6. Continued use of the substance despite knowledge of physical or psychological problems that are likely to have been caused or exacerbated by the substance.
7. Excessive time spent using the substance or recovering from its effects.

However, given the complexity of addictive behavior, it appears that a binary, either–or view implicit in the psychiatric diagnostic approach is too simplistic and provides little understanding of the complexities of the addictive process and how to change it. As noted by Shaffer and Neuhaus (1985), addictive behavior is not easily categorized and, as such, is not easily defined by a set of consensually agreed-on criteria. Indeed, different diagnostic systems often place greater emphases on different aspects of behavioral and physiological functioning in their definitions. In turn, these differences lead to fairly divergent estimates about the prevalence of alcohol and drug use disorders in the general population (for a review of this issue, see Grant & Dawson, 1999). Moreover, O'Brien, Volkow, and Li (2006) argue that dependence is often confused with physical dependence, which may occur with therapeutic applications of a variety of medications, and as a result, may create apprehension among clinicians to prescribe medications out of fear of creating addiction (Kranzler & Li, 2010). In response to this concern, given its emphasis on behavioral aspects of substance use, the DSM-5 has removed the terms abuse and dependence, and replaced them with the single diagnosis of substance-use disorder.

A Biopsychosocial Perspective Behavioral scientists have proposed an alternative biopsychosocial approach to defining alcoholism and drug abuse. According to this framework, alcohol and drug use disorders are not defined as unitary diseases, nor is it implicitly assumed that the observed substance use symptoms are the manifestation of a disease state. Instead, symptoms are viewed as acquired habits that emerge from a combination of genetic, social, pharmacological, and behavioral factors. Addiction is viewed as involving physiological changes in individuals (many of whom may be genetically and/or psychologically predisposed) and the complex interaction of environmental stressors and individual aspects of the person (including his or her experiential history) that produce and maintain addictive behaviors.

A comprehensive understanding of the synergistic relationship among these factors is essential, not only to understanding the degree and severity of substance use, but also for recognizing when use becomes abuse. This approach largely de-emphasizes labels and places greater emphasis on understanding the interplay between multiple factors that have led to and maintained the observed behavior.

Cultural and Social Issues

Definitions of substance abuse do not develop in isolation; the point at which substance use is said to move from recreational to disordered is determined by the social and cultural context in which the behavior occurs (e.g., Thombs, 2006). Thus, societal norms and definitions of substance use and abuse are inextricably intertwined. How we determine what qualifies as an alcohol or drug problem is derived from the boundaries implicitly (e.g., social stigma associated with being labeled an alcoholic or drug addict) or explicitly (e.g., laws prohibiting use of certain substances) drawn by the society in which the behavior takes place. In many respects, the norms for acceptable drinking and other drug use are delineated and communicated (implicitly or explicitly) to members of the society by the way the culture defines addiction.

A Sociocultural View of Alcoholism and Drug Abuse From a sociological perspective, clinical diagnostic criteria for alcoholism and other drug abuse are derived from societal norms and thus vary depending on when and where the diagnosis is made. More specifically, drinking or drug-taking behaviors that are considered disordered are those that deviate from socially accepted standards. Perhaps the cultural foundations of alcoholism, which can also be applied to other addictive behaviors, are best captured by Vaillant (1990), who stated: "Normal drinking merges imperceptibly with pathological drinking. Culture and idiosyncratic viewpoints will always determine where the line is drawn" (p. 6).

Moreover, problems with alcoholism and drug abuse have become increasingly medicalized, and certain factions appear to have an agenda in viewing these behaviors as symptoms of a disease state and convincing others to view them in a similar manner. If addictive behavior is defined as a disease, the label itself gives credibility to physicians' efforts to control, manage, and supervise the care provided to individuals seeking treatment. Thus, the medical community may have a strong, vested interest in defining addictive behavior as a disease. At its core, treatment of substance abuse is a business; as with all business, economics play a critical role (Carlson, 2006). The label serves to make legitimate such financially lucrative efforts as hospital admissions, insurance billing, expansion of the pool of patients available for hospital admission, consulting fees, and so forth.

However, it would be short-sighted to assume that societal norms alone shape the parameters for defining alcoholism and drug addiction. In some respects, the process of labeling what constitutes substance abuse or dependence restricts drinking and drug-using behavior by members of a given culture. In our culture, public intoxication, drinking early in the morning, drinking while at work, and drinking and driving are considered signs of problem drinking, which are included as indicators in many of our widely used diagnostic instruments (e.g., Michigan Alcoholism Screening Test; Selzer, 1971; Alcohol Use Disorders Identification Test; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). Clearly, these "symptoms"