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Reflections on Treating Addictive Disorders: A Psychodynamic Perspective

Edward J. Khantzian, MD

Harvard Medical School, Boston, Massachusetts

INTRODUCTION

In this paper I would like to reflect and draw upon a psychodynamic perspective and four decades of work with drug-dependent patients, to look at the struggles and suffering that make addictions so powerful and compelling. Drawing on that perspective and experience, I would then like to offer some thoughts about essential elements of good treatment and how clinicians can develop a focus to address, understand, and modify in psychotherapy the vulnerabilities that have caused drug-dependent individuals to suffer and behave in the ways that they do. The paper will sound familiar to many practitioners of my generation, and in this respect it is intended as a recap and summation of my work, but it is also my aim to introduce these ideas to a new generation of clinicians who are taking up the challenge to provide a humanistic psychological approach to understanding and treating addictive disorders.

Treating addictive disorders, as with other medical and psychiatric conditions, rests on the principle that effective treatment best occurs when the underlying processes and mechanisms involved in the disorder are understood and targeted. Over the past several decades considerable evidence has emerged, as recently reviewed by Shedler,[1] on the efficacy of psychodynamic psychotherapy as an effective model for understanding and treating a wide range of psychiatric disorders. Dating back to the 1980s there is evidence as well that psychotherapeutic approaches derived from a psychodynamic paradigm are effective in treating addictive disorders.[2–4] Although there have been few if any such studies since the 1990s, Shedler suggests that nonpsychodynamic therapies such as cognitive behavioral therapy (CBT), dialectic behavioral therapy (DBT), and motivational interviewing (MI) incorporate techniques central to psychodynamic theory and practice. Especially in the case of MI, the reader will recognize the empathic and humanistic attitudes explicitly embodied in the evidence-based work of Miller and Rollnick,[5] drawing on the work of Carl Rogers.

From my perspective a psychodynamic approach, more simply put, gets at the human psychological underpinning of addictive behavior. Such a perspective is needed given the stigma, negative stereotyping, and the horrible judgment placed on individuals with addictive disorders, not the least of which addicted individuals place on themselves. More than anything, I would like to stress that suffering is at the heart of addictive disorders and that this consideration should remain central in considering the treatment needs of individuals with addictive disorders. To understand and to be understood is a powerful antidote to the confusion, chaos, and suffering associated with addictions. The treatment relationship offers a humane, comforting, and containing remedy to the dehumanizing, discomforting, and disorganizing causes and consequences of addictive disorders.

WHAT DOES A PSYCHODYNAMIC PERSPECTIVE INSTRUCT ABOUT ADDICTION?

At the outset I would like to emphasize what addiction *is not*. In my experience, addiction is not about pleasure seeking; nor is it about human self-destructiveness or oral dependency—as some well-accepted formulations suggest. Take, for example, the language of modern day neuroscientists who speak of and seek the "reward" and "pleasure" pathways in the brain to explain the reinforcing properties of addictive substances; or the cynical view that addiction is suicide on the installment plan. In the case of neuroscience, such a paradigm is more suitable to explain the drug effects with short-term or intermittent use, but seems insufficient to explain the complexities of what makes addictive behavior and relapse so powerful and driven. It bears repeating that many individuals experiment with these so-called powerfully addicting drugs but few become addicted. The

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Address correspondence to Dr. Khantzian, 10–12 Phoenix Row, Haverhill, MA 01830-5702. E-mail: drejk26@comcast.net.

power in addiction resides in the interaction of the drug with the internal terrain of the person who uses it and discovers its pain-relieving effects if they are susceptible. As for invoking suicidal motives about addictive behavior, it is probably the case that suicidal behavior associated with addiction is more likely the result of the long-term crippling and demoralizing consequences of chronic drug use. Over the course of nearly a half-century of clinical work with addicted individuals I have yet to meet a person who became or remained addicted to drugs because of the pleasurable aspect of their use, or whose motives in initiating and using drugs was suicidal in nature.

ADDICTION AS A SELF-REGULATION DISORDER

A psychodynamic perspective suggests that addiction is fundamentally a disorder of self-regulation. More precisely, individuals with addictions suffer because they cannot or do not regulate their emotions, self-esteem, relationships, and their behavior. As humans we are governed less by instincts and more by coping skills and capacities acquired from the caretaking environment. Requirements for human survival and adaptation place a lifelong challenge on humans for self-regulation. Regulating emotions, self-esteem, relationships, and self-care are among the main functions upon which our survival depends.[6] In my experience, individuals self-medicate the distress and pain associated with their self-regulation difficulties.

Not withstanding factors of temperament, it is both the good news and the bad news about our human nature that we are not hardwired to adjust to our inner and external environment. That is, we are challenged to learn how to figure out who we are, what goes on inside us, how we feel about ourselves, and how to get along with the human and nonhuman environment that surrounds us. This makes for possibilities of satisfaction and joy or the alternatives of dissatisfaction and misery. The former is the result of adequately comforting, caring, and loving relationships over a person's life span that can insulate against injuries and insults, both relationally and materially. The latter grows out of a range of misalignments, neglect, and trauma over the course of a lifetime. Needless to say, genetic loading and related biological processes are clearly important in the etiology of addictions; alone, however, they are insufficient to account for the development of addictive disorders. Adequate nurturing and protective environments likely can protect and help to overcome harsh external environments as well as factors of biological loading.

Based on work with more than a thousand patients over 40 years of practice ("practice-based evidence"), the self-regulation problems that are central to addictive vulnerability involve the following:

- an inability to recognize and regulate feelings;
- an inability to establish and maintain a coherent, comfortable sense of self and self-esteem;
- an inability to establish and maintain adequate, comforting, and comfortable relationships;
- an inability to establish and maintain adequate control/regulation of behavior, especially self-care.

Although addictions are a multifaceted disorder, in my experience these four areas have proven to be extremely fruitful in exploring some of its key components. To varying degrees, addiction involves problems with regulating emotions, relationships, self-esteem, and behavior interacting with each other, environmental influences, and genetic factors to make addictive disorders more likely.

Adopting a structure and focus serves both the clinician as well as the patient. This is especially important given that the discomforting and disorganizing aspects of addiction can derail both the person who experiences addiction as well as those who witness it, including the clinician who is challenged to understand and treat it. A focus on self-regulation factors in addictive disorders has proven to be useful to me in identifying the core issues in need of understanding and therapeutic modification.

So one might ask if addiction is a self-regulation problem, how do addictive drugs "help" with self-regulation?

- Drugs enhance or contain feelings.
- Drugs affect one's sense of self, well-being, and self-esteem.
- Drugs affect our ability or inability to care about or to connect to others.
- Experimentation with and dependence on drugs are influenced by one's capacity for self-care.

Notice that the word help is in quotes. Based on my experience, addiction is an attempt at self-correction that fails. It is the real and illusory nature of addictive drugs and behaviors. Short-term addictive drugs might work; they can provide a temporary fix for what the person suffers with. That is what is "reinforcing" about addictions. Long-term, addictive drugs fail. They do so because they become an end in themselves. They erode any existing human capacities to cope, and preclude possibilities to develop solutions to the challenges of regulating emotions, self-esteem, relationships, and self-care.

What Are the Problems with Feelings?

The capacity to identify, differentiate, verbalize, and tolerate feelings is on a continuum. As with other aspects of life, there is a normal developmental trajectory for the development of feelings. Henry Krystal, a distinguished psychoanalyst, has been seminal in appreciating this aspect of feeling life.[7] At the outset feelings are undifferentiated (ie, the infant does not distinguish between anxiety and depression), feelings are experienced bodily, and they are without words. Optimally, with normal progression (major trauma

can reverse this progression) we come to distinguish feelings (and eg, know the difference between feeling "nervous" or being "blue"), experience them emotionally, and are able to give words to them. Individuals with characterologic, behavioral, and addictive disorders tend to be more singularly troubled with respect to how they process and express their feelings. I continue to be impressed by how invariably my patients with addictive disorders have trouble being aware of, identifying, and verbalizing their feelings. At one extreme, feelings can be inaccessible, confusing, or vague; at the other extreme patients seem unable to think about, cope with, or tolerate their feelings of anger, rage, anxiety, or sadness. For some the activating properties of stimulants or the releasing effects of sedatives and alcohol give vitality to the emotional lifelessness of not knowing, being confused about, or devoid of feelings; for others heavier doses of alcohol, and related depressants, or opiates calm or relieve the intolerable and threatening emotions of intense anger, rage, and associated agitation.

What Are the Problems with Self-Esteem?

Working with individuals with addictions, I have been impressed that problems with self-esteem go beyond the pale of simply not feeling good about self. As the self-psychologists put it, inner states of well-being and cohesion are elusive or lacking (ie, anxiety about self amplifies into fragmenting disarray); feelings of inadequacy, impoverishment, helplessness, and compensatory rage loom large. Narcissistic defenses of omnipotence and bravado (I call it strutting) detract self and others from appreciating the underlying feelings of inadequacy and emptiness. I tell my students, "Don't assume the person sitting in front of you can handle what they profess they can." Is it any wonder that expansive individuals find the sense of omnipotence induced by amphetamines exhilarating, or that relief of feelings of enfeeblement in the more impoverished is experienced as a magical compensation when such individuals use stimulants? I often wonder if the undue emphasis on pleasure and euphoria ascribed to addictive drugs is a reflection of an inherent problem of anhedonia in addictively prone people. Namely, the activating or pain-relieving action of the drugs powerfully corrects and ameliorates dysphoria or enhances a sense of well-being, and that is what is experienced as "pleasure [and] reward."

What Are the Problems with Relationships?

Although early psychodynamic formulations and contemporary stereotypic depictions characterize addicted individuals, especially alcoholic individuals, as "oral . . . clinging . . . dependent," in my experience, and as often described by patients themselves, addicted individuals are more often counter-dependent. That is not to say such individuals do not yearn for or need contact or comfort; the problem more often is they cannot or dare not admit or exercise such needs. They act as if they do not need others and suffer as "born isolationist(s)" as one patient put it. Feeling cut-off, cold, and alienated are a few of the terms that come to mind to capture the affect states that such isolation engenders. Some of this is grounded in defensive postures of self-sufficiency and disdain for the need of others. In others it seems to be the result of depressive inertia that may make connection to others unlikely or impossible. In part, it is on this basis that some investigators[8,9] have characterized addiction as an attachment disorder. It turns out we are more likely comfort and contact seeking than we are pleasure seeking. Pleasure is momentary and not unimportant, but human connection and the comfort we derive from each other is more sustaining and lasting. Opiates can quiet and contain the rage that threatens relationships; sedatives, especially alcohol, can dissolve defenses against otherwise threatening connection to others (it turns out alcohol is at least as good an ego solvent as it is a super-ego solvent); and stimulants can break through the inertia and inhibitions that do not allow contact with other human beings.

What Are the Problems with Self-Care?

Self-care functions insure safety, well-being, and survivability. Early in my career working with intravenous heroin users in a methadone program I found myself having a powerful subjective reaction to the idea of injecting oneself with illicit drugs. I realized my reaction of repugnance to that idea was one of counter-transference (modern theorists would call it an "intersubjective" response, namely, our patients getting us to feel something they need us to feel that they are unaware or incapable of). I decided to tactfully share my recoil and discomfort with the many patients I was evaluating at that time. My inquiry consistently and monotonously elicited reactions of little or no emotions or concerns of alarm about crossing the so-called "needle barrier." Subsequently, working with abstinent drug- or alcohol-dependent patients in psychotherapy I was struck by how such lack of worry or thought persisted when no longer addicted. I observed these deficiencies to be involved in interpersonal and physical mishaps, slip-ups around management of important matters of unpaid premiums, lapsed licenses, and preventable medical and dental problems. It is in this context that I began to conclude that a major contributing factor to the development of addictions involved deficits in a capacity for self-care. What I was observing was that addictively prone individuals think and feel differently about potential and real situations of harm and danger. Anxiety, fear, worry, or apprehension are deficient or absent and fail to guide such individuals in risky or self-harmful situations. And there is a failure to draw cause/consequence relationship in the face of risk. Where anticipatory shame and guilt might guide when self-care capacities are better developed, in addictively prone people shame and guilt come after the fact (eg, "I felt stupid and bad when I did that" [rather than] "I will feel stupid

and bad if I do that"). It is the combination of self-care deficits interacting with the pain and suffering involved in self-regulation difficulties that make vulnerable individuals more likely to develop addictive disorders.

TREATING THE SELF-REGULATION PROBLEMS OF ADDICTED INDIVIDUALS

Because addicted individuals are overwhelmed or confused by their feelings, because their self-esteem is shaky, because relationships are elusive or absent, and because their self-care is undeveloped or inadequate, I have concluded practitioners should be guided by the following essential elements for their work with patients:

- Kindness
- Comfort
- Empathy
- Avoid confrontation
- Patience
- Instruction
- Self-awareness
- Climate of mutual respect
- Balance—talking/listening[10]

Although many of the listed elements seem self-evident and basic, it is worth commenting upon how and why they are important. I begin with kindness because it is so important yet, because of certain traditions and tendencies, it often wanes or is absent in the treatment relationship. First of all, most of us are influenced more than we like to think by the early psychodynamic paradigm that fostered reserve and impassivity thus making kindness in treating clinicians less likely apparent. Second, whether we like to admit it or not, addicted patients foster disbelief or distrust in clinicians (and worse still if we are unaware of the mistrust) thus making it less likely to be kindly disposed to our patients.

Appreciating the pain and suffering that is at the root of addictive disorders, we need to remember all the things our addicted patients are uncomfortable about and how not understood they feel. In this respect the role of empathy is critical in countering such distress. I say, "avoid confrontation . . . but if the devil makes you," because addictive disorders are maddening to self and others, including treating clinicians. Our patients make us madly angry and crazy given how insane and irrational addictive behavior can seem or be. I believe this in part is what fosters counterproductive and harmful confrontations, more likely angry than not, in clinicians if they are not careful. But "if the devil makes you," because on certain occasions firm proscribing interventions are necessary to insure safety, confrontations have to be done in such a way that preserve self-esteem and are supportive. We need to keep in mind how out of touch our patients can be with regard to their thoughts and feelings. Thoughtfulness and emotions fail to serve addictively prone patients in assuring self-preservation, and instructive approaches are necessary and consistent with psychodynamic approaches. And finally, regarding the final three bullets, in my estimation self-awareness in the patient and clinician, and the balance between talking and listening, are central for a climate of mutual respect, all key to establishing and maintaining a positive therapeutic alliance.

The Problem of Comorbidity

Given the high rates of psychiatric comorbidity, including presumed sociopathy, associated with substance use disorders (SUDs), one might ask do the principles of kindness, empathy, etc. that I have outlined here apply in working with patients so affected? I would emphatically respond in the affirmative. Although in many previous publications I have addressed the importance of psychiatric comorbidity, including sociopathy, as predisposing to addiction, I do not focus on these factors here. The essential elements that I have listed apply in what follows considering the enormous suffering and dysregulation associated with the range of psychiatric diagnoses that co-occur with addictive disorders. In the case of sociopathy presumably associated with addiction, I have not met a pure type in my years of clinical practice. Perhaps my impressions would be different if I worked in offender or prison populations. But discussing my findings with clinicians who do work with drug-dependent offenders, they tell me that the disruptive and antisocial behaviors witnessed with such individuals detract from underlying suffering and self-regulation difficulties with which offenders struggle. So whether it be the great pain that patients with co-occurring bipolar disorders or post traumatic stress disorder (PTSD) endure, or the emotional and behavioral instability associated with personality-disordered individuals, kindness, empathy, and patience should remain the order of the day.

Addressing Disordered Affects

Because individuals with addictive disorders tend to experience their emotions in extremes of intense or absent affect, our therapeutic responses must be tailored accordingly. For those who seem cut-off or without words for their feelings ("alexithymia"), clinicians should be prepared to actively elicit, label, and put into words for their patient the feelings that seem elusive or confusing. When patients say they do not know what they are feeling one should be less inclined to consider such reactions as denial or defensive. More likely it is an indication that our patients are often truly out of touch with and confused by their emotions. The recent work of Fonagy and associates[11] on "mentalizing" helps us to consider the fundamental importance of labeling, clarifying, and processing thoughts, emotions, and behaviors, a basic aspect of individual psychotherapeutic work. The story-telling traditions in group therapy as well as 12-step programs are extremely helpful in cultivating

a growing capacity to recognize and process emotions as members listen and share their experiences and stories.

In instances where affects are more intense, overwhelming, and intolerable, therapeutic efforts should be geared to helping patients modulate and contain feelings that are threatening for self and others. In this respect the therapeutic alliance is in and of itself an important containing influence. Yet, for those whose grievances and rage are lodged in major trauma and neglect, the therapist should be undisguised in acknowledging and validating the legitimacy of such intense feelings. The time-honored tradition of exploring and clarifying the origins and displacements of intense affect and how they became connected to drug use can be invaluable ("the truth will set you free"). Helping patients mentalize about and reframe their experiences can assist them in working out alternative ways to ameliorate the distress associated with intense affect and reversion to drug use. Given the natural pressure in groups for balance, the modulating and interpersonal benefits of therapeutic and self-help groups can be extremely beneficial in containing intense affect. Finally a brief word is in order about the judicial use of psychotropic medications in helping to modulate intense or overwhelming affect. In my experience the modulating action of medications reduces the intensity of feelings to tolerable levels and thus permits therapeutic examination and modification of otherwise intolerable emotions.

Addressing Disordered Self-Esteem

Honoring the supportive and empathic traditions of psychotherapy is crucial in offsetting the enormous problems with self-esteem that predispose to, and are the consequence of, addictive disorders. This is because an inner sense of well-being and cohesion that ordinarily helps us to feel together is elusive or lacking. Feelings of helplessness, states of alienation and vacuousness, and for some compensatory rage, accompany the low self-regard that such patients experience. This is where kindness and patience is especially important. The rage is both reactive and defensive. I have to constantly remind myself that such reactions and defenses should be approached gingerly and respectfully, albeit such defenses can be off-putting. More often, behind such responses are feelings of emptiness and impoverishment. For those who are more visibly enfeebled and seem vacuous I try to use my own energy to strengthen and activate in my patients a better sense of self and vitality. Beyond the importance of mirroring and validating patients in individual psychotherapy, I have found the accepting and celebratory aspects of group experiences to be a major corrective for the self-esteem problems associated with addictive disorders.

Addressing Disordered Relationships

Predisposing and resulting self-esteem problems associated with addictions leave affected individuals feeling unworthy, especially for the support, care, and affection of others. Little wonder such people are avoidant and isolative, if not defensively off-putting. Kindness and empathy remain the order of the day. From my perspective, impassive and strict interpretive approaches recapitulate and perpetuate relationship problems. Individual psychotherapy can address and focus on contradictory attitudes of relational manipulations and disavowal of needs and problems with counter-dependence can and should be addressed and clarified. Keeping in mind the attachment difficulties with which addicted patients struggle, individual and group psychotherapy are extraordinarily valuable for the relational disconnections and alienation.

Addressing Disordered Self-Care

Our patients evoke in us what they want us to feel or that they cannot feel. In the case of self-care deficits our alarm over so many aspects of addictive involvements alert us to the affective and cognitive deficiencies in our patients that cause them to be unaware of or oblivious to danger, especially those involved with addictions. I have discovered over and over that it is crucial to clarify with my patients that something causes them to react differently to potential and real danger. They do not feel and think clearly around potential or real danger, if they think or feel at all. Long-term psychotherapy may help to get at what that something is, namely to understand how over-/underprotective and traumatizing environments leave them prone to self-care deficits. An interactive and instructive approach is essential to stimulate a growing awareness and vigilance about harm and danger, particularly those associated with relapse to addictive behavior. The feeling of alarm that patients evoke in the therapist should be tactfully shared, and their self-esteem deficits should be examined, as these cause our patients to treat themselves so shabbily and unworthy of self-protection. The range of individual and group treatments we employ should incorporate more sensitivity about self-care deficits. We need to help patients use self-respect, feelings of apprehension/worry, relationships with others, and thoughtfulness as a guide for safe behavior and self-preservation.

IN CONCLUSION

I remain convinced that a psychodynamic perspective remains one of the most powerful paradigms to guide clinicians in addressing and modifying the vulnerabilities which precipitate and maintain addictive behavior. The treatments that work do so because they address and relieve the pain and distress associated with addictions. Attitudes of kindness, empathy, support, and instruction are necessary and consistent with a psychodynamic approach for treating patients who suffer with addictive disorders. Individual and group treatments, guided by such a humanistic understanding, provide powerful antidotes to the alienation, dysphoria, and anguish that are so intimately a part of substance use disorders. And finally it bears

repeating that to understand and be understood is a powerful correction for the confusion, chaos, and suffering associated with addictions.

Declaration of Interest

The author reports no conflicts of interest. The author alone is responsible for the content and writing of the paper.

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Commentary

We live in a time when the neurobiologic underpinnings of addictive disorders have received an increasing amount of attention, and valuable information that can guide the development of new therapeutic approaches is emerging. Nevertheless, therapeutic advances based on discoveries in the neuroscience arena are limited. Meanwhile, the importance of the interactions between patients with addictions and their healthcare providers provides a day-to-day challenge for those who treat patients with addictions.

The essay by Dr. Khantzian calls our attention back to a very fundamental and critical area in addictions that is underappreciated and understudied, yet is something we deal with in every therapeutic encounter. Understanding the psychodynamic forces that underlie addictive behaviors and the feeling states of patients with addictions is critical to developing the therapeutic relationship that can provide the context for a healing experience.

Dr. Khantzian reminds us that the view of addiction as "pleasure-seeking" is a widely held misperception that contributes to the view that addictions should be managed in the criminal justice sector rather than be viewed as a disease or disorder. Anyone who treats individuals who suffer from addictive disorders recognizes that substance use is associated with shame, pain, chaos, and confusion for the addict. The notion that addictions are a manifestation of suicidal intent is another misguided perception that is discussed. Most people with addictions have dreams and aspirations for their future and look forward to the day when they have sustained abstinence and stability in their lives. Viewing these individuals as suicidal can lead to misaligned therapeutic endeavors. As Dr. Khantzian points out, one of the most important principals in the therapeutic context is that patients need to feel heard and understood. Imposing a predetermined interpretation of an individual's motives as either pleasure-seeking or suicidality rather than listening to their story and trying to understand their perspective is a recipe for a failed therapeutic relationship.

Importantly, this essay is written by a very seasoned and expert clinician reflecting on 40 years of clinical work. Dr. Khantzian reminds us to treat our addicted patients with the compassion, care, and understanding that they need to overcome their addiction. In a world where friends, family, healthcare providers, and society in general often stigmatize individuals with addictions, the addiction professional may provide the only safe outlet for feelings, acceptance, and hope for the future.

Kathleen T. Brady, MD, PhD
Acting co-Editor,
The American Journal on Addictions
Director, Clinical and Translational Research Center,
Distinguished University Professor,
Associate Dean, Clinical and Translational Research,
Medical University of South Carolina,
Charleston, South Carolina