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Bioethical analysis to the therapeutic use of Cannabis: Integrative review

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Abstract

Introduction: Despite being considered as a contravention under some countries' legislation, the therapeutic use of *Cannabis sativa* has been growing in Brazil, due to the promising results observed in many pathologies. Such a scenario has fostered the need to deepen discussions on the subject and possibly revise legislation governing the substance use and access.

Objectives: Identify the types of stigma related to the therapeutic use of *Cannabis* and describe the strategies people use to overcome stigma.

Methods: This integrative review was carried out in the databases PubMed, Scopus, CINAHL, MEDLINE, PsycINFO, Web of Science, and Cochrane Library, with 565 articles being retrieved. Triads' cross-check were done, first maintaining the "cannabis" and "therapeutic use" pair, added by "stigma," "bioethics," "ethics," "social consequences," and "legal consequences." The final selection resulted in six articles.

Ethical Consideration: However, the ethical issues that pervade and regulate decisions on this subject must be considered.

Results: Different dimensions and types of stigma related to the therapeutic use of *Cannabis* have been identified. The bioethical principle of autonomy was an expression of citizenship and human rights, mitigating internal conflicts related to self-stigma and the effects of external stigma on the person's life.

Conclusion: It was possible to identify the types of stigma related to the therapeutic use of *Cannabis* is an internal dimension represented (self-stigma) and an external dimension, represented (social and structural stigmas) and to identify strategies adopted to face this stigma: skills training group for users, elaboration of laws and specific programs to clarify the therapeutic use of *Cannabis* with a greater social scope, and support for family members. Thus, contributing to the building of people's autonomy in a broader context of decision-making autonomy and executive autonomy will provide the development of people's capacity to perform complex tasks of self-management and, consequently, to continue promoting and preserving their decision-making process and their capacity to plan and perform tasks associated with managing their lives and their treatments.

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Introduction

Conflicts between prohibitive legislation and the indication of the therapeutic use of *Cannabis*, popularly known as marijuana, have worried professionals in comprehensive healthcare. Considered the most used recreational drug worldwide and associated, in some cases, with the onset of intense drug use,[1,2] it was consumed by ancient people from different cultures and for various purposes (religious, medical, recreational, among others).[3]

The inclusion of *Cannabis* in therapeutic prescription has broadened debates in several sectors of society. Its use can benefit the population by alleviating symptoms such as neuropathic pain, muscle spasticity, anorexia, nausea, and sleep disorders.[4,5] Dependent on other psychoactive substances has also used *Cannabis* as a harm reduction strategy to relieve the craving by a heavy drug,[6,7] besides patients in palliative care in order to improve their general condition and quality of life.[8] However, its indication relates to the failure of more conventional therapies and to the search for quality of life.[6,9]

One justification for the therapeutic use of *Cannabis* is the existence of a human endocannabinoid system that has endogenous receptors and ligands responsible for regulating various organic functions and that have been related to the efficacy of the mechanism of action of synthetic cannabinoids in the organism, as well as the occurrence of side effects to an acceptable level.[10] Nevertheless, their use may cause tolerance and dependence.[11] Moreover, there is no complete understanding of pharmacokinetics and pharmacodynamics, which lack specific data on correct dosage, safety, and efficacy with long-term use.[12]

The therapeutic use of *Cannabis* also associates with socio-cultural stigma, which consists of the process of rejection and exclusion based on a person's health condition, social status, or pattern of behavior. For Goffman,[13] stigmas are identities impaired by social action, which represent an evil within society and should be avoided. Furthermore, stigmas arise from a physical coexistence among different individuals, the normal and the stigmatized, emphasizing that the social annuls the individuality and determines the model to maintain the power standard.[13] Therefore, it is important to bring bioethics to instigate discussions and reflections on the stigma related to the therapeutic use of *Cannabis*, to contribute to solve the conflicts of social and clinical practices, as well as to strengthen the patient to participate in the caring process more securely and autonomously.

One believes that the contribution of this research relates to the hypothesis that studying the types of stigma experienced by people in the therapeutic use of *Cannabis* will allow subsidizing the use of bioethics in this aspect, solve conflicts in clinical practice, and strengthen the patient to participate in the process of caring more safely and autonomously.

One opted for a review of previous studies to provide scientific evidence to answer the following question: what are the types of stigma related to the therapeutic use of *Cannabis*? The objectives of the study were to identify the types of stigma related to the therapeutic use of *Cannabis* and to describe the strategies that people use to overcome them.

Method

This is an integrative review of scientific production.[14] The search for articles was carried in the following databases: Scopus, MEDLINE (Medical Literature Analysis and Retrieval System Online), CINAHL, PubMed (U.S. National Library of Medicine National Institute of Health), Cochrane Library, PsycINFO and Web of Science.

Triads' cross-check were done, with the descriptors controlled and indexed in the MeSH terms, keeping first the pair "*cannabis*" and "therapeutic use," added by "stigma," "bioethics," "ethics," "social consequences," and "legal consequences" in every search, all using the Boolean operator "AND." The keywords "personal autonomy" and "*cannabis*" were crossed; the articles from this cross were not included in the sample because they did not approach the type of stigma related to the therapeutic use of *Cannabis*, the central focus of this research.

Two researchers performed the crossings of the descriptors explained in the article at the same time, but double blind. The search results were calibrated between them with 100% accuracy. The same procedure was performed during the pre-selection phases of the articles until the selection of the final sample.

For the selection of articles, the titles and abstracts were initially read, observing the inclusion criteria: approach to stigma related to the therapeutic use of *Cannabis*; published in languages Portuguese, English, or Spanish; and indexed in the selected databases. The population of the research will be people in therapeutic use of *Cannabis*, regardless of the pathology, age, sex, route of administration, or time of treatment. The studies in which the population surveyed were people using *Cannabis* as a recreational or harm reduction for dependence on other drugs were excluded. The flowchart of this methodological step is described in Figure 1.

The data of the articles were extracted following a validated instrument.[15] It was also decided to organize the results in tables and texts to facilitate the analysis and construction of the summarization of the scientific evidence, responding to the objectives of this review.

All methodological procedures of search, selection, and analysis of the articles were carried out by two independent researchers, who compared their selections, and in the face of disagreements, a third researcher was consulted.

All articles from the final sample of this integrative review article were descriptive, exploratory, cross-sectional, and with qualitative approach, presented level of evidence IV, according to Stillwell et al.,[16] being the recommendations of Loney et al.[17] indicated to evaluate the quality of the studies and for the bias risk.

The conceptions related to the principle of autonomy and the stigma experienced by people in therapeutic use of *Cannabis* guided the analysis of the selected studies.

Results

PsycINFO and Cochrane Library databases have not retrieved any articles. The final sample of this review consisted of six articles, described in Table 1. All articles were published in international journals, being four in *Harm Reduction Journal*, one in *Criminology and Criminal Justice*, and one in *International Journal of Drug Policy*. Four articles were developed in Canada, one in Australia, and one in the United States. These countries have official *Cannabis* dispensaries and federal laws regulating their medicinal use of *Cannabis*. It is highlighted that the existence of clear and specific laws was pointed out by the participants of the articles of this review as an important strategy to reduce the stigma related to the therapeutic use of *Cannabis*.

Among the therapeutic indications of *Cannabis* stands out the search for the relief of symptoms related to chronic diseases, such as HIV/AIDS, cancer, neurological diseases, mood disorders, and arthritis. In addition, *Cannabis* has been used as a strategy of harm reduction and consumption decrease in other psychoactive substances.

All articles addressed "social stigma" as being generated by family, friends, and professionals or by the police. Besides, it was considered as a barrier to healthcare search. Users reported fearing such social stigma for criminal sanctions, loss of social, and professional status, being recognized as dependent and incapable and also perceiving the questioning of their intellectual and moral capacity at every moment.

Only one article uses the term "inner stigma" to report the negative perceptions one feels for oneself, highlighting feelings of guilt and error about using an illegal substance. This same article uses the term

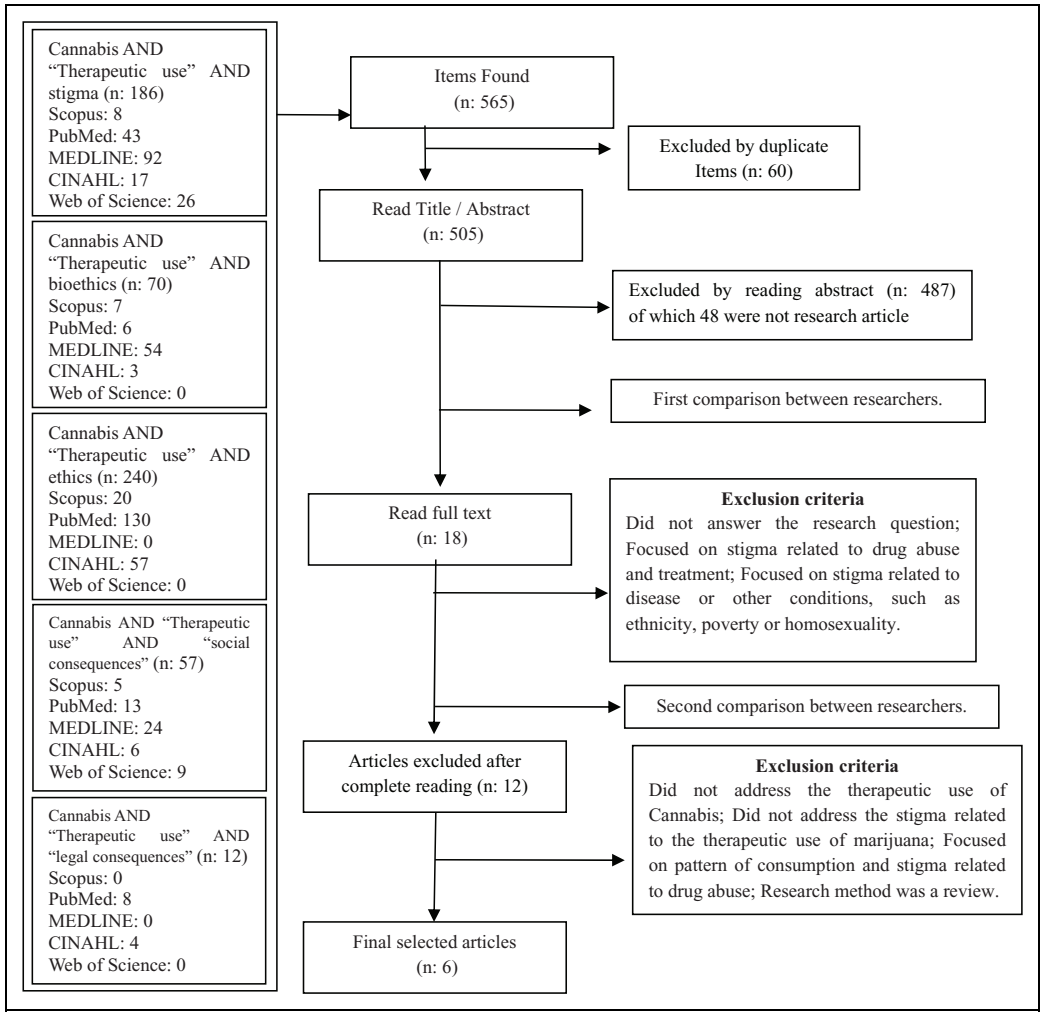

Figure 1. Results of the search in database, selection of articles by independent researchers, and comparison of the selections for construction of the final sample.

"external stigma" as synonymous with "social stigma." The other articles mention only how people in therapeutic use of *Cannabis* react to the stigma suffered.

One article addresses "gender stigma" to explain that women suffer more stigma than men. Another article states that the stigma related to the therapeutic use of *Cannabis* comes from stigma to drug users in general, who are often marginalized and socially excluded.

The results also pointed out that the strategies used by people to overcome this stigma have focused both on "external stigma" (relative to the users' community, institutions, professionals, and police) and "internal stigma" (relative to own user).

Thus, it was observed that the themes related to "external stigma" focused on clarifying the therapeutic use of *Cannabis* and its legalization, as part of a public healthcare policy for this population, to provide a way of education of society and institutions on this therapeutic resource.

Table 1. Characterization of the articles.

Author	Study design	Sample (♀/♂)	Indication of the therapeutic use of *Cannabis*	Type of stigma	Main resultsStrategies used to deal with stigma
Bottorff et al. (2013)[18]	Descriptive, exploratory, qualitative study	23 (13/10)	HIV/AIDS, fibromyalgia, mood and anxiety disorders, cancer, neurological disease, others	Internal stigma (self-stigma), external stigma (social, family, friends and health professionals)	To use *Cannabis* secretly To use *Cannabis* responsibly To legalize *Cannabis* use and cultivation To convince others about the benefits of *Cannabis* To defend the right to choose your medicine
Janiche and Reiman (2012)[19]	Descriptive, exploratory, quantitative study	303 (91/212)	Relief of symptoms, harm reduction, consumption reduction in other psychoactive substances	Social stigma	To gather more information about psychoactive substances To learn about harm reduction To participate in groups for life skills training (decision-making, anger management, stress management, coping and relational skills) Thus, they will have the autonomy to decide on their treatment and face the stigma.
Hathaway et al. (2011)[20]	Descriptive, exploratory, qualitative study	92 (36/56)	Relief of symptoms, search for well-being, nausea	Social stigma (family and work partners), stigma by police officers, self-stigma (blame for using illegal substance and being a socially disapproved attitude)	More specific laws and programs on legalizing the therapeutic use of *Cannabis* To explain the benefits of medical *Cannabis* To discuss the therapeutic use of *Cannabis* To legitimize the therapeutic use of *Cannabis* Responsible use (do not use at work or with coworkers, nor close to children and children)
Walsh et al. (2013)[21]	Cross-sectional, quantitative study	628 (185/443)	Treatment of multiple symptoms (nausea, anorexia, anxiety, pain, sleep disorders), arthritis, cancer, HIV/AIDS	Social stigma (stigma associated with recreational use and mental illness)	To clarify about the therapeutic use of *Cannabis* as a legal practice To report the benefits of this therapy
Swift et al. (2005)[22]	Descriptive, exploratory, quantitative study	128 (48/80)	Chronic pain, depression, arthritis, nausea, weight loss	Social stigma	To support families and people in therapeutic use of *Cannabis* To provide legal access to medical *Cannabis* To explain to the user about *Cannabis* treatment, so he/she can choose
Lucas (2012)[23]	Cross-sectional, qualitative study	100 (20/80)	Relief of symptoms, chronic pain, anorexia, anxiety, depression, nausea, mood disorder, others	Social stigma, stigma by health professionals, gender-related stigma	To facilitate legal access to the therapeutic use of *Cannabis* (reduce bureaucracies) To discuss with professionals about the therapeutic use of *Cannabis* To guide people on the therapeutic use of *Cannabis*

Source: research data.

About the "inner stigma," they focused on skills training techniques, individual and group consultations, legalization of consumption, and self-cultivation. It was noticed that these strategies aimed at helping people in therapeutic use of *Cannabis* in their process of caring, regarding the clarification of the mechanisms of action of *Cannabis*, the risks and benefits of *Cannabis*, and, thus, to contribute to the awareness and the ability of choice about their treatment.

Another aspect identified in the results was the issue of the autonomy of the person in therapeutic use of *Cannabis* that was pointed out by all the articles of this review as being the most important aspect to be approached to reduce the stigma suffered by someone, because the autonomy is related to the person's ability to choose about their life and treatment. They also considered that access to information on *Cannabis* provides the building of a responsible choice based on what the person understands to be the best for his life while preserving his dignity and human rights.

Discussion

The results showed that there are two dimensions of the stigma, the internal (self-stigma) and the external, which, in turn, are divided into social, structural, and gender-related. Self-stigma refers to negative conceptions about one's own behavior, in which feelings of guilt and error stand out.[24–26]

Social stigma describes the phenomenon of large social groups that endorse stereotypes about how to act with a stigmatized group.[27] Structural stigma refers to the rules, policies, and procedures of institutions and their representatives that restrict rights and opportunities for stigmatized groups.[28]

In gender-related stigma, there is more prejudice to women for using an illicit drug and for violating specific gender norms due to illegal behavior.[29] Therefore, her gender characteristics related to the protective figure, family caregiver, and social order as well as her socially expected behaviors are confronted when she decides to consume a psychoactive substance whether for therapeutic or recreational reasons.

Thus, the social role of women relates to social and behavioral factors, being identified as a gender variable.[30]

Thus, gender stigma tends to be related to behavioral and social aspects attributed to men, women, and consumption of *Cannabis*, which portrays this use by women as a socially unexpected attitude, whether for therapeutic, recreational, or drug trafficking.[31] In view of the above, the use of *Cannabis* by women was comparatively more stigmatized than men, regardless of the purpose of its use.

This reality may appear as a barrier for women to seek the therapeutic use of *Cannabis* legally, and women are encouraged to use it secretly, exposing themselves to the risk of access to the substance through the black market.[32] In addition, the phenomenon of gender stigma may explain the underreporting by legal institutions of women in therapeutic use of *Cannabis*, represented by the predominance of men in treatment identified among participants in the sample of articles selected in this review.

Thus, contributing to the construction of people's autonomy in a broader context of decision and executive autonomy, it will provide the development of people's capacity to perform complex tasks of self-management and, thereby, continue with their decision-making intact, preserving their ability to plan and perform tasks associated with managing their life and treatment.[33]

In this context, relating the principle of autonomy as an aspect of bioethics to solve conflicts arising from the stigma related to the therapeutic use of *Cannabis* is to believe that strengthening people in their conceptions, their rights, and their well-being is a viable path for the exercise of their autonomy and citizenship, softening the guilt internalized by these conflicts stemming from the stigmas related to the chosen treatment.

Moreover, there are scientific evidence that demonstrates the importance of the person's decision regarding the treatment and the execution of their healthcare. When considering the diverse multicultural conceptions of a person's personality and autonomy, including it more fully in his or her care process,

within the context of his or her own culture, stimulating his or her executive potential, and the role of his or her family and community.[33–35]

These same authors pursue the discussion on autonomy as the ability to define life plans as well as the ability to adapt to new circumstances. Thus, they emphasize three dimensions of autonomy: autonomy of thought, autonomy of the will, and autonomy of action. They corroborate, therefore, the discussion of this present revision by bringing to light the bioethical reflections under the prism of autonomy and contributing to guide the resolution of the conflicts arising from the stigma related to the therapeutic use of *Cannabis* helping the person in his or her decisions.

Although the discussion focuses on the principle of autonomy, it is worth mentioning that another principle becomes a product of the action of granting autonomy to the individual, which is beneficence, defined as the principle that all medical action should promote the good and the participation of the other, necessitating a balance between losses and benefits of certain actions. In this sense, when a professional promotes relief of suffering of any nature to the patient, beneficence is fulfilled, emphasizing that it is only truly practiced when in conjunction with autonomy, since the participation of the individual in the choice of he or she considers best for his or her treatment becomes necessary.[36]

The principle of autonomy, as well as stigma, involves a question often neglected and, in the articles resulting from the present search, the same was evident. Access to information is a determining factor in the exercise of autonomy, and its lack contributes to the construction of a stigma. People cannot exercise autonomy if deprived from the necessary information, since the lack of information interferes in the freedom of decision.

Several articles mentioned the need for education of users, women and professionals, as a basic need to combat stigma. In many cases, lack of knowledge causes scientific knowledge to be replaced by beliefs and myths that can generate prejudice. On the other hand, in the presence of stigma, it is common to assume behaviors considered deviant under covert conditions, often involving risks, either by the consumption of a product of doubtful quality or by the risks arising from exposure to illegal activities in the search for the substance.

In this way, people in therapeutic use of *Cannabis* have used strategies to overcome stigma, such as empowerment through their treatment group, family conversations, avoiding situations of exposure to consumption, and participation of community groups to clarify their treatment.[37]

Access to information is still imperative for managers, politicians, and legislators, as they create the conditions for regulation and are responsible for keeping the state structure in place. Therefore, these discussions must permeate the spheres of the three powers to favor a change in the current scenario.

Thus, planning strategies that consider the multi-causality of the phenomenon of stigma related to *Cannabis* use prove to be more effective than those that only address the consumption of the substance in a punctual and isolated way as part of an individual behavior.[38]

Conclusion

This review allowed the identification of dimensions and types of stigma related to the therapeutic use of *Cannabis*, which are internal dimension, represented by self-stigma, and external dimension, represented by social and structural stigmas. Understanding these aspects related to the phenomenon of stigma is an important subsidy for the planning of interventions aimed at reducing it.

Besides, it has made it possible to describe the strategies used by people in therapeutic use of *Cannabis* to overcome stigma as an important aspect of the process of caring for these people. Among the strategies used are skills training group for users, elaboration of laws and specific programs to clarify the therapeutic use of *Cannabis* with a greater social scope, and support from family members.

It also allowed the identification of the scarcity of studies that discuss bioethical aspects related to stigma due to the therapeutic use of *Cannabis*, justifying the construction of this review, which in addition to describing the types of stigma related them to the bioethical principle of autonomy. Such principle that figured as an expression of citizenship and human rights mainly softened the internal conflicts related to self-stigma and consequently the effects of external stigma on the person's life and his behaviors.

It is expected that this review will contribute to insert bioethical reflections in the resolution of conflicts due to the therapeutic use of *Cannabis* and thus to subsidize the reduction in the stigma suffered by these users, as well as to instrumentalize them for the defense of their rights and autonomy.

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References

1. Kolliakou A, Fusar-Poli P and Atakan Z. Cannabis abuse and vulnerability to psychosis: targeting preventive services. *Curr Pharm Des* 2012; 18(4): 542–549.
2. Howden ML and Naughton MT. Pulmonary effects of marijuana inhalation (Review). *Expert Rev Respir Med* 2011; 5(1): 87–92.
3. Green AJ and De-Vries K. Cannabis use in palliative care—an examination of the evidence and the implications for nurses. *J Clin Nurs* 2010; 19(17–18): 2454–2462.
4. Crippa JAS, Zuardi AW and Hallak JEC. Therapeutical use of the cannabinoids in psychiatry. *Rev Bras Psiquiat* 2010; 32: S56–S65.
5. Duarte C. Potencial analgésico dos canabinóides (Analgesic potential of cannabinoids). *Rev Soc Portugue Anestesiol* 2012; 21(3): 13–18.
6. Collen M. Prescribing cannabis for harm reduction. *Harm Reduct J* 2012; 9(1): 1.
7. Carter GT, Flanagan AM, Earleywine M, et al. Cannabis in palliative medicine: improving care and reducing opioid-related morbidity. *Am J Hosp Palliat Care* 2011; 28(5): 297–303.
8. Van den Elsen GA, Ahmed AI, Lammers M, et al. Efficacy and safety of medical cannabinoids in older subjects: a systematic review. *Ageing Res Rev* 2014; 14: 56–64.
9. Mather LE, Rauwendaal ER, Moxham-Hall VL, et al. (Re)introducing medicinal cannabis. *Med J Aust* 2013; 199(11): 759–761.
10. Robson PJ. Therapeutic potential of cannabinoid medicines. *Drug Test Anal* 2014; 6(1–2): 24–30.
11. Laranjeira R, Bordin S and Figlie NB. *Aconselhamento em dependência química* (Counseling in chemical dependency). São Paulo: Roca, 2010.
12. Porsche DJ. Legalization of medical marijuana (*Cannabis*). *Am J Mens Health* 2013; 7(6): 449.
13. Goffman E. *Estigma: notas sobre a manipulação da identidade deteriorada* (Stigma: notes on the manipulation of impaired identity) (ed J Zahar). Rio de Janeiro: Márcia Bandeira de Mello Leite Nunes (Trad.), 1975.
14. Souza MT, Silva MD and Carvalho R. Integrative review: what is it? How to do it? *einstein* 2010; 8(1 Pt 1): 102–106.
15. Ursi ES. *Prevenção de lesões de pele no perioperatório: revisão integrativa da literatura* (Prevention of perioperative skin lesions: an integrative review of the literature). Master Thesis, University of São Paulo, São Paulo, 2005.
16. Stillwell SB, Fineout-Overholt E, Melnyk BM, et al. Evidence-based practice step by step. Searching for the evidence strategies to help you conduct a successful search. *Am J Nurs* 2010; 110(5): 41–47.

17. Loney PL, Chambers LW, Bennett KJ, et al. Critical appraisal of the health research literature: prevalence or incidence of a health problem. *Chronic Dis Can* 1998; 19(4): 170–176.
18. Bottorff JL, Bissell LJL, Balneavs LG, et al. Perceptions of cannabis as a stigmatized medicine: a qualitative descriptive study. *Harm Reduct J* 2013; 10(2): 1–10
19. Janichek JL and Reiman A. Clinical service desires of medical cannabis patients. *Harm Reduct J* 2012; 9(12): 1–6.
20. Hathaway AD, Comeau NC and Erickson PG. *Criminology & Criminal Justice* 2011; 11(5): 451–469.
21. Walsh Z, Callaway R, Belle-Isle L, et al. Cannabis for therapeutic purposes: patient characteristics, acess, and reasons for use. *Int J of Drug Policy* 2013; 24: 511–516.
22. Swift W, Gattes P and Dillon P. Survey of Australians using cannabis for medical purposes. *Harm Reduc J* 2005; 2(18): 1–10.
23. Lucas P. It can't hurt to ask; a patient-centered quality of service assessment of health canada's medical policy and program. *Harm Reduc J* 2012; 9(2): 1–11.
24. Livingston JD and Boyd JE. Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Soc Sci Med* 2010; 714(12): 2150–2161.
25. Lucas P. Moral regulation and the presumption of guilt in Health Canada's medical cannabis policy and practice. *Int J Drug Policy* 2009; 20(4): 296–303.
26. Gordon AJ, Conley JW and Gordon JM. Medical consequences of marijuana use: a review of current literature. *Curr Psychiatry Rep* 2013; 15(12): 419.
27. Corrigan P, Kerr A and Knudsen L. The stigma of mental illness: explanatory models and methods for change. *Appl Prev Psychol* 2005; 11(3): 179–190.
28. Levav I, Corrigan PW, Roe D, et al. Challenging the stigma of mental illness: lessons for therapists and advocates. *Stigma Res Action* 2011; 2(1): 46–47.
29. Reinarman C, Nunberg H and Lanthier F. Who are medical marijuana patients? Population characteristics from nine California assessment clinics. *J Psychoactive Drugs* 2011; 43(2): 128–135.
30. Lima EH. Gender, masculinities, youth and drug use: theoretical contributions to the development of strategies in health education. *Pesquisas Práticas Psicossociais* 2012; 7(2): 279–289.
31. Haines-Saaha RJ, Johnsona JL, Reptaa R, et al. The privileged normalization of marijuana use—an analysis of Canadian newspaper reporting, 1997–2007. *Crit Public Health* 2014; 24(1): 47–61.
32. Hathaway AD. Cannabis users' informal rules for managing stigma and risk. *Deviant Behav* 2004; 25(6): 559–577.
33. Naik AD, Dyer CB, Kunik ME, et al. Patient autonomy for the management of chronic conditions: a two-component re-conceptualization. *Am J Bioeth* 2009; 9(2): 23–30.
34. Beauchamp TL and Childress JF. *Principles of biomedical ethics*. Oxford: Oxford University Press, 2001.
35. Bergsma J and Thomasma DC. *Autonomy and clinical: medicine*. Dordrecht: Kluwer Academic, 2000.
36. Souza LAF, Pessoa APC, Barbosa MA, et al. The bioethical principlism model applied in pain management. *Rev Gaúcha Enferm* 2013; 34(1): 187–195.
37. Motta MA. *Estigma no CAPSad III: prevenção de marcas indeléveis* (Stigma in CAPSad III: prevention of indelible marks). *Monografia de Especialização em Atenção Psicossocial*. Florianópolis: Orientadora, Priscila Orlandi Barth, 2014.
38. Livingston JD, Milne T, Fang ML, et al. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction* 2011; 107(1): 39–50.