

## Stimulant Withdrawal

### Diagnostic Criteria

- A. Cessation of (or reduction in) prolonged amphetamine-type substance, cocaine, or other stimulant use.
- B. Dysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criterion A:
  - 1. Fatigue.
  - 2. Vivid, unpleasant dreams.
  - 3. Insomnia or hypersomnia.
  - 4. Increased appetite.
  - 5. Psychomotor retardation or agitation.
- C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

*Specify the particular substance that causes the withdrawal syndrome* (i.e., amphetamine-type substance, cocaine, or other stimulant).

**Coding note:** The ICD-10-CM code depends on whether the stimulant is an amphetamine-type substance, cocaine, or other stimulant and on whether or not there is a comorbid amphetamine-type substance, cocaine, or other stimulant use disorder. If mild amphetamine-type substance or other stimulant use disorder is comorbid, the ICD-10-CM code is **F15.13**. If moderate or severe amphetamine-type substance or other stimulant use disorder is comorbid, the ICD-10-CM code is **F15.23**. For amphetamine-type substance or other stimulant withdrawal occurring in the absence of amphetamine-type substance or other stimulant use disorder (e.g., in a patient taking amphetamine solely under appropriate medical supervision), the ICD-10-CM code is **F15.93**. If mild cocaine use disorder is comorbid, the ICD-10-CM code is **F14.13**. If moderate or severe cocaine use disorder is comorbid, the ICD-10-CM code is **F14.23**. For cocaine withdrawal occurring in the absence of a cocaine use disorder, the ICD-10-CM code is **F14.93**.

### Diagnostic Features

The essential feature of stimulant withdrawal is the presence of a characteristic withdrawal syndrome that develops within a few hours to several days after the cessation of (or marked reduction in) stimulant use (generally high dose) that has been prolonged (Criterion A). The withdrawal syndrome is characterized by the development of dysphoric mood accompanied by two or more of the following physiological changes: fatigue, vivid and unpleasant dreams, insomnia or hypersomnia, increased appetite, and psychomotor retardation or agitation (Criterion B). Bradycardia is often present and is a reliable measure of stimulant withdrawal.

Anhedonia and drug craving can often be present but are not part of the diagnostic criteria. These symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms must not be attributable to another medical condition and are not better explained by another mental disorder (Criterion D).

## Associated Features

Acute withdrawal symptoms (“a crash”) are often seen after periods of repetitive high-dose use (“runs” or “binges”). These symptoms are characterized by intense and unpleasant feelings of lassitude and depression and increased appetite, generally requiring several days of rest and recuperation. Depressive symptoms with suicidal thoughts or behavior can occur and are generally the most serious problems seen during “crashing” or other forms of stimulant withdrawal. Many individuals with stimulant use disorder may experience a withdrawal syndrome at some point.

## Differential Diagnosis

**Stimulant-induced mental disorders.** Stimulant withdrawal is distinguished from stimulant-induced mental disorders (e.g., stimulant-induced depressive disorder, with onset during withdrawal) because the symptoms (e.g., depressed mood) in these latter disorders are in excess of those usually associated with stimulant withdrawal, predominate in the clinical presentation, and are severe enough to warrant clinical attention.

## Comorbidity

Given the typical overlap of stimulant withdrawal with stimulant use disorder, see “Comorbidity” under Stimulant Use Disorder for more details about co-occurring conditions that are likely to be encountered.

# Stimulant-Induced Mental Disorders

The following stimulant-induced mental disorders (which include amphetamine-type substance-, cocaine-, and other stimulant-induced mental disorders) are described in other chapters of the manual with disorders with which they share phenomenology (see the substance/medication-induced mental disorders in these chapters): stimulant-induced psychotic disorder (“Schizophrenia Spectrum and Other Psychotic Disorders”); stimulant-induced bipolar and related disorder (“Bipolar and Related Disorders”); stimulant-induced depressive disorder (“Depressive Disorders”); stimulant-induced anxiety disorder (“Anxiety Disorders”); stimulant-induced obsessive-compulsive disorder (“Obsessive-Compulsive and Related Disorders”); stimulant-induced sleep disorder (“Sleep-Wake Disorders”); stimulant-induced sexual dysfunction (“Sexual Dysfunctions”); and stimulant-induced mild neurocognitive disorder (“Neurocognitive Disorders”). For stimulant intoxication delirium and delirium induced by stimulants taken as prescribed, see the criteria and discussion of delirium in the chapter “Neurocognitive Disorders.” These stimulant-induced mental disorders are diagnosed instead of stimulant intoxication or stimulant withdrawal only when the symptoms are sufficiently severe to warrant independent clinical attention.

## Unspecified Stimulant-Related Disorder

This category applies to presentations in which symptoms characteristic of a stimulant-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific stimulant-related disorder or any of the disorders in the substance-related and addictive disorders diagnostic class.

**Coding note:** The ICD-10-CM code depends on whether the stimulant is an amphetamine-type substance, cocaine, or other stimulant. The ICD-10-CM code for an unspecified amphetamine-type substance or other stimulant-related disorder is **F15.99**. The ICD-10-CM code for an unspecified cocaine-related disorder is **F14.99**.

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## Tobacco-Related Disorders

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Tobacco Use Disorder  
Tobacco Withdrawal  
Tobacco-Induced Mental Disorders  
Unspecified Tobacco-Related Disorder

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### Tobacco Use Disorder

#### Diagnostic Criteria

- A. A problematic pattern of tobacco use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
1. Tobacco is often taken in larger amounts or over a longer period than was intended.
  2. There is a persistent desire or unsuccessful efforts to cut down or control tobacco use.
  3. A great deal of time is spent in activities necessary to obtain or use tobacco.
  4. Craving, or a strong desire or urge to use tobacco.
  5. Recurrent tobacco use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., interference with work).
  6. Continued tobacco use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of tobacco (e.g., arguments with others about tobacco use).
  7. Important social, occupational, or recreational activities are given up or reduced because of tobacco use.
  8. Recurrent tobacco use in situations in which it is physically hazardous (e.g., smoking in bed).
  9. Tobacco use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by tobacco.
  10. Tolerance, as defined by either of the following:
    - a. A need for markedly increased amounts of tobacco to achieve the desired effect.
    - b. A markedly diminished effect with continued use of the same amount of tobacco.
  11. Withdrawal, as manifested by either of the following:
    - a. The characteristic withdrawal syndrome for tobacco (refer to Criteria A and B of the criteria set for tobacco withdrawal).
    - b. Tobacco (or a closely related substance, such as nicotine) is taken to relieve or avoid withdrawal symptoms.

*Specify if:*

**In early remission:** After full criteria for tobacco use disorder were previously met, none of the criteria for tobacco use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use tobacco,” may be met).

**In sustained remission:** After full criteria for tobacco use disorder were previously met, none of the criteria for tobacco use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use tobacco,” may be met).

*Specify if:*

**On maintenance therapy:** The individual is taking a long-term maintenance medication, such as nicotine replacement medication, and no criteria for tobacco use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the nicotine replacement medication).

**In a controlled environment:** This additional specifier is used if the individual is in an environment where access to tobacco is restricted.

**Code based on current severity/remission:** If a tobacco withdrawal or tobacco-induced sleep disorder is also present, do not use the codes below for tobacco use disorder. Instead, the comorbid tobacco use disorder is indicated in the 4th character of the tobacco-induced disorder code (see the coding note for tobacco withdrawal or tobacco-induced sleep disorder). For example, if there is comorbid tobacco-induced sleep disorder and tobacco use disorder, only the tobacco-induced sleep disorder code is given, with the 4th character indicating whether the comorbid tobacco use disorder is moderate or severe: F17.208 for moderate or severe tobacco use disorder with tobacco-induced sleep disorder. It is not permissible to code a comorbid mild tobacco use disorder with a tobacco-induced sleep disorder.

*Specify current severity/remission:*

**Z72.0 Mild:** Presence of 2–3 symptoms.

**F17.200 Moderate:** Presence of 4–5 symptoms.

**F17.201 Moderate, In early remission**

**F17.201 Moderate, In sustained remission**

**F17.200 Severe:** Presence of 6 or more symptoms.

**F17.201 Severe, In early remission**

**F17.201 Severe, In sustained remission**

## Specifiers

“On maintenance therapy” applies as a specifier to be added to “in remission” if the individual is both in remission and on maintenance therapy. “In a controlled environment” applies as a further specifier of remission if the individual is both in remission and in a controlled environment (i.e., in early remission in a controlled environment or in sustained remission in a controlled environment). Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.

## Diagnostic Features

Tobacco use disorder can develop with use of all forms of tobacco (e.g., cigarettes, chewing tobacco, snuff, pipes, cigars, electronic nicotine delivery devices such as electronic cigarettes [e-cigarettes]) and with prescription nicotine-containing medications (nicotine gum and patch). The relative ability of these products to produce tobacco use disorder or to induce withdrawal is associated with the rapidity of the route of administration (smoked over oral over transdermal) and the nicotine content of the product. The name of this substance category was changed from “nicotine” in prior editions of DSM to “tobacco” in DSM-5 on the basis of harms from addiction being associated mostly with tobacco and much less with nicotine.

Tobacco use disorder is common among individuals who use cigarettes and smokeless tobacco daily, is less common among individuals who use e-cigarettes, and is uncommon

among those who do not use tobacco daily or use nicotine medications. Tolerance to tobacco is exemplified by the disappearance of nausea and dizziness after intake and by a more intense effect of tobacco the first time it is used during the day. Cessation of tobacco use can produce a well-defined withdrawal syndrome. Many individuals with tobacco use disorder use tobacco to relieve or to avoid withdrawal symptoms (e.g., after being in a situation where use is restricted). Many individuals with tobacco use disorder have tobacco-related physical symptoms or diseases and continue to smoke. The large majority report craving when they do not smoke for several hours. Spending excessive time using tobacco can be exemplified by chain-smoking (i.e., smoking one cigarette after another with no time between cigarettes). Because tobacco sources are readily and legally available, and because tobacco intoxication is very rare, spending a great deal of time attempting to procure tobacco or recovering from its effects is uncommon. Giving up important social, occupational, or recreational activities can occur when an individual forgoes an activity because it occurs in tobacco use-restricted areas. Use of tobacco rarely results in failure to fulfill major role obligations (e.g., interference with work or home responsibilities), but persistent social or interpersonal problems (e.g., having arguments with others about tobacco use, avoiding social situations because of others' disapproval of tobacco use) or use that is physically hazardous (e.g., smoking in bed, smoking around flammable chemicals) occur at an intermediate prevalence. Although these criteria are less often endorsed by tobacco users, if endorsed, they can indicate a more severe disorder.

## Associated Features

Smoking within 30 minutes of waking, smoking daily, smoking more cigarettes per day, and waking at night to smoke are associated with tobacco use disorder. Environmental cues can evoke craving and withdrawal. Serious medical conditions often occur, including lung and other cancers, cardiac and pulmonary disease, perinatal problems, cough, shortness of breath, and accelerated skin aging.

## Prevalence

Although cigarettes are the most commonly used tobacco product, use of other tobacco products (especially e-cigarettes) has become more common. In the United States, 19% of adults used a tobacco product in the last year, 19% used more than one product, 14% used cigarettes, 4% used cigars, 3% used e-cigarettes, and 2% used smokeless tobacco. One fourth (24%) of current U.S. smokers are nondaily smokers.

The 12-month prevalence of DSM-5 tobacco use disorder in the United States in 2012–2013 was 20% among adults age 18 years and older and 29.6% among Native Americans, 22.3% among non-Latinx Whites, 20.1% among African Americans, 12.2% among Latinx, and 11.2% among Asian Americans and Pacific Islanders. Prevalence was higher among men; those who were young, unmarried, less educated, poor, or residing in the southern United States; and those with almost any psychiatric disorder. The prevalence among current daily smokers is approximately 50%.

Global comparisons show that in all geographic regions of the world, the age-standardized prevalence of daily tobacco smoking is higher in men than in women, but the gender ratio varies greatly, from 16.9:1 in East Asia to 1.2:1 in Australasia.

## Development and Course

About 20% of U.S. high school seniors report having ever smoked cigarettes, and about 5% have used in the past 30 days. Among adolescents who smoke cigarettes at least monthly, most of these individuals will become daily tobacco users in the future. Initiation of smoking after age 21 years is rare. Some of the tobacco use disorder criteria symptoms (e.g., craving) occur soon after beginning tobacco use, suggesting the addiction process begins with initial use; however, fulfilling DSM criteria usually occurs over several years. Non-

daily smoking has become more prevalent since the late 1990s in the United States, especially among individuals ages 18–34 years, Blacks, Hispanics, and individuals with at least a college education.

## Risk and Prognostic Factors

**Temperamental.** Individuals with externalizing personality traits are more likely to initiate tobacco use. Children with attention-deficit/hyperactivity disorder or conduct disorder, and adults with depressive, bipolar, anxiety, personality, psychotic, or other substance use disorders, are at higher risk for starting and continuing tobacco use and of tobacco use disorder.

**Environmental.** Persons with low incomes and low educational levels are more likely to initiate tobacco use and are less likely to stop.

**Genetic and physiological.** Genetic factors contribute to the onset of tobacco use, the continuation of tobacco use, and the development of tobacco use disorder, with a degree of heritability equivalent to that observed with other substance use disorders (i.e., about 50%). Some of this risk is specific to tobacco, and some is common with the vulnerability to developing any substance use disorder.

## Culture-Related Diagnostic Issues

Acceptance of tobacco use varies across cultural contexts. Age-standardized prevalence of daily tobacco smoking varies greatly by geographic region, ranging from 4.7% in Western Sub-Saharan Africa to 24.2% in Eastern Europe. The degree to which these geographic differences are the result of income, education, and tobacco control activities in a country is unclear. Prevalence of tobacco use in the United States varies by age, gender, and ethnoracial background, with lower rates of smoking onset and progression to daily smoking among Black youth, especially young women. Liver enzyme polymorphisms that vary across ethnoracial groups can affect nicotine metabolism, contributing to variation in smoking behavior. Higher tobacco use disorder prevalence is also associated with exposure to racism and ethnic discrimination. Prevalence of DSM-IV nicotine dependence is higher among adult lesbian, gay, and bisexual individuals than among heterosexuals, possibly also due to an association with exposure to sexual orientation-related discrimination. Among individuals with DSM-IV nicotine dependence, lower income and education are associated with disorder persistence.

## Sex- and Gender-Related Diagnostic Issues

The ratio of men to women among U.S. smokers is approximately 1.4:1 and has been stable between 2004 and 2014. This ratio is generally consistent across various income and educational levels. The ratio diminishes in older age groups as fewer men are smoking as age increases. The literature from several U.S. settings suggests that negative reinforcement (i.e., that smoking relieves negative affect) is a greater motivator in women than in men. Menstrual cycle effects on smoking are found inconsistently, but tobacco withdrawal appears worse in the luteal than the follicular phase of the cycle. Pregnant females smoke at a lower rate than nonpregnant females but relapse back to smoking rapidly after delivery.

## Diagnostic Markers

The following biomarkers can be used to measure the extent of tobacco or nicotine use: carbon monoxide in the breath and nicotine and its metabolite cotinine in blood, saliva, or urine; however, these are only weakly associated with tobacco use disorder.

## Association With Suicidal Thoughts or Behavior

National U.S. survey data show that past-year cigarette use is associated with a two- to threefold increased risk of suicidal thoughts and behavior, with earlier age at first tobacco use increasing risk. Evidence from the U.S. Veterans Health Administration shows that even after adjustment for covariates, tobacco use disorder is associated with an increased risk of suicide. A large study of twins in Finland found that the relationship between tobacco use and suicide increased in a dose-response manner, and that for identical twins discordant for tobacco use, tobacco use was associated with a sixfold increased risk for suicide.

## Functional Consequences of Tobacco Use Disorder

Medical consequences of tobacco use often begin when tobacco users are in their 40s and usually become progressively more debilitating over time. One-half of smokers who do not stop using tobacco will die early from a tobacco-related illness, and smoking-related morbidity occurs in more than one-half of tobacco users. Most medical conditions result from exposure to carbon monoxide, tars, and other non-nicotine components of tobacco. The major predictor of reversibility is duration of smoking. Secondhand smoke increases the risk of heart disease and cancer by 30%. Long-term use of nicotine medications does not appear to cause medical harm.

## Comorbidity

The most common medical conditions from smoking are cardiovascular illnesses, chronic obstructive pulmonary disease, and cancers. Smoking also increases perinatal problems, such as low birth weight and miscarriage. Prevalence of smoking is almost twice as high in individuals with major depressive disorder; although the prevalence of smoking in the United States is higher among individuals with low socioeconomic status, the increased prevalence of smoking among those with depression is independent of socioeconomic status. The most common psychiatric comorbidities associated with smoking are alcohol and other substance, depressive, bipolar, anxiety, personality, and attention-deficit/hyperactivity disorders. In the United States, individuals with a psychiatric disorder are three times more likely than others to have tobacco use disorder. Adults with DSM-5 tobacco use disorder are significantly more likely than other adults to have comorbid psychiatric disorders, including other DSM-5 substance use disorders, major depressive disorder, bipolar I disorder, panic disorder, generalized anxiety disorder, posttraumatic stress disorder, and borderline and antisocial personality disorders.

# Tobacco Withdrawal

## Diagnostic Criteria

**F17.203**

- A. Daily use of tobacco for at least several weeks.
- B. Abrupt cessation of tobacco use, or reduction in the amount of tobacco used, followed within 24 hours by four (or more) of the following signs or symptoms:
  1. Irritability, frustration, or anger.
  2. Anxiety.
  3. Difficulty concentrating.
  4. Increased appetite.
  5. Restlessness.
  6. Depressed mood.
  7. Insomnia.

- C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The signs or symptoms are not attributed to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

**Coding note:** The ICD-10-CM code for tobacco withdrawal is **F17.203**. Note that the ICD-10-CM code indicates the comorbid presence of a moderate or severe tobacco use disorder, reflecting the fact that tobacco withdrawal can only occur in the presence of a moderate or severe tobacco use disorder.

## Diagnostic Features

Withdrawal symptoms impair the ability to stop tobacco use. The symptoms after abstinence from tobacco are in large part due to nicotine deprivation. Tobacco withdrawal is common among daily tobacco users who stop or reduce their use of tobacco. Symptoms are more intense among individuals who smoke cigarettes and also use smokeless tobacco or electronic cigarettes daily. This symptom intensity is likely attributable to the more rapid onset and higher levels of nicotine with cigarette smoking. Significant withdrawal among those who are nondaily cigarette users or use only nicotine medications is uncommon.

Typically, heart rate decreases by 5–12 bpm in the first few days after stopping smoking, and weight increases an average of 4–7 lb (2–3 kg) over the first year after stopping smoking. Tobacco withdrawal can produce clinically significant mood changes and functional impairment. Because of conditioning effects, withdrawal can be prompted by environmental cues such as seeing others smoking. Gradual reduction of tobacco decreases the severity of withdrawal.

## Associated Features

Craving for tobacco or nicotine is very common during abstinence and has a large effect on the ability to remain abstinent. Abstinence can increase impulsivity and anhedonia and can decrease positive affect. Abstinence from tobacco or nicotine also appears to increase craving for sweet or sugary foods and impairs performance on tasks requiring vigilance. Smoking increases the metabolism of many medications used to treat mental disorders; thus, cessation of smoking can increase the blood levels of these medications, and this can produce clinically significant outcomes. This effect appears to be due not to nicotine but rather to other compounds in tobacco.

## Prevalence

Approximately 50% of daily smokers who quit for 2 or more days will have four or more symptoms of tobacco withdrawal. The most commonly endorsed signs and symptoms are anxiety, irritability, and difficulty concentrating. The least commonly endorsed symptoms are depression and insomnia.

## Development and Course

Tobacco withdrawal usually begins within 24 hours of stopping or cutting down tobacco use, peaks at 2–3 days after abstinence, and usually lasts 2–3 weeks. Tobacco withdrawal symptoms can occur among adolescent tobacco users, even prior to daily tobacco use. Prolonged symptoms beyond 1 month can occur but are uncommon.

## Risk and Prognostic Factors

**Temperamental.** Smokers with depressive disorders, bipolar disorders, anxiety disorders, attention-deficit/hyperactivity disorder, and other substance use disorders have more severe withdrawal.

**Genetic and physiological.** Genotype can influence the probability of withdrawal upon abstinence.

### **Diagnostic Markers**

The following biomarkers can be used to measure the extent of tobacco or nicotine use but are only weakly associated with tobacco withdrawal: carbon monoxide in the breath and nicotine and its metabolite cotinine in blood, saliva, or urine.

### **Functional Consequences of Tobacco Withdrawal**

Tobacco withdrawal can cause significant distress and difficulty functioning in a minority of smokers, but this may be uncommon. Withdrawal impairs the ability to stop or control tobacco use. Whether tobacco withdrawal can prompt the development of a new mental disorder or recurrence of a mental disorder is debatable, but if this occurs, it would be in a small minority of tobacco users.

### **Differential Diagnosis**

The symptoms of tobacco withdrawal overlap with those of other substance withdrawal syndromes (e.g., alcohol withdrawal; sedative, hypnotic, or anxiolytic withdrawal; stimulant withdrawal; caffeine withdrawal; opioid withdrawal); caffeine intoxication; anxiety, depressive, bipolar, and sleep disorders; and medication-induced akathisia. Admission to smoke-free inpatient units or voluntary smoking cessation can induce withdrawal symptoms that mimic, intensify, or disguise other disorders or adverse effects of medications used to treat mental disorders (e.g., irritability thought to be due to alcohol withdrawal could be due to tobacco withdrawal). Reduction in symptoms with the use of nicotine confirms the diagnosis.

### **Comorbidity**

Given the typical overlap of tobacco withdrawal with tobacco use disorder, see “Comorbidity” under Tobacco Use Disorder for more details about co-occurring conditions that are likely to be encountered.

## **Tobacco-Induced Mental Disorders**

Tobacco-induced sleep disorder is discussed in the chapter “Sleep-Wake Disorders” (see “Substance/Medication-Induced Sleep Disorder”).

## **Unspecified Tobacco-Related Disorder**

**F17.209**

This category applies to presentations in which symptoms characteristic of a tobacco-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific tobacco-related disorder or any of the disorders in the substance-related and addictive disorders diagnostic class.

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## Other (or Unknown) Substance-Related Disorders

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Other (or Unknown) Substance Use Disorder

Other (or Unknown) Substance Intoxication

Other (or Unknown) Substance Withdrawal

Other (or Unknown) Substance-Induced Mental Disorders

Unspecified Other (or Unknown) Substance-Related Disorder

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### Other (or Unknown) Substance Use Disorder

#### Diagnostic Criteria

- A. A problematic pattern of use of an intoxicating substance not able to be classified within the alcohol; caffeine; cannabis; hallucinogen (phencyclidine and others); inhalant; opioid; sedative, hypnotic, or anxiolytic; stimulant; or tobacco categories and leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
1. The substance is often taken in larger amounts or over a longer period than was intended.
  2. There is a persistent desire or unsuccessful efforts to cut down or control use of the substance.
  3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
  4. Craving, or a strong desire or urge to use the substance.
  5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
  6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
  7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
  8. Recurrent use of the substance in situations in which it is physically hazardous.
  9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
  10. Tolerance, as defined by either of the following:
    - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    - b. A markedly diminished effect with continued use of the same amount of the substance.
  11. Withdrawal, as manifested by either of the following:
    - a. The characteristic withdrawal syndrome for other (or unknown) substance (refer to Criteria A and B of the criteria sets for other [or unknown] substance withdrawal).