I am an unapologetic drug user. I take drugs as part of my pursuit of happiness, and they work. I am a happier and better person because of them. I am also a scientist and a professor of psychology specializing in neuroscience at Columbia University, known for my work on drug abuse and addiction. It has taken me more than two decades to come out of the closet about my personal drug use. Simply put, I have been a coward.

The philosopher John Locke once noted that pursuing happiness is “the foundation of liberty.”. This idea is at the core of the Declaration of Independence, the document that gave birth to our nation. The Declaration asserts that each of us is endowed with certain “unalienable Rights,” including “Life, Liberty and the pursuit of Happiness,” and that governments are created for the purpose of protecting these rights. The use of drugs in the pursuit of happiness, in my view, is arguably an act that the government is obliged to safeguard.

Why is our government arresting hundreds of thousands of Americans each year for using drugs, for pursuing pleasure, for seeking happiness? The short answer is that it’s a very long story. The long answer is the book you are reading. America’s drug regime is a monstrous, incoherent mess.
TO GRASP HOW we got here and what we can do about it, I’d like to start by telling you something about my life and work as a “drug abuse” scientist. In the fall of 1999, I landed my dream job, as an assistant professor and researcher at Columbia University’s College of Physicians and Surgeons. My research involved giving thousands of doses of drugs, including crack cocaine, marijuana, and methamphetamine, to a range of people in order to study the effects. I believed my work contributed to our understanding of drug addiction. I would be awarded multimillion-dollar grants from the National Institute on Drug Abuse (NIDA) to conduct this research, and I would be invited to serve on some of the most prestigious committees in the area of neuropsychopharmacology. It was a thrilling time.

Twenty years later—twenty years I’ve spent studying the interactions among the brain, drugs, and behavior and observing how moralizing about drug use is expressed in social policy—my initial excitement has given way to skepticism, cynicism, and disillusionment. When I was a naive graduate student, I believed that I was doing God’s work by telling people to stay away from drugs. I believed that the poverty and crime that plagued my childhood community were a direct result of drug use and addiction. I now know that telling people to avoid drugs is no more godly than the Church prohibiting my Catholic wife from using birth control, but it is just as paternalistic, a way of restricting one’s freedom and autonomy.

What about the notion that drugs led to poverty and crime in my neighborhood? Well, that is simply an ugly fantasy, an incredibly effective one to be sure. It’s effective not only because it is still believed by large segments of the American public but also because it seemingly provides a simple solution to complicated problems faced by poor and desperate people. Many other complex factors are responsible for the turmoil seen in the places of my youth and other communities. But it took me a long time to see that clearly myself. I was too busy for too long being a soldier in the regime, caught up in the cause of “proving” how dangerous drug use is.
I HAD THE COOLEST job in the world. I got people high on a daily basis. I instructed the twenty-five-year-old white man to light the marijuana cigarette, which was to be smoked through a hollow plastic cigarette holder so that the contents were not visible. He inhaled for five seconds, then held the smoke in his lungs for another ten seconds before exhaling. He repeated this two more times, with a forty-second interval between each puff. We called this our paced-puffing procedure. We used it to standardize, to the best of our ability, the amount of drug inhaled.

Although I couldn’t know for sure whether he was getting placebo or active THC, the major psychoactive ingredient in marijuana, I could tell from his glassy red eyes and the serene smile on his boyish flushed face that he really enjoyed what he had gotten. Nodding slowly and with more bass in his voice than usual, he said, “Yeah, that’s it.” I could also tell that he was an experienced smoker; it took him only three puffs to suck down nearly three-fourths of the 1 g cigarette. Marijuana smoke now filled the small sterile room.

The smoker, whom I’ll call John, was a research participant in one of my studies. And there I was, a young black dreadlocked scientist, trying to conceal the perpetual anxiety I felt about having the strong, distinct smell of marijuana in my hair for another entire workday. I was concerned that as I traveled, on the elevator, from floor to floor or sat in on a lecture or meeting, some judgmental person might think disparagingly, “Typical, dreadlock smoking while at work.” Never mind that marijuana has never been my primary drug of choice. Never mind that I had a personal rule, for fear of biasing my results, against using the drug I was currently studying. The year was 2000.

In this particular experiment, I was trying to understand how cannabis affected regular users’ brain functioning and behavior. I had received a grant from NIDA to conduct the study. My hard work and commitment were finally paying off. When I started the study, I believed, as did most people, that pot temporarily impairs mental processes such that smokers exhibit memory problems and other cognitive disruptions. There are certainly plenty of anecdotal accounts in line with that view. But, of course, anecdote is not evidence. That’s why we do the science. Still, there are even scientific data suggesting that pot temporarily diminishes short-term memory ability in infrequent users. Of course, this is not surprising, because many
drugs—alcohol, Ambien, and Xanax, among others—temporarily disrupt selective mental processes in people who have less experience with that particular drug. But the negative impact of so-called recreational drug use on the mental functioning of regular, experienced users is less clear, at least in the scientific literature. So I was seeking to determine the detrimental cognitive effects of marijuana in people who smoked the drug nearly every day. I wanted to know how they would perform on mental tests after smoking, to establish whether the drug would produce widespread brain dysfunction, even if only temporarily.

John was a typical participant. He smoked multiple joints nearly every day. He was affable, bright, curious, college-educated, and ambitious. He was an artist, an actor between gigs. As a result, he had the time to complete my three-session, outpatient weed study, which paid a couple of hundred dollars. Neither he nor our other research participants fit stereotypical media portrayals of the pothead, who does little besides sitting on the couch, eating Cheetos, and playing video games.

Throughout the experiment, even when under the influence of cannabis, John was lucid and socially appropriate, as were the other participants. No participant failed to show up because they had forgotten the time or day of their scheduled appointment. Not one quit the study because the tests were too difficult or tedious. No one complained that the pot was too weak. And absolutely none of the participants ever became violent. They all complied with our stringent study rules, which imposed demands on their schedules, requiring participants to do considerable planning, to inhibit behaviors that might have been inconsistent with meeting study schedule requirements (e.g., drug use other than marijuana), and to delay immediate gratification.

At the time, I didn’t even register the impressive level of responsibility demonstrated by these research participants. I think, despite my best efforts, I mainly saw them as “potheads,” “stoners,” and all the terms that were inconsistent with the phrase “responsible adults.” But I would soon enough find, working with all types of drug users throughout my career, that they have been some of the most responsible people I have ever known.
“Where do you get the pot from?” John asked as he handed the roach back to me. He looked pleasantly surprised to learn that the marijuana he had just smoked was supplied by the federal government. In fact, there is only one pot supplier for researchers in the United States: the NIDA-funded University of Mississippi marijuana-cultivation program.

With a huge smile plastered across his face and a twinkle in his eyes, he said, “Damn, never before have I been so proud of my government.” We both laughed, but the joke also took me to a serious place. No one I knew had ever uttered the word “proud” when discussing the U.S. government and pot. Consider the fact that the federal government currently lists marijuana on Schedule I under the federal Controlled Substances Act. This means that the drug is viewed as having “no acceptable medical use in treatment” and is therefore banned in the United States, apart from limited research studies.

This classification is hypocritical, although I only recently came to this conclusion. A plethora of data now demonstrates the medical utility of marijuana. We know—based on research from dozens of scientists, myself included—for example, that the drug stimulates appetite in HIV-positive patients, which could be a lifesaver for someone suffering from AIDS wasting syndrome, and that marijuana is useful in the treatment of neuropathic pain, chronic pain, and spasticity due to multiple sclerosis. The list of conditions for which marijuana has been found to be helpful grows each year.

Therapeutic benefits such as these have compelled citizens to vote repeatedly over the past two decades to legalize medical marijuana at the state level. Today, thirty-three states, plus the territories of Guam and Puerto Rico and the District of Columbia, allow patients to use marijuana for specific medical conditions. In addition, since 1976, the government has supplied pot to a select group of patients, as part of their medical treatment, through the federal medical-marijuana program. And yet federal law still technically forbids the use of marijuana for medical purposes. The inconsistency of federal laws with these initiatives and programs, and with the increasing number of studies demonstrating the medical usefulness of the substance, highlights our government’s hypocrisy and undoubtedly undermines people’s trust in the government when it comes to regulating other drugs as well.
Not only has the trust of governmental regulatory agencies been eroded as a result of their handling of specific drugs, a growing number of people have begun to question the objectivity of government-funded scientists who study drugs. Consider frequent statements made by some of these scientists, including Dr. Nora Volkow, director of NIDA, which emphasize the possible neurological and psychiatric dangers of drug use—cannabis included—while virtually ignoring these drugs’ potential medicinal or other beneficial effects.

Nora and other scientists have been quick to caution that pot, for example, is a “gateway” drug to harder substances, but they never mention the more than half a million Americans who are arrested each year mainly for simple possession of the drug, to say nothing of the shameful racial discrimination in marijuana arrests. At the state level, black people are four times more likely to be arrested for marijuana than their white counterparts. At the federal level, Hispanics represent three-fourths of the individuals arrested for marijuana violations. This is despite the fact that blacks, Hispanics, and whites all use the drug at similar rates, and they all tend to purchase the drug from individuals within their racial groups.

I would learn later in my career that the marijuana gateway theory grossly overstates the evidence by confusing correlation with causation. It’s true that most cocaine and heroin users started out using marijuana first. But the vast majority of pot smokers never go on to use so-called harder drugs. To say marijuana is a “gateway” to “harder” drugs is baseless: correlation, a mere link between factors, does not mean that one factor is the cause of another.

I myself had long been guilty of focusing almost exclusively on the harmful effects produced by drugs, including marijuana. In the above experiment, for example, I didn’t even consider the fact that cannabis might not produce negative effects on mental performance, let alone that it might produce positive ones. In June 2000, I was invited to give a talk at a meeting of the Behavioral Pharmacology Society. My study had not yet been completed, but preliminary data were showing that the drug produced virtually no disruptive effects on the complex mental abilities (e.g., reasoning and abstraction) of regular users and that it even improved performance on a test of vigilance. And in terms of mood, the drug produced euphoria and pleasurable feelings.
Never mind: at the conclusion of my talk, I virtually ignored any beneficial effects and speculated that perhaps had I given participants multiple marijuana cigarettes prior to testing their mental functioning, I would have observed more cognitive disruption. Dr. Jack Bergman, a Harvard Medical School–based psychobiologist, asked me a reasonable follow-up question: “Is it possible that marijuana, at euphoric doses, is without effect on cognitive flexibility, mental calculation, and reasoning, at least in this group of subjects?” I was so utterly focused on the harmful effects of drugs that I couldn’t see this as a possibility, even though it was exactly what the data were showing. Stumped, I managed to babble on about the possibility of including more complicated test measures in future studies.

Jack’s question would continue to nag at me. More and more, I came to realize that drug-abuse scientists, especially government-funded ones, focus almost exclusively on the detrimental effects of drugs, even though these are, in fact, a minority of effects. This has had a damning impact on how so-called recreational drugs are regulated and inevitably on your own decision as to whether or not to partake of them.

Here’s the bottom line: over my more than twenty-five-year career, I have discovered that most drug-use scenarios cause little or no harm and that some responsible drug-use scenarios are actually beneficial for human health and functioning. Even “recreational” drugs can and do improve day-to-day living. Several large research studies have shown that moderate alcohol consumption, for example, is associated with decreased risk of stroke and heart disease, the top killers in the United States each year. As you will discover, a number of beneficial effects have been observed with other drugs as well. From my own experience—the combination of my scientific work and my personal drug use, I have learned that recreational drugs can be used safely to enhance many vital human activities.

WITH SOME Trepidation, I chart in this book for the first time my awakening as a citizen-scientist trying to make people aware of these facts. I also describe my struggles to convince other drug-abuse researchers that we operate under some important biases, which
in some cases are more damaging than the drugs themselves and prevent us from exploring new treatments and healthier, humane policies. I provide detailed strategies that you, as a responsible, adult drug user, can employ in order to enhance positive drug effects, while minimizing negative ones. These are the same strategies that I use in my government-funded research to keep research participants safe.

A point I need to emphasize here is that this is a book for grown-ups. By that I mean autonomous, responsible, well-functioning, healthy adults. These individuals meet their parental, occupational, and social responsibilities; their drug use is well planned in order to minimize any disruptions of life activities. They get ample sleep, eat nutritiously, and exercise regularly. They don’t put themselves or others in physically dangerous situations as a result of their drug use. These are all grown-up activities.

Growing up is difficult and it’s not guaranteed. In other words, neither this book nor drug use is for everyone. They are for those who have managed to grow up.

I recognize that people with mental illness and those experiencing acute emotional crises (e.g., the death of a loved one or a divorce) may also be interested in the ideas expressed within these pages. But because people with specific mental illnesses and those in crisis are at greater risk for experiencing negative drug-related effects, it would be irresponsible of me to encourage use by these groups without detailing each caveat associated with any particular substance and psychiatric disorder. Frankly, that analysis is beyond the scope of this book.

A related issue is drug addiction. Drug Use for Grown-Ups is unapologetically not about addiction. But because I use the terms addict and addiction throughout, it’s incumbent upon me to clearly define them. Simply knowing that a person uses a drug, even regularly, does not provide enough information to tell whether that person is “addicted.” It doesn’t even mean that the person has a drug problem. To meet the most widely accepted definition of addiction—the one in psychiatry’s Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)—a person must be distressed by their drug use. In addition, the individual’s drug use must interfere with important life functions, such as parenting, work, and intimate relationships. This use must take up a great deal of time.
and mental energy and must persist in the face of repeated attempts to stop or cut back. Other symptoms that the person may experience include needing more of the drug to get the same effect (tolerance) and suffering withdrawal symptoms if use suddenly ceases.

My use of the term *addiction* throughout this book is interchangeable with *DSM-5’s Substance Use Disorder*, which always means problematic use of the sort that interferes with functioning—not just ingesting a substance regularly.

Too often, the conversation about recreational drug use is hijacked by peddlers of pathology as if addiction is inevitable for everyone who takes drugs. It is not. Seventy percent or more of drug users—whether they use alcohol, cocaine, prescription medications, or other drugs—do *not* meet the criteria for drug addiction. Indeed, research shows repeatedly that such issues affect only 10 to 30 percent of those who use even the most stigmatized drugs, such as heroin and methamphetamine. This observation highlights two important points. The first is society’s flagrant, disproportionate focus on addiction when discussing drugs. Addiction represents a minority of drug effects, but it receives almost all the attention, certainly the media attention. Think about that. Have you ever read a newspaper article or seen a film about heroin that didn’t focus on addiction? Imagine if you were interested in learning more about cars or driving and could only find information about car crashes or information about how to repair a car after a crash. That would be ridiculous.

Another related point is this: if most users of a particular drug do not become addicted, then we cannot blame the drug for causing drug addiction. It would be like blaming food for food addiction. Can you imagine us waging a war on cheesecake or steak? You’ve seen the histrionic headlines that blame specific drugs for their extraordinary “addictive powers,” as if certain drugs have magical qualities. Drugs are inert substances. The evidence tells us that we must look beyond the drug itself when trying to help people with drug addiction. In fact, regarding the relatively small percentage of individuals who do become addicted, co-occurring psychiatric disorders—such as excessive anxiety, depression, and schizophrenia—and socioeconomic factors—such as resource-deprived communities and un-
underemployment—account for a substantial proportion of these addictions.\footnote{11}

I recognize, too, that nowadays it’s nearly impossible to engage in a discussion about drugs without addressing their purported negative impact on the brain. You will discover within these pages that scientists have frequently overinterpreted and distorted many of these effects. Adding to the problem, misrepresented “brain findings” are then amplified by less than careful media coverage. By looking critically beyond the pretty pictures produced by brain imaging, I will challenge the notion that recreational drugs cause brain dysfunctions. You will see that the sexy images so frequently touted by some neuroscientists rarely show any actual data, but this doesn’t temper the unsubstantiated claims made about the brain-damaging effects produced by drugs. This irresponsible behavior, you will see, has contributed to inappropriate drug policies that have led to racial discrimination, group marginalization, and preventable deaths.

A broader argument I make within these pages is that adults should be permitted the legal right to sell, purchase, and use recreational drugs of their choice, just as they have the rights to engage in consensual sexual behaviors, drive automobiles, and even purchase and use guns. Of course, all these activities carry some level of risk, including death. But rather than banning sex, cars, or guns, we have implemented age and competence requirements as well as other safety strategies, strategies that minimize harms and enhance positive features associated with these activities. This is already done, of course, with the widely used recreational drug known as alcohol. After reading this book, you will, I hope, come to the inescapable conclusion that the same should be done with other recreational drugs.

Recreational drug use is an activity engaged in by millions of closeted adults around the globe. Now that I have learned that taking drugs to alter one’s state of being isn’t as dangerous as I had been taught, I share my story in an effort to encourage others, especially successful professionals who are less at risk than people on the margins of society, to get out of the closet about their own drug use. If they did so, more people would see that there are far more respectable drug users than our criminal-justice regime and popular culture would have us know.
Media coverage of the current so-called opioid crisis is but one clear example of the pervasive spread of misinformation about drugs and the people who partake of them. This type of coverage has made it damn near impossible for rational adults to acknowledge publicly their recreational opioid use. According to the lore, one must be in excruciating pain, mentally ill, or extremely troubled to use opioids, because any use is said to be accompanied by a high risk of addiction, overdose, and death. The same was said about methamphetamine in the early 2000s and crack cocaine in the late 1980s. I’m embarrassed to say that I learned that such statements simply aren’t true not from critically analyzing my research data, but from my own personal drug use.

Heroin and other opioids, such as oxycodone and morphine, bring me pleasurable calmness, just as alcohol may function for the drinker subjected to uncomfortable social settings. Opioids are outstanding pleasure producers; I am now entering my fifth year as a regular heroin user. I do not have a drug-use problem. Never have. Each day, I meet my parental, personal, and professional responsibilities. I pay my taxes, serve as a volunteer in my community on a regular basis, and contribute to the global community as an informed and engaged citizen. I am better for my drug use.

But I am also a parent of a teenager and young adults. So, you may ask, how could I, in good conscience, admit to using some of our most vilified drugs, especially now that the country is experiencing an opioid “crisis”? Am I not concerned what my children will think? Am I not concerned that publicly acknowledging my own drug use will increase the likelihood of my own children using drugs? Also, not least, am I not breaking the law by using heroin?

The answers to these questions lie in my story and in the science, both of which speak to how society is constantly misled about drugs and how this leads not only to countless preventable deaths but also to policies that force adults to behave like children and to social conventions that place ridiculous moratoriums on the use of mind-altering drugs for pleasure. By exploring the myths and social forces that shape our views on drugs and policy, we can tear away the misinformation that actually drives so-called drug crises and get down to the vital business of pursuing happiness.