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Cannabis and Christianity: Scientific, Social, and Theological Reflections on THC and Christian Faith

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With the legalization of cannabis and the proliferation of products containing its main psychoactive component, tetrahydrocannabinol (THC), the use of cannabis-associated psychoactive substances has moved from the margins to the mainstream and, in the case of recreational marijuana, involves products of increasing potency. This development raises several specific interdisciplinary questions, including how THC interacts with the endocannabinoid system to alter synaptic neurotransmission, what current clinical and public health evidence indicates regarding its risks and potential therapeutic applications, and how Christian theological and ethical frameworks may be applied to evaluate cannabis use across medical, recreational, and spiritual contexts. This article outlines the state of neurobiological, clinical, public health, and social research on THC and its effects, as well as prior Christian theological and ethical assessments of marijuana. Through the integration of scientific, societal, and theological perspectives, this article seeks to clarify a Christian ethical perspective on THC use for recreation, therapeutic, and spiritual purposes.

Keywords: THC (tetrahydrocannabinol), marijuana, psychoactive substances, cannabis legalization, medical ethics, public health, recreation, biblical theology of pharmaceuticals, Christian pharmaceutical ethics, Christian spirituality

Introduction

The increasing normalization of cannabis use, and more particularly of high-concentration tetrahydrocannabinol (THC)-containing products, has raised not only medical and legal challenges but also a complex suite of issues with broad implications for individuals and society. In this context, THC

use raises specific concerns for Christians because it intersects with broader social patterns of addiction risk, commercialization, and the normalization of intoxication, while also directly involving the alteration of cognition, perception, and self-control and raising questions of bodily stewardship and moral agency.

This article examines the implications of THC use through multiple disciplinary lenses. To clarify how THC might and might not pose concerns similar to those of other psychoactive substances such as alcohol, caffeine, and morphine, we begin with scientific studies on THC's neurobiological mechanisms and effects. This foundation then informs our understanding of how cannabis use intersects with public health concerns, and regulation. Next, we approach

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THC from a Christian ethical and theological perspective. This includes developing relevant biblical and theological principles for thinking about psychoactive substances and their potential use for recreational, medical, and spiritual uses. Finally, we integrate these three perspectives within a holistic Christian framework to reflect on how THC use affects our relationships with ourselves, with the broader community, and with God's kingdom.

Our goal is not to provide definitive conclusions about whether or not THC should be used for particular purposes, but to provide resources that will foster reflective, critical engagement and dialogue to enable readers to engage THC thoughtfully, responsibly, and faithfully.

I. Scientific Perspective on THC: Function, Effect, and Comparison to Other Mind-Altering Substances

As cannabis use becomes increasingly widespread, understanding the scientific basis of its holistic effects and those of its main psychoactive component, THC, is crucial. Through its interaction with the body's endocannabinoid system, THC produces a wide spectrum of psychoactive, physiological, and behavioral responses.¹ This section explores the neurobiological mechanisms of THC, outlines its short-term and long-term effects, and compares them with other commonly used psychoactive substances. Although these substances have different mechanisms of action from those of THC, such comparisons provide important context for assessing outcomes associated with THC use and the implications of THC for public health. A clear understanding of the effects of THC is also crucial for developing the ethical, cultural, and theological understandings needed to assess THC use later in this article.

What is THC, and how does it work?

The *Cannabis sativa* plant produces a variety of bioactive compounds, including terpenes, flavonoids, and cannabinoids.² Of the more than 100 cannabinoids identified in *Cannabis sativa*, THC and cannabidiol (CBD) are the most widely used and extensively studied.³ The term "marijuana" is commonly used to describe cannabis strains with high THC content, which are typically used for recreational or medicinal purposes.⁴ There are several types of THC, which differ slightly in chemical structure. These include Delta-9, Delta-8, Delta-10, THC-A, THC-O, and HHC. Of these, Delta-9 is the most abundant and is primarily responsible for the psychoactive "high" associated with cannabis use.⁵

The chemical structure of THC shares certain pharmacophoric similarities with anandamide (N-arachidonoyl-ethanolamine, AEA), a naturally occurring endocannabinoid signaling molecule in the brain (fig. 1).⁶ This similarity allows THC to bind to cannabinoid receptors, particularly CB1 receptors, which are primarily concentrated in the hippocampus, cortex, cerebellum, basal ganglia; and to CB2 receptors, which are primarily found in immune and peripheral tissues. The CB1 and CB2 receptors together constitute the endocannabinoid system, which regulates mood, memory, appetite, cognition, pain processing, and immune function.⁷

Under normal physiological conditions, the endocannabinoid system primarily operates via retrograde signaling, in which postsynaptic neural activity triggers the synthesis of AEA. AEA then diffuses retrogradely across the synaptic cleft and activates presynaptic CB1 receptors, thereby modulating presynaptic neurotransmitter release. By mimicking AEA but bypassing endogenous spatial and temporal regulatory mechanisms, THC

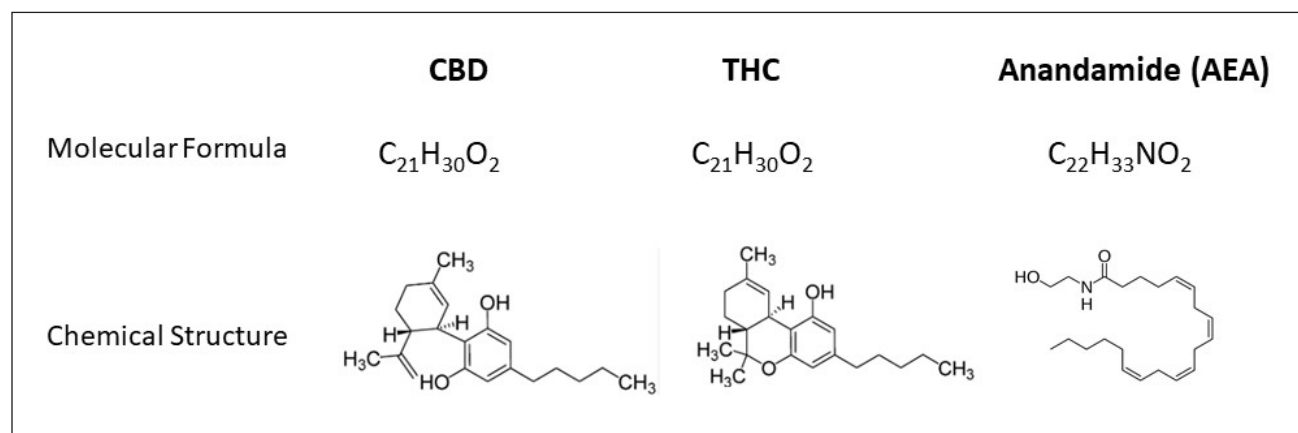


Figure 1. Molecular Comparison of THC with CBD and Anandamide (AEA). This figure compares the chemical structures of Δ^9 -tetrahydrocannabinol (THC), cannabidiol (CBD), and anandamide (AEA). Although THC, CBD, and anandamide (AEA) differ substantially in their overall chemical structures, all three molecules exhibit overlapping pharmacophoric features relevant to cannabinoid receptor binding, including hydrophobic regions and hydrogen-bonding functional groups arranged in spatial configurations compatible with receptor interaction.

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produces prolonged and less precisely regulated activation of cannabinoid receptors. Unlike endogenous ligands, which are rapidly synthesized and degraded to maintain tight physiological control, THC disrupts the precision of endocannabinoid signaling, leading to altered neural circuit activity and a range of psychological and physiological effects.⁸

The effects of THC in both recreational use and medical use are mediated through its activity at cannabinoid receptors. During recreational use, the psychoactive effects of THC primarily arise from strong CB1 receptor activation in brain regions involved in reward, memory, cognition, and sensory processing.⁹ Although THC can also activate CB2 receptors at the higher concentrations often reached during recreational use, these effects are generally considered secondary to CB1-mediated central nervous system activity.¹⁰ In medical uses, therapeutic actions may involve both CB1- and CB2-mediated pathways. Therefore, therapeutic use depends on careful dosage and formulation to maximize clinical benefit while minimizing unwanted psychoactive outcomes from excessive CB1 activation.¹¹

What are the effects of THC?

While most literature focuses on the overall use of cannabis, a growing body of research is beginning to focus on the specific neural and cognitive effects of THC.¹² These include a variety of short-term and long-term effects, which vary depending on dosage, frequency of use, mode of administration, age, physiological condition, and individual biological differences and sensitivities.¹³ Table 1 summarizes the key physiological and neuropsychological effects of THC, based on the work of Kroon et al., Crean et al., and multiple other peer-reviewed studies.¹⁴

In recreational use, psychoactive effects, including euphoria, relaxation, altered sensory perception, and enhanced sensory experiences, tend to be the primary purpose for consumption.¹⁵ Although recreational use generally seeks such psychoactive effects, the degree of intoxication can vary considerably among users and patterns of use. These acute effects are typically transient following use. However, long-term or high-dose THC use is associated with an increased risk of adverse psychiatric disorder outcomes, including anxiety, depression, and psychosis, as well as more persistent cognitive deficits affecting memory, attention, and executive function.¹⁶ Adolescents may be particularly vulnerable to these long-term effects because brain development, particularly in areas related to executive function and mood regulation, continues into early adulthood.¹⁷ Long-term or excessive use may also lead to cannabinoid hyperemesis syndrome which entails vomiting and abdominal pain.¹⁸

In the medical field, THC has been investigated for several therapeutic applications. THC analogues such as dronabinol and nabilone are approved for the treatment of chemotherapy-induced nausea and vomiting and for appetite stimulation in patients with HIV/AIDS.¹⁹ THC can also provide analgesic benefit in chronic neuropathic and cancer-associated pain;²⁰ however, the strength and consistency of the evidence are inconsistent across studies.²¹ Findings from both animal and human studies suggest that biological sex may influence some physiological and neurological responses to cannabinoids.²² The proposed “entourage effect,” whereby THC and other cannabinoids, such as CBD, are held to act together to maximize cannabis’s physiological effects, remains debated in terms of strength and clinical relevance.²³ At the same time, acute or chronic exposure to high doses of THC, or long-term use of THC, may lead to cognitive

Table 1. Short and Long-term Effects of THC Use

Category	Short-Term Effects	Long-Term Effects
Mood & Perception	Euphoria; altered sensory perception (sight, sound, taste)	Possible changes in emotional regulation; reduced neuroplasticity
Memory	Difficulty retaining episodic memory.	Persistent memory deficits affect both short-term and long-term memory
Cognition & Learning	Temporary confusion; reduced concentration; impairs (non)-verbal learning	Learning difficulties; decreased attention span; potential decline in cognitive function
Motor function	Impaired coordination; slower reaction times	Long-term impact less clear, but sustained impairment possible with chronic use
Emotional Effects	Anxiety or paranoia, especially at high doses or in sensitive individuals	Heightened risk of mood disorders or anxiety, especially with early or heavy use
IQ & Brain Development	Not applicable for short-term use	Potential IQ decline if use begins in adolescence, when the brain is still developing
Neuroplasticity	Not significantly affected in the short term	May interfere with the brain's ability to adapt and form new neural connections

impairment and mental health risks, similar to the consequences of recreational THC use.²⁴

Pregnant women are a particularly vulnerable group.²⁵ As a lipophilic compound, THC can easily cross the placenta and may interfere with fetal brain development.²⁶ Prenatal exposure to THC is associated with low birth weight, increased risk of preterm birth, and potential long-term learning and behavioral disorders in children. New evidence suggests that prenatal exposure to THC may also increase the risk of miscarriage and stillbirth.²⁷

What's the difference between THC and other mind-altering substances?

Psychoactive substances are compounds that alter mood, perception, or cognitive abilities by acting on the central nervous system.²⁸ THC, alcohol, caffeine, morphine, and other opioids belong to this category, although their mechanisms of action, uses, and social acceptance vary considerably, as summarized in table 2.²⁹ Because these substances affect the mind in different ways, comparing them helps to clarify the similarities and differences in the effects of THC and other psychoactive substances.

Alcohol and caffeine are common examples to be compared with THC to illustrate the differences between recreational and medical uses, cultural norms, and psychoactive effects. Alcohol functions as a central nervous system depressant, enhancing inhibitory signaling through GABA receptors and producing relaxation, sedation, and anxiolysis.³⁰ In cases of heavy intoxication, it may even provoke hallucinations.³¹ Caffeine is a stimulant

that blocks adenosine receptors in the brain. Adenosine normally promotes sleep and relaxation, so caffeine can increase alertness, wakefulness, and excitement.³² At typical doses, caffeine does not impair judgment, cause intoxication, or reduce self-control.³³

Analgesics such as morphine, other opioids, and acetaminophen differ in both purpose and effect.³⁴ Morphine and related opioids act on opioid receptors in the central nervous system to relieve pain. Although high doses may produce sedation and euphoria, opioids are not primarily hallucinogens. They have substantial risks of dependence and overdose and thus are strictly regulated.³⁵ In contrast, acetaminophen relieves pain and fever by inhibiting the synthesis of prostaglandins in the central nervous system. Its psychoactive effects are minimal and, as it does not alter mood or perception,³⁶ it poses low risks of addiction and overdose.

The distinctive aspect of THC is that it can produce various effects: hallucinogenic and altered perception effects, which distinguish it from substances such as alcohol, whose primary effects involve sedation; stimulants such as caffeine; and analgesics, such as opioids or acetaminophen.³⁷ In particular, THC can alter sensory perception, subjective experience, and consciousness while also producing hallucinogenic effects that partially overlap with these broader perceptual changes. These effects are an inherent component of THC and occur in both its recreational use and its therapeutic applications. As a result, questions surrounding THC use extend beyond concerns about safety and impairment to include broader issues

Table 2. Psychoactive and Analgesic Substances

Substance	Primary Action	Mechanism of Action	Typical Use	Psychoactive Effect Type
THC ³⁸	Hallucinogen	Activates CB1 receptors in the brain, altering neurotransmitter signaling	Recreational (euphoria, altered perception); medical (pain, appetite stimulation, etc.)	Alters perception, mood, and cognition (hallucinogenic properties)
Alcohol ³⁹	Depressant	Enhances GABA receptor activity, increasing inhibitory signaling	Recreational (social, relaxation); limited historical medical use	Sedation, relaxation, anxiolytic effects; rare hallucinations in extreme intoxication or withdrawal
Caffeine ⁴⁰	Stimulant	Blocks adenosine receptors, increasing alertness and arousal	Recreational and functional (alertness, focus)	Increased wakefulness, alertness, no intoxication
Morphine ⁴¹	Opioid analgesic	Binds to mu-opioid receptors in CNS to reduce pain	Medical (severe pain management)	Euphoria at high doses; sedation; risk of dependence; not a hallucinogen
Other opioids ⁴²	Opioid analgesic	Bind to opioid receptors (mu, kappa, delta) in CNS	Medical (pain relief), sometimes misused recreationally	Sedation, euphoria, risk of dependence; typically, no hallucinations
Acetaminophen ⁴³	Analgesic/antipyretic	Inhibits prostaglandin synthesis in CNS	Medical (mild to moderate pain, fever)	Minimal psychoactive effects; does not intoxicate, sedate, or alter cognition

regarding the intentional alteration of consciousness, the pursuit of altered states of experience, and the role such experiences should play in recreation, medicine, and spirituality. Recognizing this distinction highlights the position of THC among psychoactive substances and can further elucidate its broader social and theological implications.

II. Societal Perspective on THC: Public Health, Culture and Regulatory Context

Cannabis is one of the earliest cultivated plants, with a long history of ceremonial, medicinal, industrial and cultural use across Asia, the Middle East, and Africa. Through trade, colonization, and exploration, cannabis eventually spread to Europe and the Americas, where

its role has continued to evolve.⁴⁴ Most notably, with the rise in recreational cannabis use over recent decades, cannabis use has generated public health concerns such as mental health problems, addiction, impaired driving, adolescent exposure, family and social disruption, as well as broader legal and regulatory debates over legislation, commercialization, and public access.⁴⁵ Different societies have responded to these concerns in distinct ways.

Table 3 summarizes current national regulatory approaches. Some countries, such as Portugal and Canada,⁴⁶ adopt public-health-oriented frameworks that emphasize harm reduction, education, and treatment.⁴⁷ Other countries, including Japan and China, tend to adopt harsher punitive measures, focusing on law enforcement and deterrence.⁴⁸ Meanwhile, in parts of India and Africa, cannabis continues to be integrated into cultural and spiritual practices.⁴⁹ Its use in such contexts is not always

Table 3. Global Views and Responses to Cannabis Use

Country / Region	Legal Status of THC	Public Health Orientation	Cultural Attitudes	Primary Societal Concerns Addressed
Canada ⁵⁰	Legal for both medical and recreational use	Harm reduction, mental health, public education	Increasing normalization, especially among youth	Youth protection, impaired driving, substance abuse treatment
United States ⁵¹	Varies by state	Addiction prevention, opioid alternatives, health disparities	Deeply polarized: progressive in some states, conservative in others	Criminal justice reform, racial equity, access regulation
Netherlands ⁵²	Decriminalized for personal use	Controlled access through licensed outlets; preventive education	Tolerant but regulated	Soft vs. hard drug distinction, tourism impact, public nuisance
Portugal ⁵³	Decriminalized all drugs	Strong public health focus: treatment over punishment	Generally non-stigmatizing toward users	Addiction recovery, harm reduction, healthcare access
Japan ⁵⁴	Strictly illegal (zero tolerance)	Abstinence based; legal deterrence	Strong stigma; severe social consequences	Moral discipline, legal enforcement, public shame
China ⁵⁵	Strictly illegal/prohibited	State-led anti-drug campaigns	Culturally and politically stigmatized	Harsh penalties, public security, ideological conformity
Germany ⁵⁶	Legalized for personal adult use (regulated)	Cautious rollout; scientific monitoring of effects	Medical-first perspective; emerging social debate	Public health monitoring, advertising restrictions, youth protection
Thailand ⁵⁷	Legal for medical and industrial use	Framed as economic opportunity and rural health aid	Mixed attitudes; economic optimism	Agricultural development, export potential, medicinal safety
India ⁵⁸	Illegal federally; tolerated in cultural use	Limited modern health messaging; some traditional uses persist	Contextual use in Hindu religious and cultural festivals, culturally distinguished from recreational use	Legal ambiguity, ritual tolerance, emerging addiction awareness
South Africa ⁵⁹	Decriminalized for private use	Developing health and policy frameworks	Gradual acceptance among youth and urban populations	Substance abuse, public safety, legal clarity

understood primarily as a recreational activity but may instead be associated with ceremonial observance, traditional healing practices, or other culturally sanctioned purposes. In the sections that follow, we examine North America, with a focus on the United States and Canada. Canada has legalized recreational cannabis nationwide;⁶⁰ the United States maintains a federal ban while gradually implementing legalization at the state level.⁶¹ These two countries provide important case studies of how law, market, and cultural attitudes shape the social landscape surrounding the use of THC.

Attention gaps with rising THC potency

One of the most significant shifts over the past few decades is the significant increase in the potency of cannabis. Historically, cannabis had a low THC content, typically between 2% and 4%. Today, modern cultivation techniques and consumer demand have driven the development of more potent varieties, often with THC contents exceeding 20% to 30%. For example, the average THC content of dried cannabis has risen from about 3% in the 1980s to about 15% today, with some varieties reaching as high as 30%. Concentrated products such as oils, edibles, vapes, and dabs can contain THC levels as high as 90%.⁶²

Since cannabis legalization in Canada (2018) and in several U.S. states, including Colorado and California, the cannabis industry has rapidly developed into a highly commercialized sector. Similar to alcohol and tobacco, these industries sell products with high THC content to meet consumer demand and compete for profits. Massive marketing campaigns by large corporations, introducing fashion brands, have normalized cannabis use by associating it with lifestyle and culture. Flavored e-cigarettes, gummies, and edible cannabis products are often designed to appeal to young people.

Scientific evidence has not kept pace with these market shifts. Much of what is known about cannabis comes from studies on older, lower-potency products. Therefore, the effects of today's high-potency cannabis are not fully understood, making it difficult for consumers to assess the risks.⁶³ Given that neurodevelopmental research indicates that brain regions responsible for decision-making, memory, and emotion regulation continue to mature until mid-20 years of age, this knowledge gap is particularly alarming for adolescents who consume cannabis.⁶⁴

As THC potency increases, there is a need for research into the health and societal effects of increasingly concentrated cannabis products. At present, public education should focus more specifically on how product high potency increases the risk of poisoning,⁶⁵ and the risk of

the delayed onset of poisoning from consuming edible products;⁶⁶ it also causes impairments in driving and decision-making abilities, particularly among adolescents and other vulnerable populations.⁶⁷

Attention gaps in THC regulation

Despite the legalization of cannabis, the cannabis regulatory frameworks in use in the USA and Canada remain inconsistent and sometimes inadequate. Health Canada has imposed a maximum of 10 mg of THC per serving for edible cannabis products to limit overconsumption and accidental ingestion, particularly among inexperienced users and vulnerable populations such as youth and frequent users, who are more susceptible to harm.⁶⁸ In contrast, the United States has no federal standard. Most states that have legalized its sale restrict edibles to 10 mg per serving and 100 mg per package, but there is no national uniform requirement.⁶⁹ Importantly, neither Canada nor the United States provides a nationally standardized guideline for daily THC consumption.

In Canada, mandatory labeling requirements regulate how cannabis products are formulated, packaged, and sold;⁷⁰ however, they provide limited direction regarding how much THC individuals should consume or what constitutes a safe level of use. These regulation gaps between product-level controls and consumption-level guidance are further complicated by differences in product types, persistence of illicit markets, inconsistent enforcement, and jurisdictional regulations. Therefore, effective product-level regulations may not fully translate into consistent safe or controlled consumption patterns, resulting in varying opportunities for consumers to access and understand cannabis products.

These gaps are especially dangerous for vulnerable groups. For example, national surveys in Canada show that youth aged 20–24 remain the largest group of cannabis users, with nearly half reporting use in the past year.⁷¹ In the United States, about one-third of 12th graders report marijuana use, and approximately 11% report using delta-8-THC, which is a lesser-known but increasingly available variant.⁷² These patterns highlight ongoing concerns regarding youth exposure to increasingly potent and widely available cannabis products.

These regulatory inconsistencies and market dynamics reveal a broader challenge in aligning cannabis policy with public health objectives. While legalization has expanded legal access and economic activity, regulatory safeguards and public education measures have not developed at the same pace. These contradictions reveal a deeper ethical challenge: governments and corporations profit from cannabis sales, yet consumers may lack the

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safeguards and education needed to make informed decisions. The lack of strong, consistent regulatory measures could allow economic interests to take precedence over public health.⁷³ Addressing these concerns will likely require continued refinement of potency labeling standards, restrictions on high-THC products, and policies governing marketing practices and youth access.⁷⁴

Attention difference between medical and recreational THC use

In general, medical THC is viewed as a therapeutic tool to be used under professional supervision, while recreational use is treated as a matter of individual freedom. Cultural and moral narratives divide between recreational and medical THC use and reflect how particular cultures navigate the tension between protecting public health⁷⁵ and upholding individual freedom.⁷⁶ Although concerns over THC users' cognitive decline and potential dependence have been raised for both forms of use, recreational THC use is regulated largely to avoid harm due to users' impaired judgment.

In medical settings, THC is prescribed under the guidance of a healthcare professional: small, carefully controlled dosages of specific formulations are administered using standardized methods to provide relief to patients while minimizing side effects. As recreational cannabis is not subject to medical regulation and its use is usually motivated by the pursuit of pleasure, relaxation, or altered states of consciousness, these cannabis products are often cultivated to maximize THC potency, with little attention paid to dosage control, purity, or long-term safety. Higher THC exposure is often sought or unintentionally escalated in recreational use because stronger doses are more likely to produce the desired subjective effects, particularly in the context of tolerance, delayed onset of poisoning from edibles, and increasingly potent commercial products.

For instance, consider the synthetic cannabinoids nabilone and dronabinol,⁷⁷ which are approved for treating chemotherapy-induced nausea and HIV-related anorexia. Typical adult doses are 1–2 mg of nabilone twice daily, and 2.5–15 mg of dronabinol.⁷⁸ A recent Delphi consensus on medical cannabis for chronic pain, with reference to the modified Delphi process, suggests careful titration of THC up to a maximum of approximately 40 mg per day under clinical supervision.⁷⁹ While most over-the-counter drugs have lower potency than those taken under the care of a physician, non-FDA approved over-the-counter recreational cannabis products, including those sometimes labelled “medical marijuana,” typically have a much higher THC content than legitimate medical cannabis products. For example, a single 30 g package

of dried cannabis labeled “THC 180 mg/g” actually contains 5,400 mg of THC,⁸⁰ which is more than 100 times higher than expert consensus recommendations for medical dosing, far beyond what is safe for a typical user in one sitting.

These differences reveal that while healthcare systems have established mechanisms to attenuate harm, the recreational market prioritizes efficacy and profit maximization at the expense of safety. Nevertheless, cannabis's Schedule I classification by the U.S. FDA,⁸¹ combined with inconsistent state-level regulations, makes coherent national guidelines and standardized dosing difficult.⁸² These barriers raise broader questions about public health, individual autonomy, and responsible cannabis use, providing an important foundation for the theological and ethical discussion that follows.

III. Biblical Perspective on THC: Ethics, Morality, and Spiritual Discernment

In this section, we reflect theologically and ethically on the use of THC. Specifically, we examine THC through the biblical narrative of creation, the fall, and redemption. This framework allows us to distinguish between the beneficial and harmful uses of cannabis. As part of God's creation, cannabis was initially declared “good” (Gen. 1:31). Historically, people cultivated varieties of *Cannabis sativa* for a range of practical uses, such as for building materials, making cloth, paper, and rope, while also being known in some cultures for medicinal, ritual, and psychoactive applications.⁸³ This dual history reflects God's provision of human creativity and management capabilities in the use of natural resources and the long-standing complexity surrounding psychoactive plant use. In this context, like all created things, cannabis can also be abused in a fallen world.

What does the Bible say about mind-altering substances?

The Bible does not explicitly mention THC, so analysis must be conducted by examining the broader principles in the Bible regarding substances that influence the mind and behavior. For example, the Bible directly discusses alcohol: moderate drinking is permissible, and is depicted positively in certain contexts. Psalm 104:14–15 describes wine as a gift that “gladdens the heart”; Jesus's turning water into wine (John 2:1–11) reflects the pleasure of enjoying wine in its proper circumstance. As noted by John Anthony Dunne in *The Mountains Shall Drip Sweet Wine*, the biblical treatment of alcohol is theologically rich and requires careful contextual interpretation.⁸⁴

In certain biblical texts, alcohol is associated with alleviating extreme suffering or distress, including its limited use in contexts of pain and hardship (Prov. 31:6–7). In contemporary medical practice, the use of alcohol for analgesic or anxiolytic purposes is generally disfavored, as safer and non-addictive pharmacological alternatives are widely available.

However, intoxication is forbidden in the Bible (Eph. 5:18; Rom. 13:13; Gal. 5:19–21; 1 Pet. 4:3). The reasons are the effects of drunkenness: impaired judgment, diminished self-control, risk of addiction, and attendant lack of attention to personal responsibilities and impoverishment.⁸⁵ The principle is that the use of a substance that impairs mental clarity and self-control is forbidden except in cases in which the use is medically necessary and responsibly administered for the relief of extreme suffering or to offer palliative care.

This principle can be extended to other psychoactive substances. For example, caffeine can increase alertness without impairing cognitive abilities or moral judgment; therefore, the use of caffeine in general does not violate the biblical norms of sobriety or self-control. In most Christian communities, moderate caffeine intake is widely accepted as compatible with a devout lifestyle. The ethical assessment hinges not merely on whether a substance is psychoactive, but on whether it disrupts responsible stewardship of the mind and body.

Applying these standards to THC suggests that its recreational use is morally problematic. THC is the primary psychoactive component of cannabis and is chiefly responsible for the intoxication, perceptual changes, and cognitive effects discussed in the previous sections. Its recreational use carries the risk of serious and potentially lasting harms while intentionally altering sensory perception, cognition, and executive functioning, thereby impairing judgment and self-control. These effects are of special concern because they can undermine judgment, self-discipline, responsibility toward others, and proper care of the body. Such impairments stand in tension with biblical teachings that emphasize sobriety, wisdom, and stewardship.

What theological considerations distinguish recreational and medical THC use?

There is a wealth of clinical and epidemiological evidence that the recreational use of THC in ways that violate medical norms is associated with significant mental, physical, and social harms. Writing about the dangers of recreational cannabis use and its normalization, physician Timothy P. Millea argues that contemporary

cannabis culture often minimizes these documented risks while increasingly treating intoxication as socially acceptable.⁸⁶ Due to its documented health risks, its effects on vulnerable youth, and capacity to produce impaired judgment, the Christian Medical & Dental Associations (CMDA) in the United States strongly discourages the use of recreational marijuana, including non-FDA approved medical marijuana. Similarly, Catholic medical scholarship, including analyses published in *The Linacre Quarterly*, highlights the societal and health risks associated with recreational cannabis. These organizations have consistently maintained that deliberately altering one's perceptions to seek pleasure or escapism violates Christian ethics.⁸⁷

At the same time, alleviation of human suffering remains a morally serious concern in Christian ethics. Medicine and healthcare may be understood as expressions of common grace, equipping humanity to care responsibly for those who suffer.⁸⁸ Both CMDA USA and CMDA Canada distinguish between recreational misuse and medically supervised use, advocating ethical and responsible medical practice.⁸⁹ Christian ethical reflection suggests that while suffering has spiritual significance, its medical relief is also justifiable when it preserves clarity, enables reflection, and supports a good and dignified life and death.⁹⁰ Therefore, in certain clinical situations, cannabis may have legitimate therapeutic uses, provided its use is strictly regulated, professionally supervised, and guided by spiritual wisdom and moral discernment.

Christian counselor Mike Emlet, in his book *Descriptions and Prescriptions*, similarly emphasizes a balanced view of medical interventions, reminding us that medications can be both a gift of God's grace and a temptation to idolatry.⁹¹ Applied to THC, this means that when used humbly for genuine medical need under appropriate supervision, its use may reflect compassion and responsible care. However, when pursued primarily for escape, pleasure, or emotional avoidance, it risks becoming idolatrous, substituting chemical relief for spiritual dependence on God. Christian scholars urge Christians to think carefully about psychoactive substance use.

Neuroscientist William Struthers highlights concerns about misunderstanding, self-medication, and broader public health consequences.⁹² The lessons of the opioid epidemic underscore the importance of discernment.⁹³ In 2017, the U.S. Department of Health and Human Services declared opioid overdose a national public health emergency.⁹⁴ In many cases, opioids initially prescribed by doctors ended up causing widespread dependence crises and even death. This history demonstrates that medical approval alone does not eliminate ethical risk. Therefore,

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any considerations regarding the use of THC require more-careful theological and medical reflection, as well as a strong sense of social responsibility.

Should THC be considered a spiritual substance?

One question that has been considered in the literature is that of whether mind-altering substances might be used in Christian mysticism. Historically, studies on psychedelics such as lysergic acid diethylamide (LSD) and psilocybin have shown that, under carefully controlled conditions, some participants report experiences they describe as “mystical” or “spiritually significant,” and rank these experiences among the most meaningful of their lives.⁹⁵ Such findings have prompted renewed discussion about whether certain psychoactive substances can occasion states that resemble religious or mystical encounters.⁹⁶

Theologians such as Ronald Cole-Turner have noted that these substances can disrupt entrenched patterns of thought and increase neuroplasticity, thereby creating openness to new perspectives. When carefully interpreted and integrated within a Christian framework, such experiences may contribute to spiritual growth. However, he emphasizes that their spiritual significance depends on intentional integration, guided reflection, and supportive community.⁹⁷ His view highlights that even chemically induced experiences require thoughtful interpretation to be considered spiritually significant.

THC is classified as a hallucinogen, just as are LSD and psilocybin; this fact may lead some to speculate that it may also trigger mystical or spiritual experiences. However, LSD and psilocybin primarily act on serotonin 5-HT_{2A} receptors, a mechanism closely associated with structured mystical-type experiences.⁹⁸ In contrast, THC acts primarily on cannabinoid CB₁ receptors within the endocannabinoid system. While THC can alter perception, mood, and sensory awareness, it does not reliably produce the coherent, unity-oriented experiences characteristic of classical psychedelics,⁹⁹ in either mechanical or phenomenological terms.

Spiritual shaping in the Christian tradition is typically achieved through conscious practices such as prayer, worship, reflection, repentance, obedience, and fellowship. Personal subjective experiences are not the goal. Genuine Christian mysticism is God oriented and involves “the felt sense of the presence and the shared love between the human person and the holy, intimate other.”¹⁰⁰ Christian spiritual experiences can sometimes bring “clarity,” especially when they challenge previously held, but wrong, understandings, but they do not

necessarily bring true mental clarity. Their impacts are assessed by looking for enduring transformation rather than transient altered states. Chemically induced states, particularly if unstructured and operating outside this interpretive grounding, are at best spiritually ambiguous. Therefore, although people may experience heightened sensory perception or generate feelings of relaxation or altered awareness after taking THC, this state should not be automatically equated with genuine communion with God.

IV. Applying Integrated Perspectives to Decisions About THC Use

In closing, we consider questions that can be used to discern the right use of cannabis and THC. As discussed above, the moral legitimacy of THC use depends not merely on symptom relief, but on intention, supervision, proportional benefit, and its alignment with a vision of holistic healing and discipleship that is God oriented and honors both the body and the soul. This underscores the need for Christians to approach THC with discernment, weighing its impact on personal holiness, cognitive clarity, the stewardship of the church, caring for others, and faithful witness.

Does using THC honor the body God gave us?

Scripture teaches that the human body is not our own possession but a temple of the Holy Spirit, entrusted to us by God (1 Cor. 6:19–20). This framing calls Christians to practice stewardship, treating the body with reverence, discipline, and care. The use of substances, therefore, must be weighed against whether they preserve health, maintain clarity of mind, and respect the body as God’s creation.

THC complicates this stewardship. While moderate, supervised medical use may provide relief for suffering, recreational use often poses risks of dependence, cognitive impairment, and long-term harm to mental and physical health. Such risks raise the question of whether THC use reflects gratitude and care for God’s gift, or whether it diminishes the body’s created purpose. By contrast, practices such as nutrition, exercise, and Sabbath rest clearly support human flourishing and align with biblical stewardship.

The question of appropriate body stewardship was highlighted by Ezra Sullivan and Nicanor Austriaco in their evaluation of recreational marijuana use through an Aristotelian/Thomistic virtue ethics framework. In

"A Virtue Ethics and Recreational Marijuana," they similarly warn that such use embodies the vice of intoxication.¹⁰¹ They distinguish between the medical use of marijuana—which is aimed at alleviating illness or injury and restoring health and bodily wholeness—and the recreational use of marijuana, which is oriented toward leisure. Importantly, they note that this does not automatically make recreational marijuana use illicit, in that one Aristotelian virtue, *eutrapelia*, is to "recreate well" for "the overall well-being of the human person, because [recreation] facilitates rest, relaxation, refreshment, and strengthening, with a view to enabling [people] to fulfill the duties of [their] state of life."¹⁰² They note, however, that to recreate well entails avoiding recreation that is immoral, harmful to oneself or others' physical or mental wellbeing, or cannot be done appropriately, as fitting to what persons are and what they are called to do. They conclude that because of the inherent physical and psychological harms occasioned by recreational marijuana and because marijuana use inherently involves seeking intoxication, the recreational use is never licit. Further, they note that this is true even when users are also pursuing something that would be otherwise considered good, such as self-awareness, relaxation, stress-relief, celebration, or being sociable.

Similarly, Tyler VanderWeele, in his book *A Theology of Health*, situates substance use within a broader theology of health: the central concern is whether such practices foster holistic flourishing of body, mind, and spirit, or whether they contribute to fragmentation and alienation.¹⁰³ Using frameworks such as these believers should evaluate their motivations, assess potential harms, and consider whether THC use, whether medicinal or recreational, respects the body as a gift from God. Stewardship requires intentionality, self-discipline, and ongoing reflection to ensure that any engagement with psychoactive substances aligns with spiritual health and holistic flourishing.

Does using THC result in physical, mental, or spiritual harm to others?

Christian ethics values personal freedom but that freedom should not be identified with the notions of personal autonomy prevalent in Western individualism. For the Christian, freedom is entwined with responsibility toward others. "I have the right to do anything," you say, "but not everything is beneficial" (1 Cor. 10:23, NIV). In particular, Scripture calls Christians to pursue holiness in ways that lead to health and wellbeing for others, that strengthen communal trust, and that preserve spiritual attentiveness. Choices regarding psychoactive substances

should therefore uphold clarity of mind, self-control, and faithful witness that contribute to the spiritual flourishing of the church and society.

Recreational use of cannabis, especially high doses of THC, can impair judgment, foster dependence, and diminish spiritual attentiveness, making it harder to engage faithfully in prayer, worship, and community life. When such use becomes visible within Christian communities, it may normalize patterns of intoxication that are inconsistent with spiritual vigilance and unintentionally mislead others, undermine trust within the church, and obscure a faithful testimony, setting an example contrary to Christian values. High-profile recreational use reinforces behaviors that weaken spiritual responsibility and may lead young or vulnerable individuals to stray from careful moral discernment (Rom. 14:13–21).

Even when using medication for medical purposes under professional guidance, believers should be mindful of their words and actions and their impact on others. Responsible medication use should minimize harm, respect the body, and reflect Christian values of mercy and care. Suffering can shape character, cultivate resilience, and deepen dependence on God. Interventions that primarily numb the mind and do not contribute to genuine healing should be carefully considered.

Christian pastor and theologian Todd Miles wrote *Cannabis and the Christian* to help his parishioners and other Christians decide whether and how to use marijuana in the wake of its legalization in several U.S. states. Miles emphasizes asking whether cannabis use glorifies God, edifies others, and allows Christ to be seen in users' lives. Practically, this means that users must consider the following:

1. Take care to be informed of the implications of its use: consider the medical advisability of marijuana use and its potential for harm relative to the condition treated, and the possibility of other medically approved treatments;
2. Take care not to follow the advice of professionals (including medical professionals) who award medical marijuana cards overly easily without carefully determining whether their patients fit the appropriate pain profile;
3. Consider the susceptibility of themselves and others around them to mental illness and addiction;
4. Judge whether they will be able to fulfil reasonable work and other responsibilities such as childcare, while taking marijuana;

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5. Consider that its use might influence how others in their family think about its use and possibly use psychoactive substances themselves; and
6. Be careful to regularly examine their motives and spiritual state before deciding whether they possess the competence to make a mentally and spiritually informed decision.¹⁰⁴

Does using THC help me to fulfil Christians' calling to glorify God?

Christians are not merely to concern themselves with what is legal under the law, accepted in our culture, or done to express one's personal freedom. God calls Christians to be sober and alert to serve, glorify, and enjoy God. As 1 Peter 4:7, NSRV, exhorts, "The end of all things is near; therefore be alert and of sober mind so that you may pray." Being sober-minded means more than avoiding excess; it involves maintaining mental clarity, faithfully following, praying to, and serving God with self-discipline, spiritual clarity, and vigilance, always watching and hoping for the second coming of Christ (Mark 13:32–37). Further, Christians are called to do this, not just individually, but also communally, in part by promoting others' spiritual and communal well-being by being an example of faithful Christian discipleship to their families, churches, and the wider community.

This is the most fundamental context in which Christians are called to weigh THC use. Does a particular use of THC support individual and communal mental and spiritual health and holiness? The issue is not whether Christians may use chemical substances in general, since human life necessarily depends upon material substances such as food, water, oxygen, and medicine. Rather, the ethical question concerns the intentional use of substances that alter cognition, perception, or consciousness in ways that may affect sober-mindedness, spiritual vigilance, and faithful discipleship.

Conclusion

In summary, cannabis is a complex organism that offers potential benefits and risks when used medically, recreationally, and for spiritual purposes. As science continues to uncover its ramifications and society debates its role, Christians must weigh its use with discernment, wisdom, and moral responsibility in awareness of their call to follow God and proclaim the gospel bodily in word and deed with our whole hearts and minds. "So, whether you eat or drink or whatever you do, do everything for the glory of God" (1 Corinthians 10:31, NRSV).

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Author Contributions

Both authors contributed to the collection and analysis of relevant information and participated actively in drafting and revising the manuscript. Yong Fang Zhu wrote the first draft of the manuscript. Both authors approved the final version of the manuscript and are accountable for its content.

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All research design, conceptual development, and substantive arguments were developed by the authors. Then AI tools were used to improve the article's use of language and grammar.

Notes

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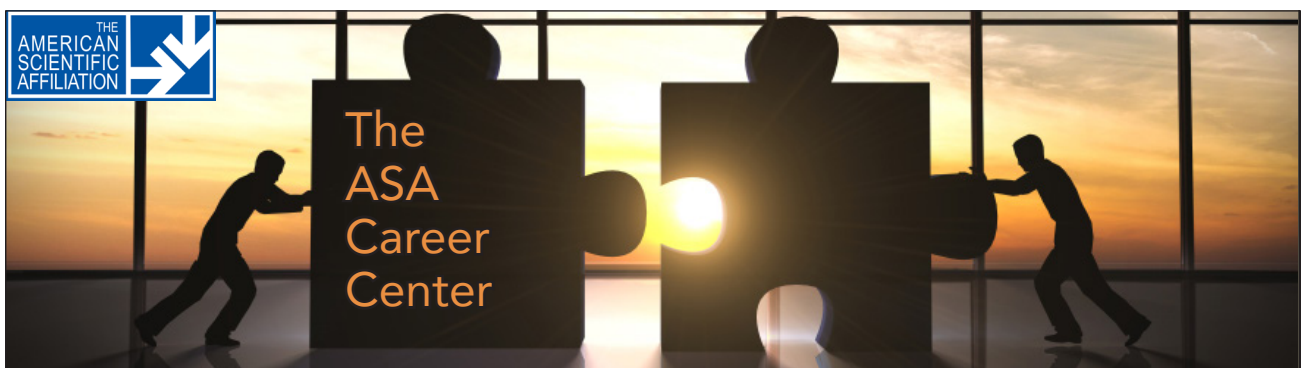
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A graphic featuring a stylized tree with a thick trunk and many green leaves. The words "DIVING DEEPER DISCUSSIONS" are written in a bold, sans-serif font across the middle of the trunk. A large, white, stylized arrow points upwards from the base of the tree, passing through the text. To the right of the tree, the text "THE AMERICAN SCIENTIFIC AFFILIATION" is written in a smaller, blue, sans-serif font.

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A graphic showing two silhouetted figures pushing large puzzle pieces together. The puzzle piece on the left has the text "The ASA Career Center" written on it in a bold, orange, sans-serif font. The background is a warm, orange and yellow sunset or sunrise scene. In the top left corner, there is a small logo for "THE AMERICAN SCIENTIFIC AFFILIATION" with a stylized arrow pointing downwards.

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