Addiction psychiatry is one of the last great frontiers in the field. For many years the preferred option for treatment of any addiction was a simple referral to a self-help group and a warning about the dangers of the particular addiction. The treatment of alcoholism in particular was hampered by a pervasive view of the disorder as a moral/behavioral failure. Thus, by nature it was separate from other psychiatric disorders, which had at least some biological basis and for which some pharmacotherapeutic remedies were available.

The two great movements that attempted to deal with alcoholism in this country during this century, the Temperance Movement and Alcoholics Anonymous, have advocated moral or psychosocial interventions. Indeed, both have been successes in limited ways. The Temperance Movement led to the era of Prohibition, which is now regarded as a great social failure. Nevertheless, it led to an impressive 80% fall in the incidence of liver cirrhosis during that era. Alcoholics Anonymous is still this country’s premiere treatment modality for alcoholism and has not been bested by any other form of psychosocial intervention.

As the development of antidepressant medications in the 1960s led to changes in the perception of the underlying cause of this disorder, it will take not just the advent of successful pharmacotherapies but, more importantly, their common usage by psychiatrists and physicians to alter the perception of alcoholism as being primarily a personal or moral failure. It is likely that it will take many more years before the pharmacotherapies outlined in this issue of CNS Spectrums become commonly used in the treatment of alcoholism, and many years after that before physicians’ views and then society’s views of alcoholism change.

It is a tribute to the skills and tenacity of the numerous researchers and clinicians highlighted or mentioned in the succeeding articles that most of the developments in the treatment of alcoholism have risen out of solidly grounded scientific work and not out of chance findings. We can, thus, hope for a change in attitudes towards alcoholism that will be grounded in solid scientific fact, making it all the more pervasive. Time will tell.

Some of the pioneering genetic work on alcoholism was completed in the early 1970s and conclusively proved that alcoholism is largely a genetic/biological disorder. Despite this, we have a long way to go before alcoholism will be regarded as inherently a medical disorder as diabetes or cancer. A number of factors contribute to this. Alcoholism has an insidious onset in the majority of sufferers. While some develop the disorder within a short number of years, most take many years to develop it and even longer to acknowledge it and seek help (if ever). The absence of a single clear line of demarcation of the disorder—alogous to the chest pain of heart disease or the limb weakness of stroke—lends itself to denial by the individual and by those closest to him/her. An enormous social stigma is attached to the disorder, and it, consequently, remains largely hidden. It remains hidden while each individual battles to maintain a normal level of function as the many edifices of life, family, friends, and work crumple around them. It remains hidden within social groups because family, friends, and colleagues may conspire to tolerate rather than confront the disorder. Finally, it remains hidden within communities and is treated in separate programs, clinics, and groups that insist on anonymity because of society’s dislike for and disregard of the problem. While other medical disorders, such as cancer, have had social stigma associated with them in the past, this has largely disappeared with increased availability of information about the disorder. This social stigma has not faded for mental illness, in general, and substance abuse, in particular. Let’s face it, there is no self-help group called Diabetics Anonymous.

The articles in this issue cover the range of neurochemical systems and pharmacotherapies currently important in the treatment of alcohol withdrawal and in the maintenance of abstinence from alcohol. Drs. Myrick and Anton review the clinical management of alcohol withdrawal, including treatments with newer agents. Dr. Pettinati and colleagues review the use of serotonergic agents in alcoholism, including the latest information from relevant clinical trials. Dr. Swift reviews the importance of opioid antagonists in alcoholism, detailing what has been done and what needs to be done in this area. Dr. Mason outlines the largely European literature on acamprosate, an N-methyl-D-aspartate antagonist that has enormous potential as an effective treatment. Finally, together with a number of colleagues, I outline the preclinical and clinical evidence for efficacy of combination pharmacotherapy as a treatment option.

I would like to thank all the authors for their contributions to what I hope is a comprehensive delineation of the current field of the pharmacotherapy of alcoholism. It is a privilege to be a part of a great research endeavor to effectively treat this largely resistant and hidden disorder as well as to hopefully help sow the seeds of a great change in attitude towards this disorder.