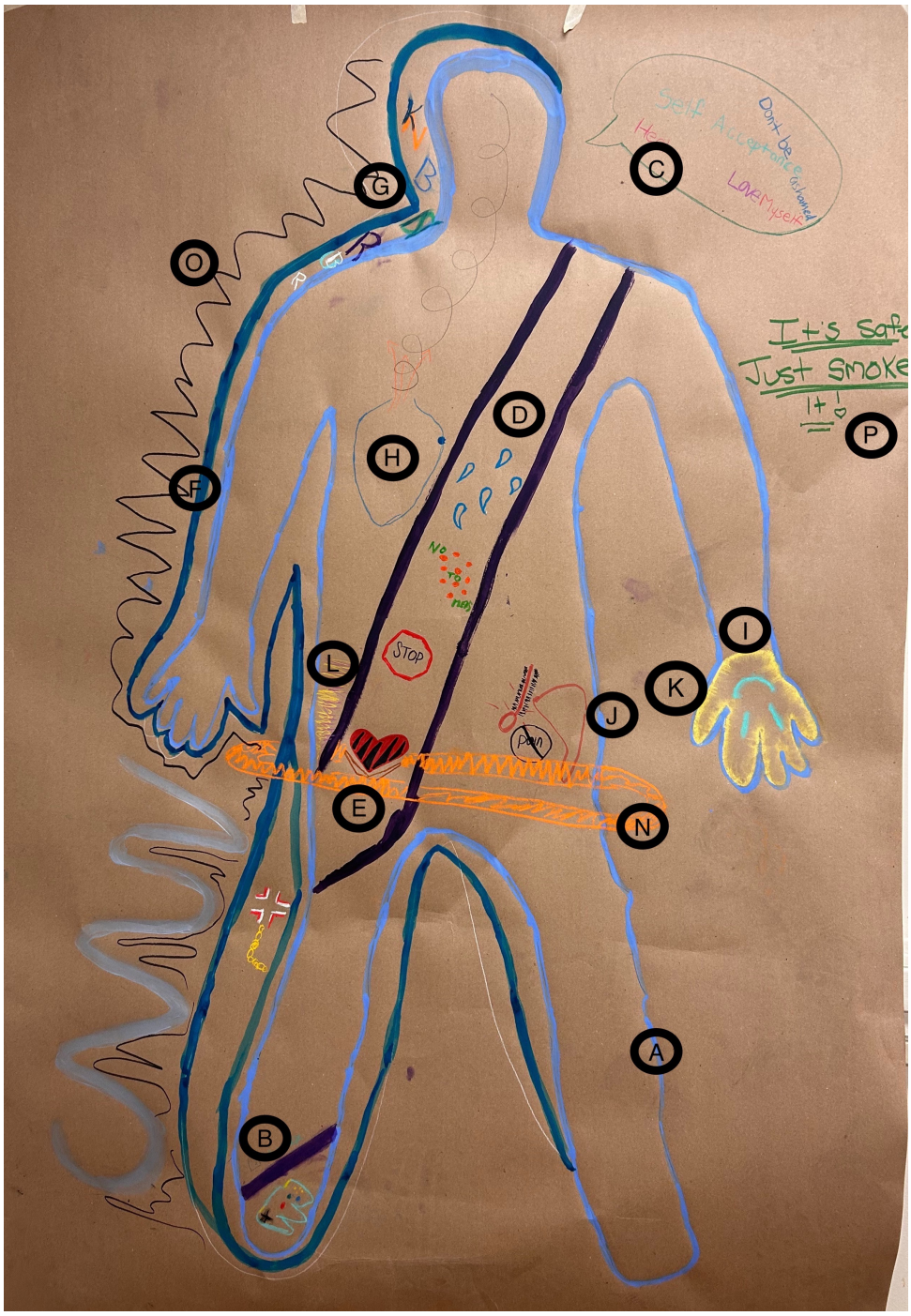
Body Mapping Exercises
Exercise 1: Body tracing
Exercise 2: Highlighting your body shape **Key: A**
Exercise 3: Drawing where you come from **Key: B**
Exercise 4: What are you moving towards. Exploring the future **Key: C**
Exercise 5: Connector and drawing life's distractions and obstacles **Key: D**
Exercise 6: Strengths **Key: E**
Exercise 7: Finding a symbol to show "using cannabis" **Key: I**
Exercise 8: Painting your support shadow **Key: F**
Exercise 9: Support systems **Key: G**
Exercise 10A: The spot **Key: H**
Exercise 10B: A personal symbol **Key: H**
Exercise 11: Experiences of consuming cannabis and impact on health and well-being **Physical health (Key J); Emotional health (Key K); Sexual health (Key L); Spiritual health (Key M)**
Exercise 12: Health and social services for women who use cannabis **Key: N**
Exercise 13: Disclosing cannabis use **Key: O**
Exercise 14: Impacts of disclosure in a context of legalization (NA)
Exercise 15: Creating a personal vision/message for health and social services for women who use cannabis **Key: P**
Exercise 16: Art gallery and honouring participants

*Note: More detailed prompts for the exercises can be found in the Facilitator's Guide – Appendix A

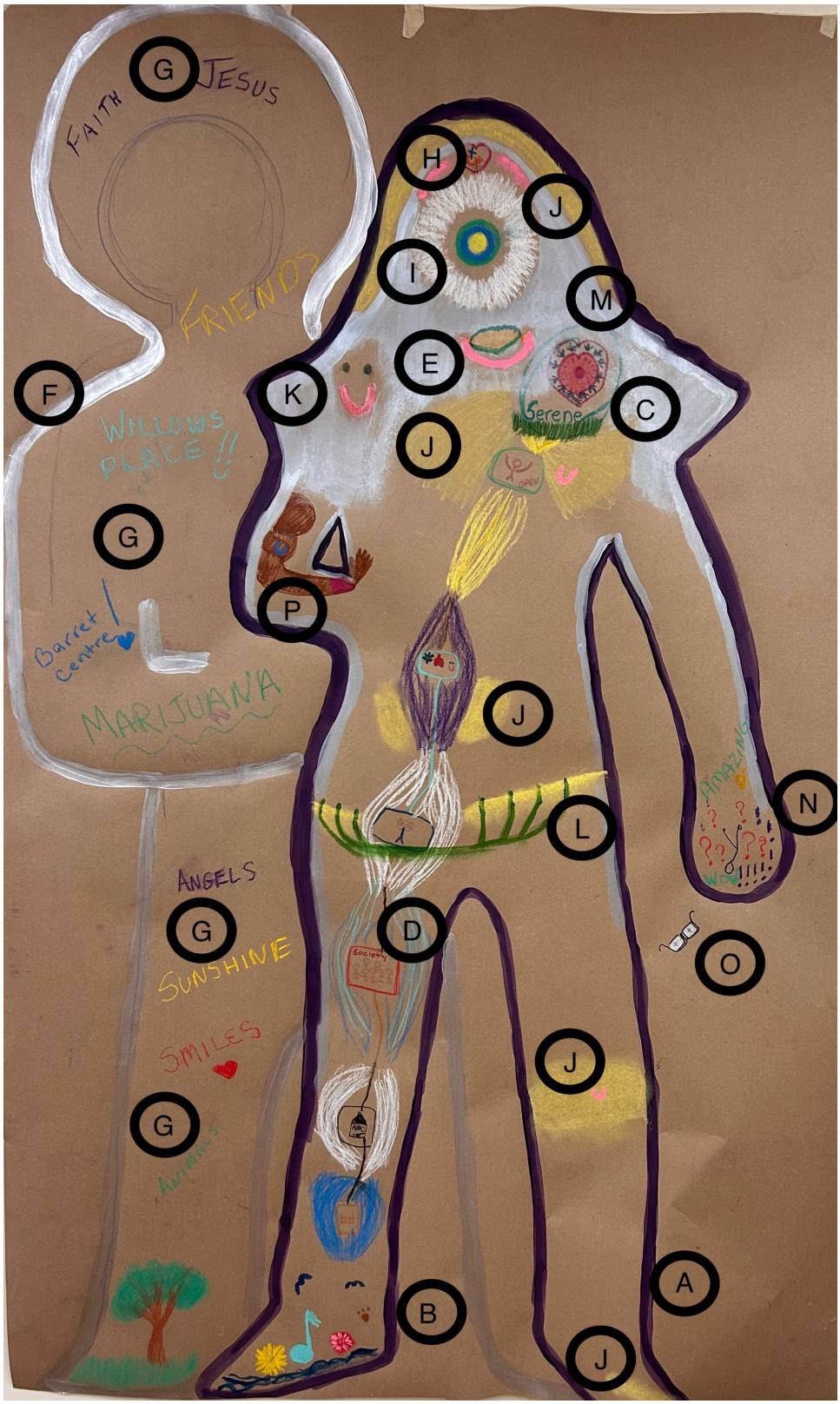
Kelly's Body Map



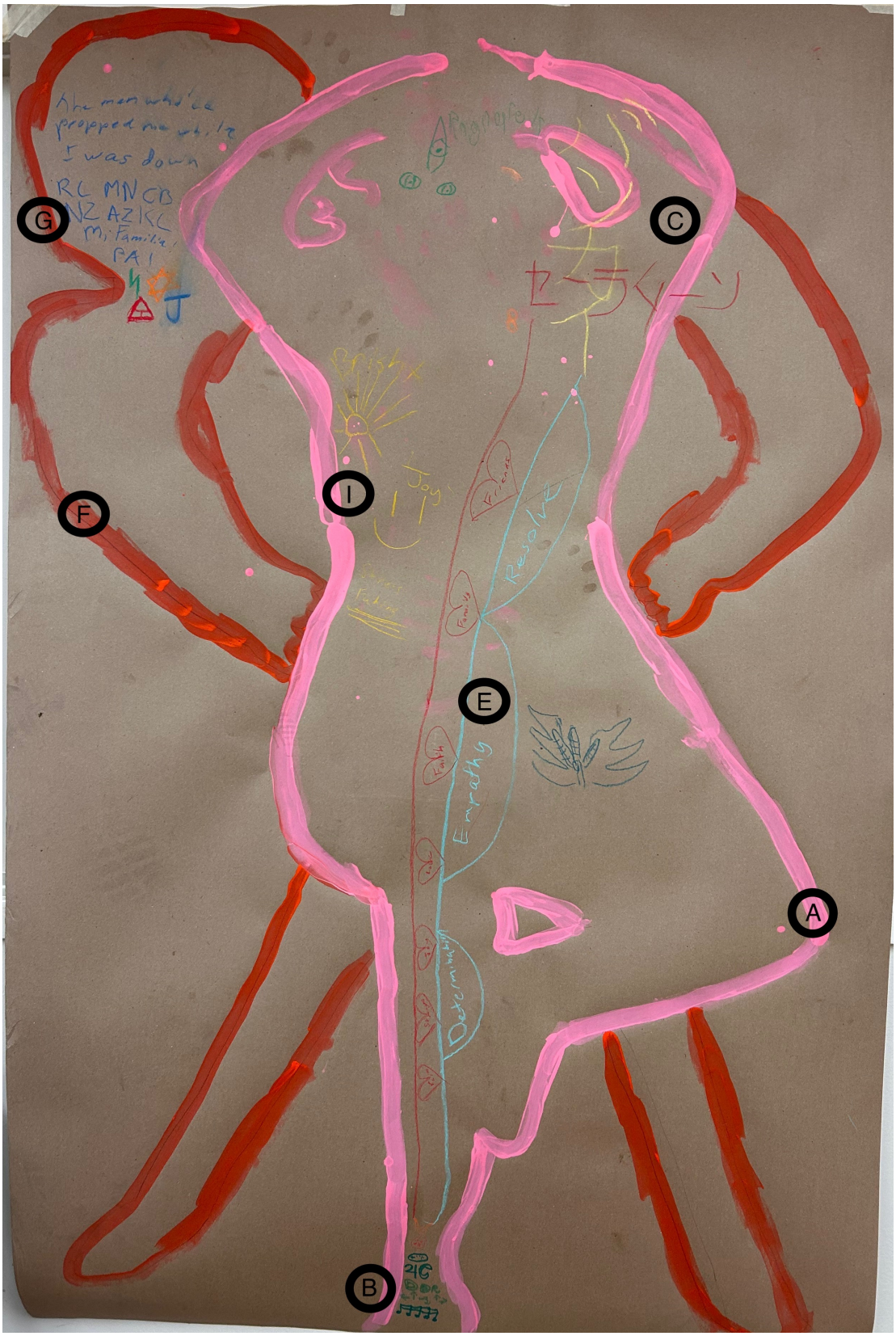
Fiona's Body Map



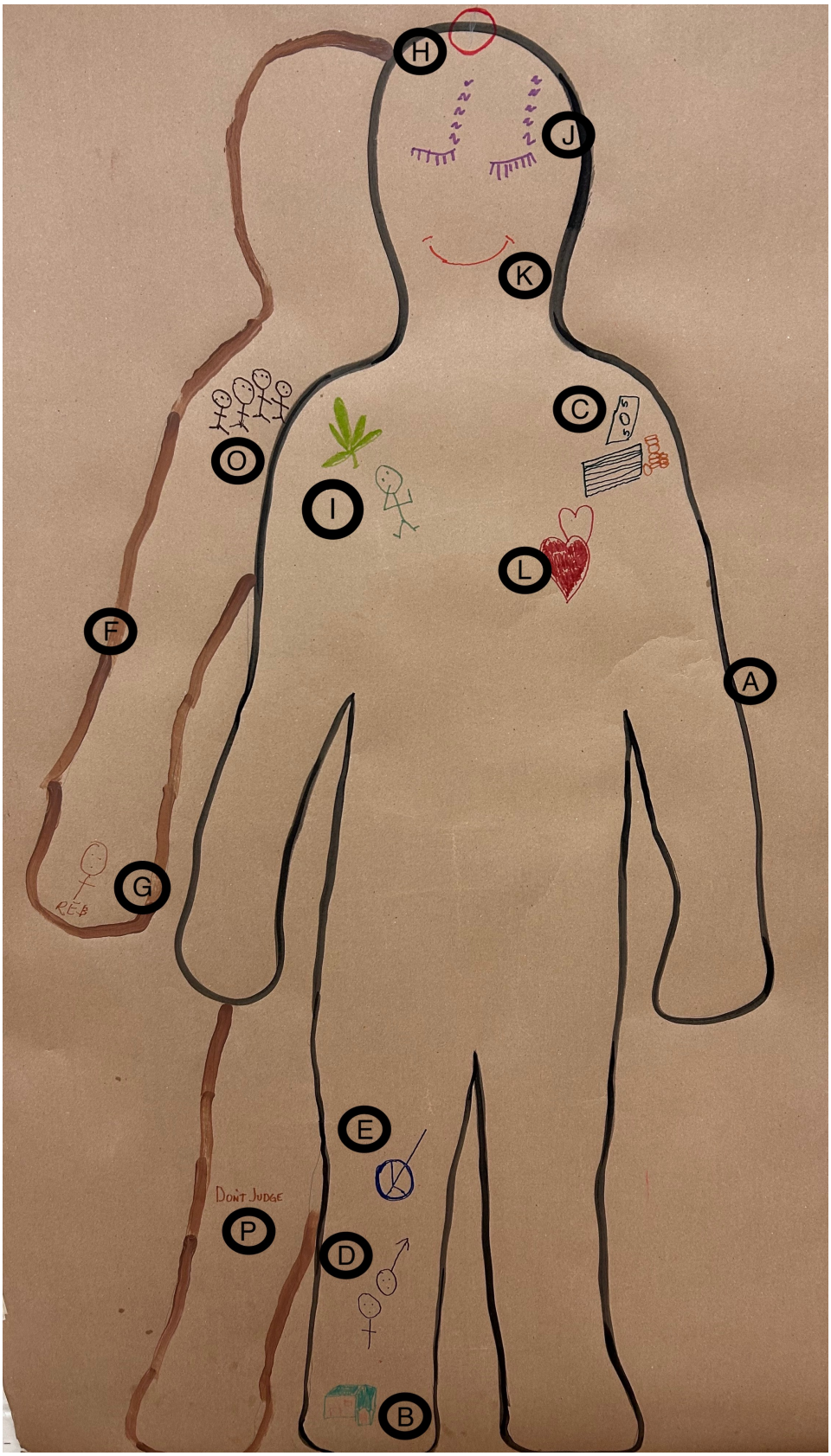
Rose's Body Map



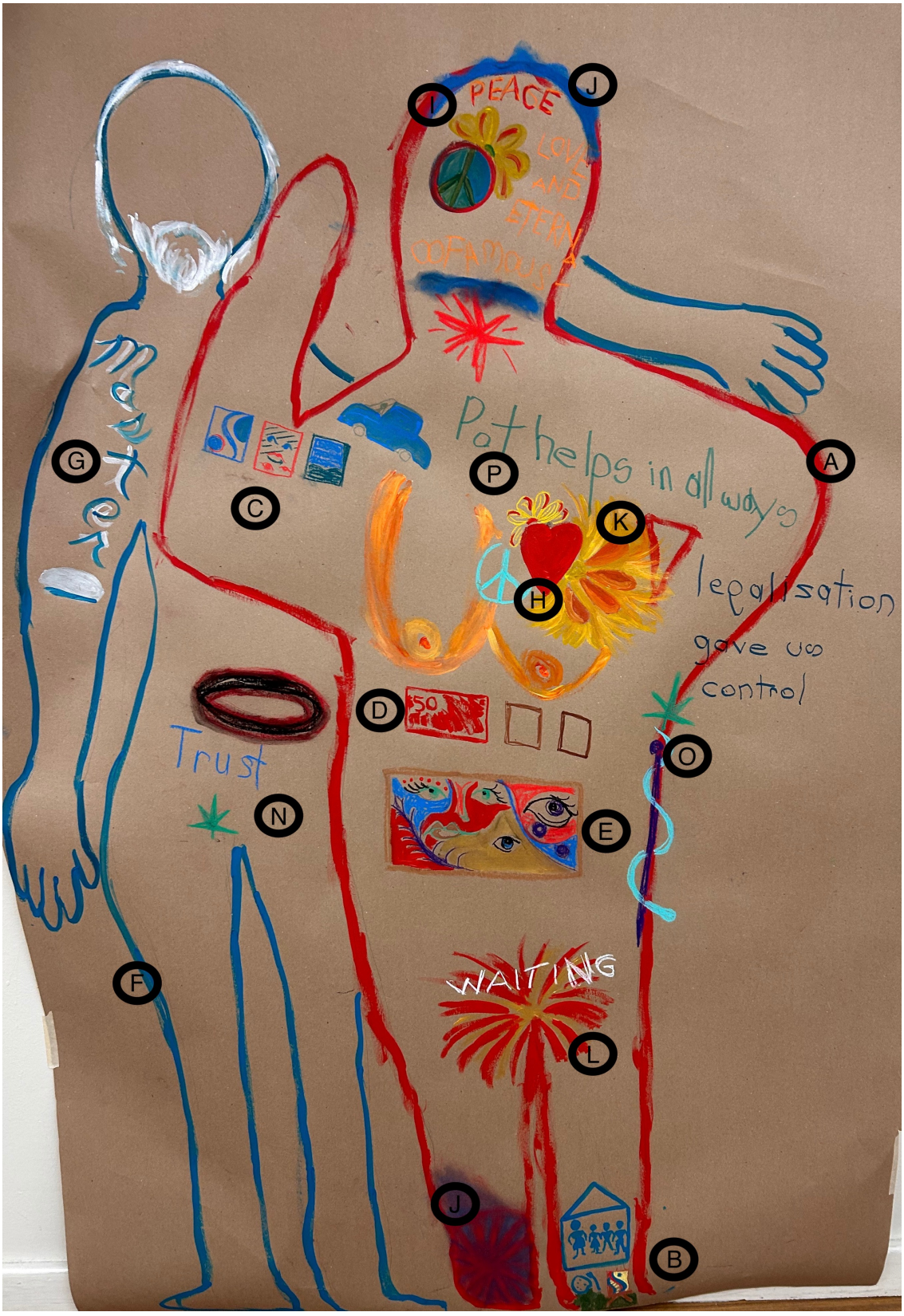
Jessie's Body Map



Colleen's Body Map

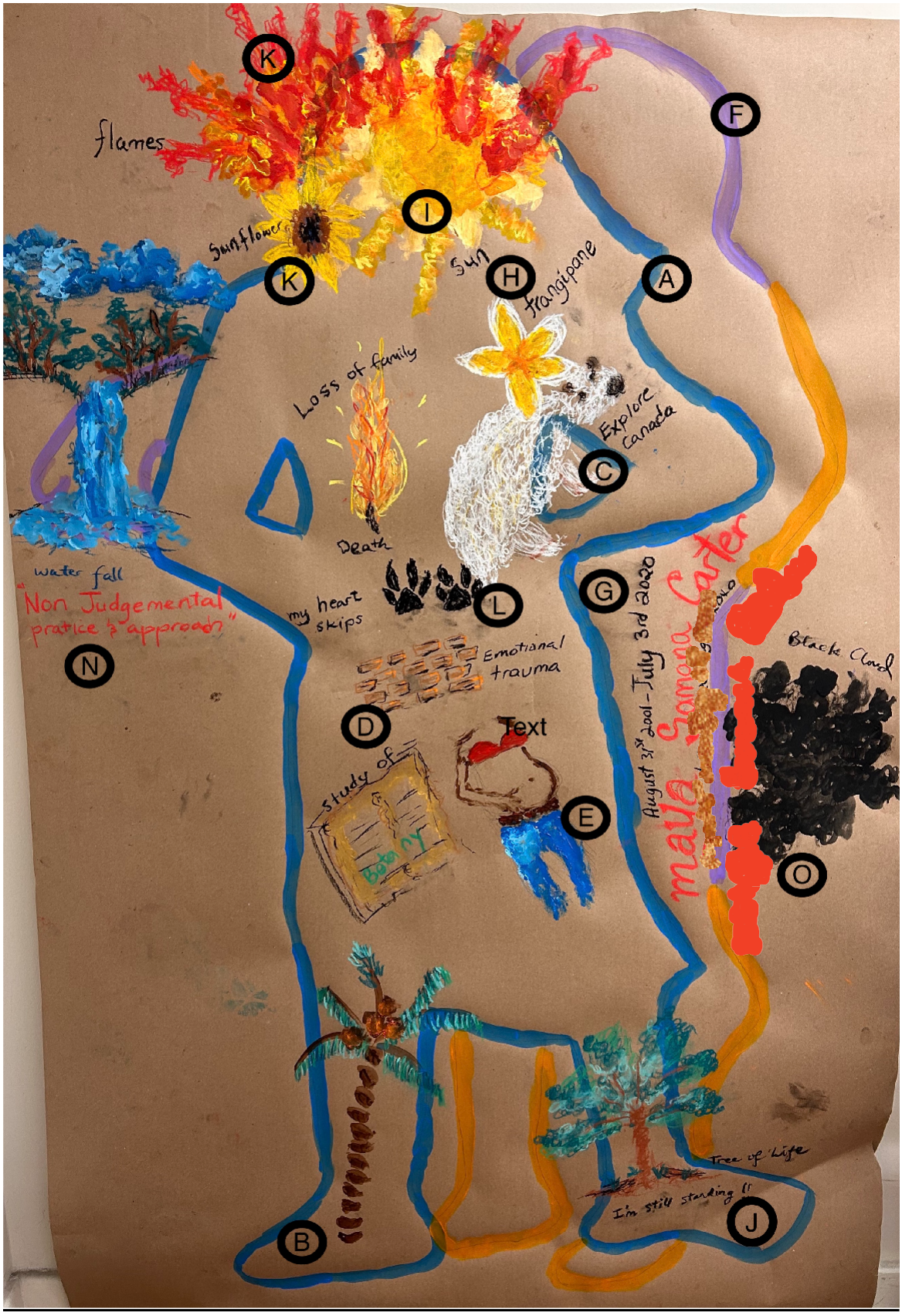


Joelle's Body Map



Stephanie's Body Map

Gia's Body Map



Appendix C

Information and Letter of Consent to Participate BODY

MAPPING WORKSHOP PARTICIPANTS

Women, Art, and Cannabis Study

Research Team

Principal Investigator:	Dr. Saara Greene, McMaster University
Co-Investigator:	Dr. Allyson Ion, McMaster University
Collaborators:	Theresa Kozak, MSW
	Violetta Nikolskaya, YWCA of Hamilton Mary Vaccaro, YWCA of Hamilton
Students:	Karen Cushing
	Samantha
	Floren
Research Coordinator:	Rochelle Maurice

Study Funder: Social Sciences and Humanities Research Council of Canada

Introduction

You are being asked to participate in an arts-based research study to explore the needs and experiences of women, trans women and gender diverse people who consume cannabis in Ontario. We are interested in how cannabis legalization impacts your life, relationships and access to health and social services. Further, we are interested in whether you feel cannabis has been normalized or has lost its stigma now that it is legal in Canada. More specifically, we are interested in how your lived experience consuming cannabis can help inform how social work and other health and care providers can effectively respond to your needs. We also hope that this research will help influence those in the cannabis industry who are directing their attention to women, trans women and gender diverse people.

We will explore these issues using an arts-based approach called Body Mapping. The Women, Art, and Cannabis research team includes women, trans women and gender diverse people who use cannabis and people from academic and community-based cannabis advocacy organizations. We hope that by putting your voices at the centre of this research, this study will create new knowledge that can inform the policies and practices of social workers and other service providers as well as shape how the cannabis industry serves women, trans women and gender diverse people.

Taking part in this study

You can decide if you want to be part of this study. Taking part in this study is totally voluntary and choosing to participate will not affect your right to receive services or access healthcare. You do not have to join this study if you don't want to.

In order to participate you must:

- be 45 years of age or older;
- identify as a woman, trans woman or as gender diverse;
- have used cannabis in the last 12 months;
- be willing and able to participate in a four-day workshop to create a Body Map.

Before you agree to take part in this study, it is very important for you to understand the information in this consent form. If there is anything that is not clear to you, we are here to answer your questions. You must sign the consent form at the end of these pages if you want to participate in the project.

The study

The Women, Art, and Cannabis study was established to develop an understanding of how the legalization of cannabis impacts the everyday life of women, trans women and gender diverse people who consume it. With the legalization of cannabis for recreational purposes under the *Cannabis Act* (subject to provincial regulations), researchers and media have argued that cannabis consumption is now normalized and is no longer stigmatized behaviour. This research asks whether this is the case for all women, trans women and gender diverse people, regardless of race, Indigeneity, socio- economic status, gender identity, ability, or sexual orientation.

The Cannabis, Women and Art research team will be conducting Body Mapping workshops to: a) explore how women, trans women and gender diverse people understand and articulate their consumption of cannabis, including b) their reasons for consuming cannabis and the role it plays in their lives; c) understand their needs and experiences accessing health and social services as women, trans women and gender diverse people who consume cannabis; d) understand how women, trans women and gender diverse people who consume cannabis interact with the cannabis industry; e) know if women, trans women and gender diverse people have experienced education or awareness- raising by the cannabis industry or advocacy groups that they feel adequately reflects their experiences as women, trans women and gender diverse people who consume cannabis; and e) understand what feelings women, trans women and gender diverse people have about their healthcare or social services they've received, and how care should be improved, for women, trans women and gender diverse people who consume cannabis in Ontario.

Two Body Mapping workshops will be held at the YWCA of Hamilton (YWCA Hamilton at 75 MacNabb Street South and the Putman Family YWCA at 52 Ottawa Street North). Both Body Mapping workshop will be co-facilitated by members of the research team. Each workshop will take place over 4 days (one evening, two full days, and one morning) and will include up to six women, trans women and gender diverse people who consume cannabis as participants.

What is Body Mapping?

Body Mapping was originally developed as a way to express one's story and life experiences through art. Body Mapping was developed by artist Jane Solomon and psychologist Jonathan Morgan (both of Cape Town, South Africa) as a way to support women living with HIV in southern Africa. Body Mapping has been used in a number of settings and has a long history a s a unique arts-based tool to explore sensitive topics including sex, sexuality, and health challenges, as well as women's experiences of HIV treatment. The Women, Art, and Cannabis Study will adapt the Body Mapping approach to explore women's, trans women's and gender diverse people's perceptions of wellness and their experiences consuming cannabis.

People use Body Mapping to gain a better understanding of themselves, their bodies and the world in which they live. Body Mapping includes drawing and painting exercises, visualization, group sharing and reflecting. It can be a way for you to use art to tell your life story.

What will happen during the Body Mapping Workshop?

At the workshop, the co-facilitators will guide you through a series of creative tasks that build on one another. Using acrylic paints, markers, and other art materials, you will be asked by the co- facilitators to add symbols, images, or words to your own personal Body Map. These images will be visual expressions of how you perceive your health and wellness, your history, your experiences of health services, and your points of personal power. At the end of each day, you will be asked to participate in sharing circles (also known as focus groups) in order to discuss the development of your Body Map and the experiences you have drawn from to create your artwork with the group.

When the Body Maps are completed, you will be asked to join in the final sharing circle to describe your art and to discuss what informed your drawing process.

The sharing circles at the workshop will be audio-recorded. A transcriptionist who is affiliated with the research team will type out the discussions word-for-word so that the text can be analysed to identify common issues and themes. The Body Maps that are produced will also be analysed for relevant issues and themes.

Daily Schedule

The first day of the workshop will begin in the evening to include a meal where we will get to know each other. We will also use this time to review the consent form and fill out the demographic questionnaire. The following three days will start with breakfast at 9am and an opening by research facilitators. Then the co-facilitators will guide you through several creative tasks that build on one another. Lunch will be provided around noon and then you will continue through more creative exercises. The day will close with a sharing circle with all participants around 5pm. The sharing circle is an opportunity for you to narrate your body map and to explain the art. Sharing circles will be audio-recorded, however, any identifying information that may be shared will be removed during transcription.

What will happen with the Body Maps?

Once the Body Mapping workshop is complete, your Body Map is yours to keep unless you would prefer the lead researcher to keep it for you in a safe place. Your Body Map belongs to you; however, the research team will ask for permission to take photographs of the body maps throughout the art-making process. If you agree to your Body Map being photographed, these images will become part of the research project and will be analysed as part of the research. Again, we will ask permission along the way before we take any photographs of your Body Map.

With your permission, we will take photographs of your original Body Map as part of the data collection process and analysis. This letter of consent is the first step in requesting your permission to share images of your Body Map in presentations, at conferences, and at other events. Your Body Map will only be shared with your permission and without your name or other identifying information. You do not have to have a photo taken of your Body Map. That decision is entirely up to you. We will ask for your consent to share images of your Body Map again at the end of the workshop (day 4).

What will happen after the Body Mapping workshop?

Sometime within the year following the Body Mapping workshop the Women, Art, and Cannabis team members who facilitated your Body Mapping workshop will contact you and provide you with a draft summary of the story you shared about your Body Map. You will have the option to set up a virtual or in-person meeting to discuss and revise the summary. You are welcome to provide input into the summary, make any corrections to make sure that it is accurate, and remove any details that you feel may be used to identify who you are. Participating in this part of the research is entirely voluntary – you do not have to attend these meetings, but you are welcome to it if you are interested in doing so. You will receive a copy of the final summary to keep.

Voluntary participation

Your participation in this study is voluntary. You may decide to stop participating and you have the right to withdraw from the study without consequence at any time. If you withdraw from the study, your medical care, education, or access to other services will not be affected. Any information gathered from you during the recruitment process and the research will be destroyed and will not be used in the study. We hope you are willing to fully participate in all project activities, but it is entirely your choice whether you do. If you choose to withdraw from the study during the workshop, you are free to do so. If you do withdraw during the workshop, you will still receive your full honorarium.

If you decide to withdraw from the study after you have created your Body Map, your Body Map is yours to keep and will not be used in any aspect of the project including analysis or sharing of the study results. We ask that you inform any member of the research team of your decision to withdraw by November 1st, 2023 to ensure your Body Map is not included in any project activities including analysis or sharing of the study results. If you choose to withdraw from the study after you have participated in any or all of the workshop, including the group discussions, we will delete your comments and answers from the group sharing circle transcript to the best of our ability.

Are there any risks involved in this project?

We do not expect this study to cause you or others any harm. The research team has considerable experience and understanding of the lived experiences of women, trans women and gender diverse people, including women, trans women and gender diverse people who are marginalized in some way or who may face structural barriers.

Some of the question you will be asked to think about and discuss during the Body Mapping workshop are personal and may make you feel emotional or upset. You are not required to answer any questions that may make you feel uncomfortable and you are not required to share any information that you wish to keep private. You are welcome to withdraw from the focus group at

any time and/or skip particular questions or exercises that you would prefer not to answer. Also, please note that all participants and Peer Research Associate facilitators at the Body Mapping workshop will be women, trans women and gender diverse people who consume cannabis. Your use of cannabis will be known to the other participants in the group.

If you feel upset during the Body Mapping workshop or at any phase in the research, support is available. For example, there will be a community support worker present during the workshop who can offer support, a counselor will be on call during the duration of the workshop, and members of the workshop facilitation team have experience supporting women, trans women and gender diverse people and can offer support. Self-care exercises and opportunities will also be offered during the workshop.

You may become emotional or upset after the Body Mapping workshop when thinking about the stories and experiences that participants have shared. It is important to have to someone connect with and provide support following the Body Mapping workshop in the even that this does happen. We will also provide you with information about support services in your community to ensure that you are connected before you leave the workshop.

There is a possibility that other workshop participants feel tempted to share stories they heard during the workshop. Therefore, the importance of confidentiality, respect and privacy will be discussed and stressed prior to the workshop and all workshop participants will be asked to respect the confidential nature of the shared. You and other workshop participants will be asked to sign a confidentiality statement (at the end of this consent form).

At the workshop, you do not have to share any information that identifies you in any way or that you are not comfortable sharing in a group setting.

What are the benefits of participating in this study?

You will have the opportunity to talk about issues that concern you. You may learn new skills that may benefit you in the other areas of your life. You may also find it helpful to share your story and hear the stories of others, sharing in the experience with other people. We will use what we learn from this study to help strengthen policy approaches, cannabis industry guidelines, and health and social services for women, trans women and gender diverse people who consume cannabis in Ontario. Therefore, in the future, there may be indirect benefits to women, trans women and gender diverse people who consume cannabis.

How will my privacy be protected?

You do not have to provide any information that will identify you to the other workshop participants or the workshop co-facilitators. Throughout the study including during the workshop and the sharing circles, you are encouraged to use a nickname or a name that you make up instead of using your real name. All workshop participants will be asked to not discuss the things said in the workshop outside of the group and to protect the privacy of workshop participants, all participants will be asked to sign a confidentiality agreement (at the end of this form).

The screening tool (questionnaire) used during the recruitment process will be destroyed once the participants for the workshop are confirmed.

During the group discussions at the Body Mapping workshop, we will record the group discussion on a digital audio recorder and notes may be written by the workshop facilitators. This is to make sure that we do not miss any of your valuable ideas and opinions. The recordings will be transcribed by a transcriptionist who is affiliated with the study and has signed as agreement to maintain the confidentiality of the study content. The transcriptionist will remove any information that identifies you. (For example, if you mention any details during the group discussion such as your name, your hometown, your employer or the name of a friend that could identify you, we will remove this information from the transcription and all written notes.) The workshop participants will not be personally identified in the transcript, notes or other research data.

We will store all the digital recordings, notes and other research data in a locked cabinet in a secured office at McMaster University. We will protect the data stores on computers by using passwords; all saved data will be kept on a secured computer system. The study reports will never show your name or any information that identifies you. Only the research team members will listen to the audio recordings and read the data of this study.

We will destroy the audio recordings when we complete this study. We will also destroy all the study transcripts, written data and other study materials five years after we complete the study.

Upon completion of your Body Map, you will be asked if you want to have your Body Map or photos of your Body Map displayed at any events and functions where we share this research with others. You do not have to include your name on your Body Map, unless you choose to do so.

Future Use of Data

The data collected during the Body Mapping workshop will be used for the sole purpose of fulfilling the aims of the research described in this consent form.

Payment

There will be no financial costs incurred by participating in this study. An honorarium of $250 CAD will be provided to all participants who attend the Body Mapping workshops.

How do I find out what was learned in this study?

We expect to have this study completed by approximately March 2024. If you would like a brief summary of the results, please let us know how we should contact you at the end of this form. We aim to disseminate research findings through community organizations, in addition to presenting study data at conferences, and publishing key findings in academic journals.

Questions about the Study

If you have questions or need more information about the study itself, please contact Saara Greene, Principal Investigator, McMaster University, 905-524-9140 x23782 or greenes@mcmaster.ca.

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext.

23142
C/o Research Office for Administrative Development and Support E-mail: ethicsoffice@mcmaster.ca

Please keep the extra copy of this consent form for your records.

Consent Process:

We will not ask you to document your consent to participate in the Body Mapping workshop. We will also ask you to confirm that the guarantee of absolute confidentiality during the research process is essential to ensure your participation and consent, and to confirm that you will not share information discussed during the Body Mapping workshop and sharing circles.

CONSENT

I have read this consent form. I am satisfied with the answers to all my questions about this study. I agree to take part in the study. I agree to be recorded during the sharing circles. I fully understand my rights as a person taking part in the study. I have a copy of this consent form for my own record. I confirm that the guarantee of confidentiality during the research process is essential to ensure my participation and consent in this research.

_____	_____	_____
(Participant name or	(Name/Pseudonym	(Date)

I confirm that I have read this consent form out loud to the participant and I have answered all questions.

_____	_____	_____
(Researcher name)	(Researcher's signature)	(Date)

Confidentiality Agreement

I agree not to disclose any information shared by another study participant that I hear during the Body Mapping Workshop.

_____ _____
(Participant name or (Date)

I confirm that I have read this confidentiality agreement out loud to the participant and I have answered all questions that she asked of me.

_____ _____
(Researcher's signature) (Date)

I would like to receive a copy of the study report when it is available: Yes D No D

Contact information (preferred telephone number, mailing and/or email address):

To be signed at the end of the workshop:
PHOTOGRAPHING BODY MAP CONSENT

Permission to Photograph Body Map
I agree to having photographs taken of the Body Map that I produce during the Body Mapping Workshop. I understand that the photographs of my Body Map will be used in the data analysis process. All photographs will be stored in a secure data drive and will not contain any identifying images of my face or body.

_____ _____
(Participant name or (Date)

If you agree to having photos taken of your Body Map, please complete the following sentence:

I want the following _____ to be assigned to my body map and used
in (name/fake name/pseudonym)
any references made to it (for e.g., in articles and presentations about the research)

Presentation of Body Map Agreement

I agree to having a photograph taken of the Body Map that I produced during the Body Mapping Workshop and that it can be shown at meetings, events, and in publications where the findings of this research project will be shared with others, including women, trans women and gender diverse people who consume cannabis and other people who consume cannabis, researchers, people in the cannabis industry, and policy makers.

_____ _____

(Participant name or (Date)

If you agree to having photos taken of your Body Map, please complete the following sentence:

I want the following _____ to be assigned to my body map and used (name/fake name/pseudonym)

in any references made to it (for e.g., in articles and presentations about the research)

Appendix D

Demographic Questionnaire

1. What is your Age? ☐☐

2. City of residence

- ☐ Toronto
- ☐ Hamilton

3. **How do you describe your race and/or ethnic background?** *Select all that apply.*

- ☐ Indigenous or Aboriginal
- ☐ Indigenous Person from a country outside of Canada
- ☐ Black African (e.g. Nigerian, Somali)
- ☐ Black Caribbean (e.g. Haitian)
- ☐ Black Other (e.g. Black Canadian)
- ☐ Caucasian/White
- ☐ Chinese or Taiwanese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Latin American (e.g., Chilean, Costa Rican, Mexican)
- ☐ South Asian (e.g., Indian, Bangladeshi, Pakistani, Punjabi, and Sri Lankan)
- ☐ Southeast Asian (e.g. Cambodian, Laotian, Malaysian, Vietnamese)
- ☐ Arab (e.g., Egyptian, Kuwaiti, and Libyan)
- ☐ West Asian (e.g. Iraqi, Israeli, Lebanese, Afghani, Iranian)
- ☐ Central Asian (e.g., Kazakhstan, Krgyzstan, Tajikistan, Turkmenistan)
- ☐ Multiple races / Multiracial / "Mixed"
- ☐ Self-identify as: _____
- ☐ Don't know / Prefer not to answer

4. If you are Indigenous or Aboriginal, do you identify as:

First Nations (Status) ☐	Métis ☐	Inuit ☐
First Nations (Non-status) ☐	Don't know ☐	Prefer not to answer ☐
Self-identify as _____ ☐	☐	

5. If you are Indigenous or Aboriginal, what Nation do you identify with? _____

I do not identify as Indigenous or Aboriginal ☐

I prefer not to answer ☐

6. Please select the populations with which you identify. More than one selection is possible.

- ☐ Indigenous/Aboriginal Women
- ☐ African, Caribbean Black Canadian Women
- ☐ Newcomer and Immigrant Women
- ☐ Younger Women (under 30 years)
- ☐ Older Women (over 50 years)
- ☐ LBGTQ Women
- ☐ Women with a history of incarceration
- ☐ Women living in rural or remote Areas
- ☐ Street Involved or Homeless Women
- ☐ Current or former sex worker
- ☐ Current or former substance user
- ☐ Living with Hepatitis Co-infection, i.e. Hep A, Hep B, and/or Heb C)
- ☐ Self-identify as _____
- ☐ None of the above

7. How do you describe your gender?

Woman			Trans Woman		
Gender queer			Prefer not to answer		
Self-identify as (specify):_____	☐				

8. How do you describe your sexual orientation?

Heterosexual / Straight			Lesbian			Gay		
Bisexual			Two-Spirited			Queer		
Pansexual	☐		Asexual	☐			
Self-identify as _____			Questioning	☐		Prefer not to answer	☐	

9. What is your current marital or partnership status?

Single			Separated / Divorced		
Common-law (living in a committed relationship)	☐		In a relationship but not living together	☐	
Legally Married			Widow/Widower/Partner deceased		
Other (specify): _____			Prefer not to answer		

10. How long have you lived in Canada?

- ☐ <1 year
- ☐ <5 years
- ☐ 5-10 years
- ☐ >10 years
- ☐ I was born in Canada

11. Where were you born?

Canada (specify province) _____	☐	United States (specify state) _____	☐
Central America (specify country) _____	☐	Caribbean (specify country) _____	☐
South America (specify country) _____	☐	Africa (specify country) _____	☐
Europe (specify country) _____	☐	Asia (specify country) _____	☐
Not known / Prefer not to answer	☐	Other (specify) _____	☐

12. What is your current legal status in Canada?

Canadian Citizen	☐	Here with Temporary Work Papers (including 2 year work Visas)	☐
Landed/Permanent Resident	☐	Here with Humanitarian and Compassionate approval	☐
Refugee/Protected Person (you have been formally approved as a refugee)	☐	Here as a Visitor	☐
Refugee Claimant/Person in need of protection (you have applied to become a refugee but your application is not yet approved)	☐	Here on a Student Visa	☐
Undocumented	☐	Other (specify):	☐
Not known	☐	Prefer not to answer	☐

13. What is the highest level of formal education you have completed?

Please select one response.

No formal education			Elementary/Grade School		
Some High School / Secondary			Completed High School / Secondary		
GED (General Education Diploma)			Trade of Technical Training		
Some college			Completed College Diploma		
Some undergraduate university			Completed Undergraduate University		
Some post-graduate university			Completed Post-Graduate Education		
Other (specify):	☐		Not known	☐	
			Prefer not to answer		

14. What is your current <u>main</u> source of income? *Please select one response.*

Paid employment, full time			Worker's Compensation		
Paid employment, part time			Employment Insurance (EI)		
Social assistance (e.g. Ontario Disability Support Program, Income and Disability Assistance, Saskatchewan Assistance Program	☐		Private Pension	☐	
Canada Pension Plan (CPP)			Personal savings		
Self employment Specify: _____	☐		Loan(s) / Student Loan(s)	☐	
Parent / friend / relative / partner income	☐		Honoraria (workshops, trainings)	☐	
Other Specify: _____	☐		Prefer not to answer	☐	

15. What is your annual <u>household</u> income (before taxes)? *Please select one response.*

Less than $10,000			$50,000 to $59,000		
$10,000 to $19,999			$60,000 to $69,999		
$20,000 to $29,999			$70,000 to $79,000		
$30,000 to $39,999			$80,000 to $89,999		
$40,000 to $49,999			$90,000 or more		
Not known			Prefer not to answer		

16. Which of the following best describes the residence in which you currently live?

House that you own	☐	A housing facility or group home where you have your own room but share a kitchen and bathroom with other people	☐
Apartment or Condominium that you own	☐	Shelter	☐
House that you rent	☐	Transition house / Halfway house / Safe house	☐
Apartment or Condominium that you rent	☐	Outdoors, on the street, parks, or in a car	☐
Self-contained room that you rent in a house or apartment with other people	☐	Couch surfing / Multiple residences	☐
Hotel	☐		
Other Specify: _____	☐	Prefer not to answer	☐

17. Are you a parent or a guardian?

☐ Yes
☐ No

18. If you are a parent or guardian, how many children do you have? (Insert # of children or N/A): _

19. How old is your child(ren)? List age(s): _____(or N/A)

20. If you are a parent or guardian, do your children live with you?

☐ Yes ☐ No ☐ N/A

21. If you are a parent or guardian and your children do not live with you, with whom do they live? *Select all that apply.*

☐ N/A
☐ They are grown up and live on their own
☐ Other parent
☐ Grandparent
☐ Other family member
☐ Friend
☐ Foster care
☐ Adoptive parent
☐ Other: _____

Appendix E

McMaster University

Do you identify as a woman / transwoman/ gender diverse? Do you consume cannabis? We want to talk to you!*

We are a team of women-identified researchers from McMaster University **recruiting research participants in Hamilton for an arts-based workshop on cannabis use**

The Study

We are inviting up to **6** women/trans women/gender diverse folks who use cannabis and who live in downtown Hamilton to share their experiences of the role of cannabis use in their lives, including their relationships and their interactions with healthcare and social services

You will be asked to participate in a 4-day arts-based workshop (one evening, 2 full days, and one morning total).

During this time, you will participate in Body Mapping- a creative process that involves drawing and painting images, symbols and words, as well as visualization exercises. Sharing circles are also integrated into workshops for participants to contribute an accompanying narrative.s, including their relationships and their interactions with healthcare and social services.

Eligibility

You are eligible to participate if you are:

- 45 years of age or older
- Identify as a woman/trans woman/gender diverse
- Have used cannabis (in any form) in the last 12 months
- Living in downtown Hamilton
- Willing and able to participate in workshop activities to create a Body

Extra Information

- Up to 5 other women/trans women/gender diverse folks will also be participating in the workshop at YWCA Hamilton.
- Participation is confidential
- You will be provided with $250 to honour your time and participation.
- Food and travel will be provided.

How do I get Involved?

To find out more about this project, and if you are eligible lo participate, please contact:
Rochelle Maurice, maurir1@mcmaster.ca, 905-519-9894

Please note: There will be a 20 to 30-minute pre-screening interview to determine your eligibility and tell you more about the study and what to expect. Any information collected during the screening will be private and confidential. Your identity will be kept private.

We would like to thank, in advance, all potential participants who take the time to inquire and screen forthis study. The research team is committed to ensuring that diverse voices and experiences of women who use cannabis are reflected in this research. All potential participants who complete the screening will be nm:ified regarding whether or not they have been selected for the study.
Thisstudy has been reviewed by and received ethics clearance by the McMaster Research Ethics Board.

Appendix F

Screening Questionnaire

Date: _____/_____/_____ Day Month Year	First Name, Last Initial: _____
Contact info:	
Phone number: _____	Email: _____

1. Basic eligibility

D Are you 18 years of age or older?

D Do you identify as a woman (inclusive of cis, trans and gender diverse women)?

D Have you used cannabis in the past 12 months or are you actively using cannabis currently?

D Are you available to participate in a 3-day body mapping workshop on [insert dates]?

D Do you currently live in the Greater Hamilton Area or the Greater Toronto Area?

2. Background information on the Body Mapping Workshops:

Interviewer: I'd like to go through some important information about the workshop so that you know what will be expected of participants so that you can assess your willingness and ability to participate. If, by the end of this conversation you feel that you would be interested in taking part in the study, we will record your phone number or email address so we can follow up with you regarding childcare arrangements or reimbursements, ground transportation, dietary needs, and to confirm accommodations.

The Women, Art, and Cannabis Study is an arts-based research study to explore how women who use cannabis - including mothers- from all intersecting social locations (i.e. racialized groups, gender identities, socio-economic statuses, sexual orientations) access and consume cannabis. We are especially interested in how women who are marginalized in some aspect of their lives experience cannabis use now that it is legalized in Canada. Some guiding questions are: Has cannabis been "normalized" for all women? How have your interactions with social service, child welfare, or health care providers been shaped by your disclosure of cannabis use and any associated stigma?

Our research goals are to:

1. identify and provide a critical analysis of the needs and experiences of women and mothers who consume cannabis in Ontario;
2. learn from women's experiences in order to identify and influence how social work and allied health and social care providers can effectively respond to their needs and experiences vis-à-vis policies and practices

The research team includes women who use cannabis, and women from academic and community organizations. We hope this study will help inform the way social work, social

services, and health providers provide services to and interact with women and mothers who use cannabis

Each Body Mapping workshop will be co-facilitated by a Peer Research Associate (women who use cannabis and have research training) and researcher who is a part of the Women, Art, and Cannabis team [insert name(s)] and members of the research team [insert names]. There is a cash honorarium of $200 for your participation over the 4-day workshop. Please understand that this is a workshop and not a retreat, so being on time each day to participate is very important.

Since we are recruiting for a diverse group of participants, you will be sharing the Workshop Experience with a diverse group of women; queer and straight, transgender and cis-identified; younger and older; people from different cultural and economic backgrounds who live in different neighbourhoods (rural, city, hotels, west end, downtown eastside etc.). We will all be on the land together as a unique community and everyone has a story to share but how much they share is up to them.

The workshop will be held at Five Oaks Education and Retreat Centre. The workshop itself will last 4 days [insert dates]. You will arrive the afternoon/evening of [insert date] and depart after lunch on [insert date]. The site caterers will serve breakfast, lunch, and dinner as well as snacks each day and childcare will be provided on site should you need it.

3. Assessing willingness and ability to participate:

a. Are you still interested in participating?

b. There will be up to 6 participants chosen for the workshop. Everyone has their own idea of what it means to them to be ready to go on a workshop. What makes you personally 'ready' to attend this workshop? (Could probe with: Do you foresee any challenges?)

c. What issues might prevent you from having a good overall experience? (e.g. active addiction, other health challenges)

d. Have you ever participated in a research project related to cannabis use before?

Yes/No. If yes, please describe.

4. Interview Closure

Interviewer:

- Go over any remaining questions from Q&A document.
- Ask if they have any further questions.

We would like to thank you so much for taking the time to screen for this study. We are so grateful for your interest. As you may have noticed on the recruitment poster, we are committed to ensuring that diverse voices and experiences of women who use cannabis in [insert location] are reflected in this research.

I will share this screening information with our research team, who will make the final decision. All potential participants who complete the screening will be notified regarding whether or not they have been selected for the study.

Those selected, may be contacted by myself and/or one of our PRAs to discuss the workshop details further.

*This interview form was adapted, with permission, from Positive Living British Columbia's Progressive Spirituality Workshop interview form.