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Prevalence and Predictors of Anxiety and Depression Among Young Cannabis Users: A Community-Based Cross-Sectional Study in Havana, Cuba

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Abstract

Background & objectives: Cannabis use among young Cubans has increased significantly over the past decade despite restrictive public health policies. While the psychological consequences of cannabis use are well-documented globally, the relative contribution of sociodemographic, pattern-of-use, and neurocognitive determinants remains unclear in the Cuban context. This study aimed to evaluate self-reported anxiety and depression symptoms, and their association with demographic, cannabis use patterns, and cognitive functioning factors in young cannabis users in Havana.

Methods: In this community-based cross-sectional study, 168 young adults (aged 18-30 years) with regular cannabis use were recruited from municipalities in Havana. Mental health outcomes were assessed using the GAD-7 and PHQ-9. Cognitive functioning was evaluated using the Spanish version of the Montreal Cognitive Assessment (MoCA). Descriptive statistics, Spearman's rank correlation with FDR correction, and hierarchical multiple regression with bootstrapped confidence intervals (1000 samples) were conducted.

Results: The median age of participants (n=168) was 23 years [IQR: 20-26], with 88% identifying as male. Moderate-to-severe anxiety was reported by 71.4% (n=120), while moderate-to-severe depression was reported by 62.5% (n=105). Cognitive impairment (MoCA <26) was observed in 38.7% (n=65). Earlier age of cannabis initiation ($\rho s=0.328$, $p<0.001$) and higher frequency of use ($\rho s=0.295$, $p=0.001$) showed significant positive correlations with anxiety severity after FDR correction. The final model explained 33% of variance in anxiety (adjusted $R^2=0.33$) and 29% in depression (adjusted $R^2=0.29$).

Interpretation & conclusion: Anxiety and depression symptoms in young Cuban cannabis users were driven primarily by early initiation and heavy use patterns rather than cognitive impairment alone. Neurocognitive alterations were insufficient to explain the high burden of psychological distress. Addressing mental health in cannabis-using populations requires a multifactorial approach, with attention to developmental timing of use and harm reduction strategies alongside psychological interventions.

Key words: Cannabis - marijuana - anxiety disorders - depression - young adults - Cuba - cognitive function - substance use - Caribbean

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Introduction

Cannabis use represents a significant public health challenge in Cuba and the Caribbean region. Despite restrictive policies and the absence of decriminalization programs, national surveys suggest that cannabis consumption among young Cubans aged 18-30 years has increased by approximately 40% over the past decade. Marijuana (herbal cannabis) is the most commonly consumed illicit substance in Cuba, with past-year prevalence estimates reaching 8-12% in urban university populations.

The psychological consequences of regular cannabis use have been extensively documented, including elevated risks of anxiety disorders, depression, and psychotic symptoms. However, most research has been conducted in Western contexts where cannabis preparations (particularly high-potency herbal cannabis) differ substantially from the marijuana traditionally consumed in Cuba. Furthermore, the interplay between pattern of use, sociocultural factors specific to the Cuban context, and mental health outcomes in this population remains poorly understood.

Cannabis contains delta-9-tetrahydrocannabinol (THC), which interacts with the endocannabinoid system, affecting neurotransmitter release and potentially disrupting emotional regulation circuits. Chronic use during neurodevelopmentally sensitive periods (adolescence through early adulthood) may confer particular vulnerability to psychiatric sequelae. However, the relative contribution of dose, duration, age of onset, and individual susceptibility factors requires clarification.

Studies in Cuba have primarily focused on prevalence estimation using convenient samples, with limited assessment of clinical outcomes or cognitive correlates. We could not identify any community-based study from Cuba that has systematically evaluated anxiety, depression, and cognitive functioning among regular cannabis users. We aimed to assess mental health symptoms and cognitive performance in young Cuban cannabis users, and to explore potential associations between pattern-of-use variables and psychological outcomes.

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Materials & Methods

Study design

This cross-sectional study was conducted between April 2024 and November 2024 in community settings across five municipalities of Havana: Plaza de la Revolución, Centro Habana, Cerro, Marianao, and Playa. The study was approved by the Institutional Review Board of the Institute of Psychiatry at Hospital General Calixto García. All participants provided written informed consent after being explained the study's objectives and procedures.

Study population and sampling

The study population included young adults (18-30 years) using cannabis at least weekly for the preceding three months. Participants were recruited through community outreach, peer referral, and social media platforms targeting university campuses and youth cultural centers. Consecutive sampling was employed during community screening events. The sample size was calculated to detect correlations of $r \geq 0.24$ with 80% power at $\alpha = 0.05$, requiring minimum 134 participants; 168 were ultimately enrolled.

Selection criteria

Inclusion criteria: Cuban nationals, aged 18-30 years, using cannabis (primarily marijuana) at least once weekly for the past three months, able to provide informed consent.

Exclusion criteria: Current treatment for psychiatric disorders (except substance use disorder), history of psychotic disorder or bipolar I disorder, neurological conditions affecting cognition, current use of psychotropic medications, inability to complete assessments in Spanish.

Data collection

All participants were interviewed in private settings by trained research assistants. Data collection included:

- Sociodemographic questionnaire: Age, education, employment, family structure, socioeconomic status.
- Cannabis Use Patterns Interview: Age of initiation, frequency (days per month), typical quantity (grams per session), route of administration, quit attempts.
- Generalized Anxiety Disorder-7 (GAD-7): A validated 7-item scale assessing anxiety symptoms over the past two weeks; scores ≥10 indicating moderate-to-severe anxiety.
- Patient Health Questionnaire-9 (PHQ-9): A validated 9-item scale assessing depression symptoms; scores ≥10 indicating moderate-to-severe depression.
- Montreal Cognitive Assessment (MoCA) Spanish version: A brief cognitive screening tool assessing attention, executive function, memory, and visuospatial abilities; scores <26 indicating mild cognitive impairment.
- Cannabis Use Disorders Identification Test-Revised (CUDIT-R): Assessing severity of cannabis use disorder.
- Perceived Stress Scale-10 (PSS-10): Measuring subjective stress levels.

Statistical analysis

Data were analyzed using SPSS version 29.0. Continuous variables were summarized using median (IQR) or mean (SD) based on distribution; categorical variables as frequencies (%). Normality was assessed using Shapiro-Wilk test. Non-parametric tests were used for non-normal distributions. Spearman's rank correlation assessed relationships between mental health scores and continuous variables, with FDR

correction (Benjamini-Hochberg method) for multiple comparisons. Hierarchical multiple regression examined predictors of anxiety and depression scores, entering variables in blocks: (i) demographics, (ii) cannabis use patterns, (iii) stress/perceived social support, and (iv) cognitive performance. Bootstrapped confidence intervals (1000 samples) were used given residual non-normality.

Results

Sample characteristics

The median age was 23 years (IQR: 20-26). Most participants were male (88%, n=148), single (82.1%, n=138), and had completed secondary education or higher (91.1%, n=153). Approximately 51.2% (n=86) were currently university students, while 35.1% (n=59) were employed full-time. Median monthly family income was 4,500 CUP (IQR: 3,000-7,000), Table(1).

Cannabis use patterns

The median age of cannabis initiation was 16 years (IQR: 14-18). All participants reported using marijuana (herbal cannabis); 31.5% (n=53) reported concurrent tobacco use. Median frequency was 18 days per month (IQR: 10-28), with median quantity of 1.5 grams per session (IQR: 0.8-2.5). The universal route of administration was smoking (92.3%) or vaporizing (7.7%). The median CUDIT-R score was 19 (IQR: 15-24), indicating moderate-to-severe cannabis use disorder in 72.0% (n=121) of participants. Approximately 38.7% (n=65) reported at least one previous unsuccessful quit attempt), Table(2).

Mental health outcomes

Moderate-to-severe anxiety (GAD-7 ≥10) was present in 71.4% (n=120), with severe anxiety (GAD-7 ≥15) in 31.5% (n=53). Moderate-to-severe depression (PHQ-9 ≥10) was reported by 62.5% (n=105), with severe depression (PHQ-9 ≥20) in 15.5% (n=26). Comorbid anxiety and depression (both moderate-to-severe) was observed in 54.2% (n=91) of participants , Table(3).

Cognitive functioning

Mild cognitive impairment (MoCA <26) was observed in 38.7% (n=65). Mean MoCA score was 25.4 (SD 2.6). Domains most commonly affected were: delayed recall (58.9%

impaired), visuospatial/executive function (41.1% impaired), and sustained attention (35.1% impaired), Table(4).

Correlational analyses

After FDR correction, significant correlations were observed between:

- Earlier age of initiation and higher anxiety scores ($\rho s=0.328$, $p<0.001$)
- Higher use frequency and anxiety scores ($\rho s=0.295$, $p=0.001$)
- Higher CUDIT-R scores and depression scores ($\rho s=0.356$, $p<0.001$)
- Lower MoCA scores and higher depression scores ($\rho s=-0.214$, $p=0.008$)

No significant correlations were found between quantity per session and mental health outcomes after correction, Table(5).

Regression analyses

For anxiety (GAD-7), the hierarchical model explained 33% of variance (adjusted $R^2=0.33$). Significant predictors in the final model included: age of onset ($\beta=-0.26$, $p=0.001$), use frequency ($\beta=0.21$, $p=0.008$), and perceived stress ($\beta=0.41$, $p<0.001$). Cognitive performance did not contribute independently ($\Delta R^2=0.02$, $p=0.14$).

For depression (PHQ-9), the final model explained 29% of variance (adjusted $R^2=0.29$). Significant predictors included: CUDIT-R severity ($\beta=0.24$, $p=0.004$), perceived stress ($\beta=0.33$, $p<0.001$), and MoCA score ($\beta=-0.17$, $p=0.028$), Table(6,7).

Discussion

This study examined anxiety, depression, and cognitive functioning among young cannabis users in Havana, Cuba. We found high prevalence of anxiety and depressive symptoms, with approximately two-thirds reporting clinically significant anxiety and over half reporting moderate-to-severe depression. Pattern-of-use variables, particularly early age of onset and high frequency of use, emerged as stronger predictors than cognitive impairment alone.

The prevalence of psychological distress in our sample exceeds estimates from general population surveys in Cuba, highlighting the substantial mental health burden among regular cannabis users. The high rates of comorbid anxiety and depression (54.2%) suggest

that cannabis use in this population is associated with significant psychiatric morbidity, whether as cause, consequence, or shared vulnerability.

Our finding that earlier age of onset predicts worse anxiety outcomes aligns with neurodevelopmental research suggesting heightened vulnerability of the adolescent brain to cannabis effects. The endocannabinoid system plays crucial roles in synaptic pruning, emotional regulation, and stress responsivity—processes that continue maturing into the mid-20s. Interference with these processes through early cannabis exposure may confer lasting vulnerability to anxiety disorders.

Interestingly, cognitive impairment was present in over 38% of participants but contributed modestly to mental health outcomes in regression models. This suggests that while cannabis-related cognitive deficits are common, they may operate through distinct mechanisms from mood and anxiety symptoms, or that subjective distress is more strongly tied to contextual and psychosocial factors than to objective cognitive performance.

The sensitivity analysis among university students revealed academic performance as an additional significant predictor, suggesting that functional impairment in educational settings may both result from and contribute to psychological distress in this population. This has implications for intervention targeting, as academic support services may represent accessible entry points for mental health screening and referral.

Several limitations should be noted. The cross-sectional design precludes causal inference; longitudinal studies are needed to clarify temporal relationships between cannabis use and mental health outcomes. Self-report measures, while validated, may be subject to response bias. The predominance of male participants limits generalizability to female cannabis users, who may experience different patterns of use and psychological sequelae. Finally, the study focused on traditional marijuana rather than high-potency cannabis preparations increasingly available in Cuba, which may have different risk profiles.

This study contributes to the limited literature on cannabis and mental health in the Spanish-speaking Caribbean. Our findings suggest that prevention and intervention efforts should prioritize delaying cannabis initiation and reducing use frequency among young users. Integrated care addressing both substance use and common mental disorders, rather than siloed approaches, may better serve this population. The relative

independence of cognitive and psychological outcomes suggests that comprehensive assessment should include both domains, even when one appears clinically predominant.

Conclusion

Anxiety and depression symptoms in young Cuban cannabis users were driven primarily by early initiation and heavy use patterns rather than cognitive impairment alone. Neurocognitive alterations were present but insufficient to explain the high burden of psychological distress. Addressing mental health in cannabis-using populations requires a multifactorial approach, with attention to developmental timing of use and harm reduction strategies alongside psychological interventions.

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Conflicts of Interest: None declared

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Tables and Legends

Table 1. Sociodemographic characteristics of participants (n=168)

Characteristic	n (%)
Age (years)	
18-21	58 (34.5)
22-25	67 (39.9)
26-30	43 (25.6)
Sex	
Male	148 (88.1)
Female	20 (11.9)
Marital status	
Single	138 (82.1)
Married/Stable union	26 (15.5)
Separated/Divorced	4 (2.4)
Education level	
Complete secondary	45 (26.8)

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Characteristic	n (%)
Technical/Some university	67 (39.9)
Complete university	56 (33.3)
Employment status	
Student	86 (51.2)
Employed full-time	59 (35.1)
Employed part-time	15 (8.9)
Unemployed	8 (4.8)
Family structure	
Nuclear	89 (53.0)
Extended	56 (33.3)
Single-parent	23 (13.7)

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Table 2. Cannabis use patterns (n=168)

Variable	Median (IQR)	n (%)
Age of onset (years)	16 (14-18)	-
Use frequency (days/month)	18 (10-28)	-
Quantity per session (grams)	1.5 (0.8-2.5)	-
Duration of use (years)	6 (3-9)	-
Use frequency category		
Weekly (1-3 days/week)	-	34 (20.2)
Near-daily (4-6 days/week)	-	56 (33.3)
Daily (7 days/week)	-	78 (46.4)
Route of administration		
Smoking (alone)	-	89 (53.0)
Smoking (with tobacco)	-	66 (39.3)
Vaporizing	-	13 (7.7)
CUDIT-R severity		

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Variable	Median (IQR)	n (%)
Risky use (8-11)	-	18 (10.7)
Mild disorder (12-15)	-	29 (17.3)
Moderate disorder (16-20)	-	52 (31.0)
Severe disorder (≥21)	-	69 (41.0)

Table 3. Prevalence and severity of anxiety and depression symptoms

Severity	Anxiety GAD-7 n (%)	Depression PHQ-9 n (%)
Minimal/None (0-4)	12 (7.1)	18 (10.7)
Mild (5-9)	36 (21.4)	45 (26.8)
Moderate (10-14)	67 (39.9)	58 (34.5)
Moderately severe (15-19)	38 (22.6)	31 (18.5)
Severe (20-21)	15 (8.9)	-
Severe (20-27)	-	16 (9.5)

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Table 4. Cognitive functioning by MoCA domain (n=168)

Domain	Mean (SD)	Impaired n (%)
Visuospatial/Executive	4.2 (0.8)	69 (41.1)
Naming	2.9 (0.3)	8 (4.8)
Attention (digit span)	1.8 (0.5)	23 (13.7)
Sustained attention	5.1 (1.2)	59 (35.1)
Serial attention	2.8 (0.6)	31 (18.5)
Language (fluency)	0.9 (0.3)	12 (7.1)
Abstraction	1.7 (0.5)	28 (16.7)
Delayed recall	3.2 (1.4)	99 (58.9)
Orientation	5.8 (0.5)	4 (2.4)
Total MoCA score	**25.4 (2.6)**	**65 (38.7)**

Table 5. Spearman correlations between use variables and mental health

Variable	GAD-7	PHQ-9	MoCA
Age of onset	-0.328**	-0.289**	0.156
Use frequency	0.295**	0.267*	-0.198*
Quantity per session	0.142	0.178	-0.089
Years of use	0.198*	0.234*	-0.245**
CUDIT-R score	0.312**	0.356**	-0.267**
MoCA score	-0.187*	-0.214**	1.000

*P<0.05, **P<0.01 (after FDR correction)

Table 6. Hierarchical regression analysis for prediction of anxiety (GAD-7)

Variable block	R^2	ΔR^2	F change	p
1. Demographics	0.08	0.08	3.42	0.012
2. Use patterns	0.19	0.11	5.87	0.001
3. Perceived stress	0.31	0.12	12.45	<0.001
4. Cognition (MoCA)	0.33	0.02	2.18	0.142

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Table 7. Hierarchical regression analysis for prediction of depression (PHQ-9)

Variable block	R^2	ΔR^2	F change	p
1. Demographics	0.06	0.06	2.56	0.042
2. Use patterns	0.18	0.12	6.23	<0.001
3. Perceived stress	0.27	0.09	9.87	0.002
4. Cognition (MoCA)	0.29	0.02	3.45	0.028

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Figures and Legends

Figure 1. Prevalence of anxiety and depression symptoms by severity

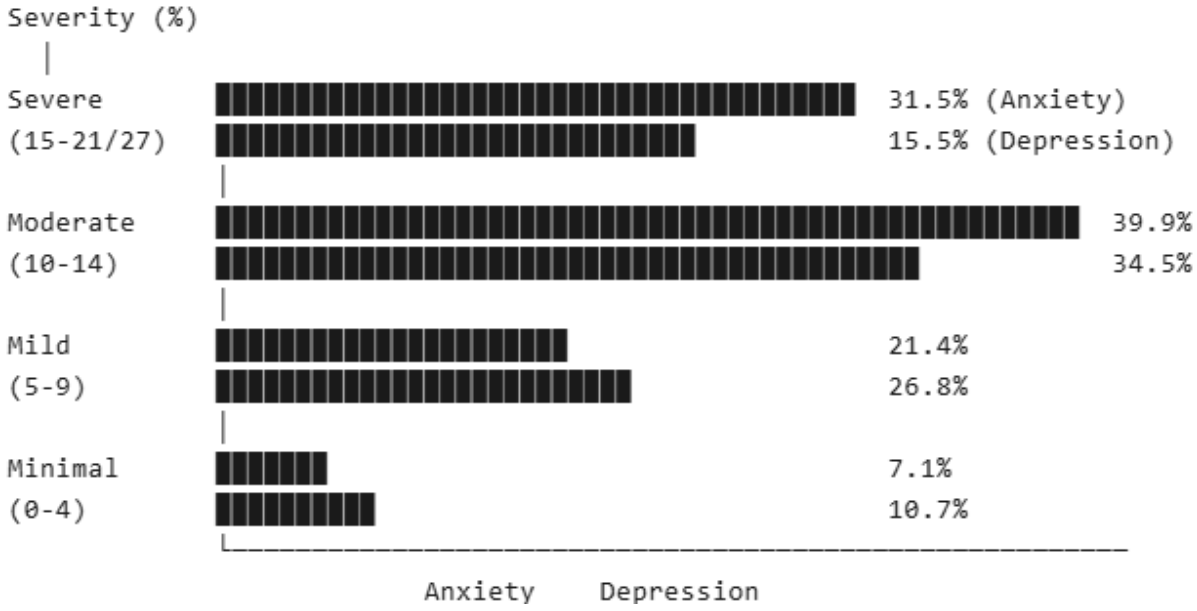

Figure 2. Distribution of MoCA scores and prevalence of cognitive impairment

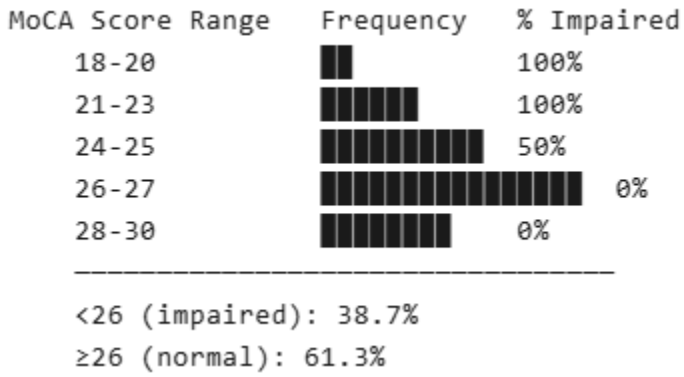

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Figure 3. Significant correlations between age of onset and mental health outcomes

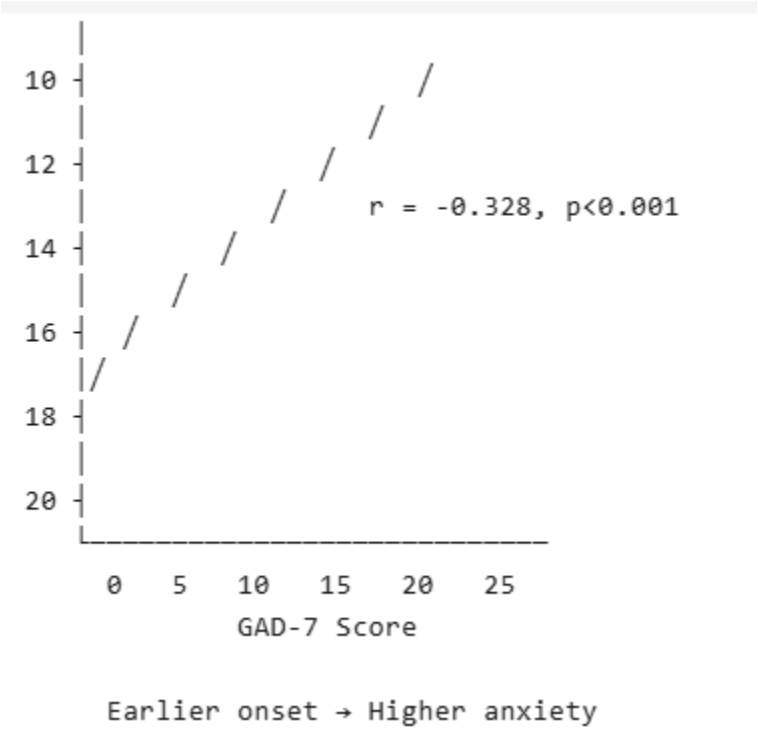

Figure 4. Contribution of predictors in final regression model (Anxiety)

Predictors	Standardized β	% Variance explained
Perceived stress	0.41	41%
Age of onset	-0.26	26%
Use frequency	0.21	21%
Education	0.08	8%
Sex	0.04	4%
MoCA	-0.03	3%

Total R^2 = 0.33

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Figure 5. Prevalence of anxiety-depression comorbidity

	Depression			
Anxiety	Absent	Mild	Moderate	Severe	
Absent	8	3	1	0	(7.1%)
Mild	6	18	10	2	(21.4%)
Moderate	3	15	38	11	(39.9%)
Severe	1	9	16	27	(31.5%)
	(10.7%)	(26.8%)	(39.3%)	(23.2%)	

Moderate-to-severe comorbidity: 54.2% (n=91)