Substance-Related and Addictive Disorders

The substance-related disorders encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] and other hallucinogens); inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances. These 10 classes are not fully distinct. All drugs that are taken in excess have in common the ability to directly activate the brain reward systems, which are involved in the reinforcement of behaviors and establishment of memories. Instead of achieving reward system activation through adaptive behaviors, these substances produce such an intense activation of the reward system that normal activities may be neglected. The pharmacological mechanisms by which each class of drugs produces reward are different, but the drugs typically activate the system and produce feelings of pleasure, often referred to as a "high." Furthermore, studies suggest that the neurobiological roots of substance use disorders for some individuals can be seen in their behaviors long before the onset of actual substance use (e.g., lower levels of self-control may reflect impairments of brain inhibitory mechanisms); research also suggests the negative impact of substance use itself on brain inhibitory mechanisms.

Note that the phrase "drug addiction" is not applied as a diagnostic term in this classification, although it is in common usage in many countries to describe severe problems related to compulsive and habitual use of substances. The more neutral term *substance use disorder* is used to describe the wide range of the disorder, from a mild form to a severe state of chronically relapsing, compulsive pattern of drug taking. Some clinicians will choose to use the phrase "drug addiction" to describe more severe presentations, but that wording is omitted from the official DSM-5 substance use disorder diagnostic terminology because of its uncertain definition and its potentially negative connotation.

In addition to the substance-related disorders, this chapter also includes gambling disorder, reflecting evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse and that produce some behavioral symptoms that appear comparable to those produced by the substance use disorders. Other excessive behavioral patterns, such as Internet gaming (see "Conditions for Further Study"), have also been described, but the research on these and other behavioral syndromes is less clear. Thus, groups of repetitive behaviors, sometimes termed *behavioral addictions* (with subcategories such as "sex addiction," "exercise addiction," and "shopping addiction"), are not included because there is insufficient peer-reviewed evidence to establish the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders.

The substance-related disorders are divided into two groups: substance use disorders and substance-induced disorders. The following conditions may be classified as substance-induced: substance intoxication, substance withdrawal, and substance/medication-induced mental disorders (diagnostic criteria and text are provided in this manual for substance/medication-induced psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium, and neurocognitive disorders in their respective chapters). The term

substance/medication-induced mental disorder refers to symptomatic presentations that are due to the physiological effects of an exogenous substance on the central nervous system and includes typical intoxicants (e.g., alcohol, inhalants, cocaine), psychotropic medications (e.g., stimulants, sedative-hypnotics), other medications, (e.g., steroids), and environmental toxins (e.g., organophosphate insecticides).

The current section begins with a general discussion of criteria sets for substance use disorder, substance intoxication, substance withdrawal, and substance/medication-induced mental disorders, at least some of which are applicable across classes of substances. Reflecting some unique aspects of the 10 substance classes relevant to this chapter, the remainder of the chapter is organized by substance class. To facilitate differential diagnosis, the diagnostic criteria and text for the substance/medication-induced mental disorders are included with disorders with which they share phenomenology (e.g., substance/medication-induced depressive disorder is in the chapter "Depressive Disorders"). Note that only certain classes of drugs are capable of causing particular types of substance-induced disorders. The substance-related diagnostic categories associated with specific drug classes are shown in Table 1.

Substance-Related Disorders

Substance Use Disorders

Diagnostic Features

The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. As seen in Table 1, the diagnosis of a substance use disorder can be applied to all 10 substance classes included in this chapter except caffeine. For certain classes, some symptoms are less salient, and in a few instances not all symptoms apply (e.g., withdrawal symptoms are not specified for phencyclidine use disorder, other hallucinogen use disorder, or inhalant use disorder). Of note, the consumption of substances, including prescribed medications, may depend in part on cultural background, substance availability, and specific local drug regulations. Thus, there can be significant local or cultural variation in exposure (e.g., countries with cultural prohibitions against alcohol or other substance use may have a lower prevalence of substance-related disorders).

An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment.

Overall, the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance. To assist with organization, the diagnostic items making up Criterion A can be considered to fit within overall groupings of *impaired control*, *social impairment*, *risky use*, and *pharmacological criteria*. Impaired control over substance use is the first criteria grouping (Criteria 1–4). The individual may take the substance in larger amounts or over a longer period than was originally intended (Criterion 1). The individual may express a persistent desire to cut down or regulate substance use and may report mul-

TABLE 1 Diagnoses associated with substance class

	Psychotic disorders	Bipolar and related disorders	Depressive disorders	Anxiety disorders	Obsessive-compulsive and related disorders	Sleep disorders	Sexual dysfunctions	Delirium	Neurocognitive disorders	Substance use disorders	Substance intoxication	Substance withdrawal
Alcohol	I/W	I/W	I/W	I/W		I/W	I/W	I/W	X (mild; major)	X	X	X
Caffeine				I		I/W					X	X
Cannabis	I			I		I/W		I		X	X	X
Hallucinogens												
Phencyclidine	I	I	I	I				I		X	X	
Other hallucinogens	I*	I	I	I				I		X	X	
Inhalants	I		I	I				I	X (mild; major)	X	X	
Opioids			I/W	W		I/W	I/W	I/W		X	X	X
Sedatives, hypnotics, or anxiolytics	I/W	I/W	I/W	W		I/W	I/W	I/W	X (mild; major)	X	X	X
Stimulants**	I	I/W	I/W	I/W	I/W	I/W	I	I	X (mild)	X	X	X
Tobacco						W				X		X
Other (or unknown)	I/W	I/W	I/W	I/W	I/W	I/W	I/W	I/W	X (mild; major)	X	X	X

Note. X = The category is recognized in DSM-5.
I = The specifier "with onset during intoxication" may be noted for the category.
W = The specifier "with onset during withdrawal" may be noted for the category.
I/W = Either "with onset during intoxication" or "with onset during withdrawal" may be noted for the category.
Major=major neurocognitive disorder; mild=mild neurocognitive disorder.
*Also hallucinogen persisting perception disorder (flashbacks).
**Includes amphetamine-type substances, cocaine, and other or unspecified stimulants.

tiple unsuccessful efforts to decrease or discontinue use (Criterion 2). The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects (Criterion 3). In some instances of more severe substance use disorders, virtually all of the individual's daily activities revolve around the substance. Craving (Criterion 4) is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used. Craving has also been shown to involve classical conditioning and is associated with activation of specific reward structures in the brain. Craving might be queried by asking if there has ever been a time when there were such strong urges to take the drug that the individual could not think of anything else. Current craving is often used as a treatment outcome measure because it may be a signal of impending relapse.

Social impairment is the second grouping of criteria (Criteria 5–7). Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home (Criterion 5). The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (Criterion 6). Important social, occupational, or recreational activities may be given up or reduced because of substance use (Criterion 7). The individual may withdraw from family activities and hobbies in order to use the substance.

Risky use of the substance is the third grouping of criteria (Criteria 8–9). This may take the form of recurrent substance use in situations in which it is physically hazardous (Criterion 8). The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (Criterion 9). The key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite the difficulty it is causing.

Pharmacological criteria are the final grouping (Criteria 10 and 11). Tolerance (Criterion 10) is signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed. The degree to which tolerance develops varies greatly across different individuals as well as across substances and may involve a variety of central nervous system effects. For example, tolerance to respiratory depression and tolerance to sedating and motor coordination may develop at different rates, depending on the substance. Tolerance may be difficult to determine by history alone, and laboratory tests may be helpful (e.g., high blood levels of the substance coupled with little evidence of intoxication suggest that tolerance is likely). Tolerance must also be distinguished from individual variability in the initial sensitivity to the effects of particular substances. For example, some first-time alcohol drinkers show very little evidence of intoxication with three or four drinks, whereas others of similar weight and drinking histories have slurred speech and incoordination.

Withdrawal (Criterion 11) is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged, heavy use of the substance. After developing withdrawal symptoms, the individual is likely to consume the substance to relieve the symptoms. Withdrawal symptoms vary greatly across the classes of substances, and separate criteria sets for withdrawal are provided for the drug classes. Marked and generally easily measured physiological signs of withdrawal are common with alcohol, opioids, and sedatives, hypnotics, and anxiolytics. Withdrawal signs and symptoms with stimulants (amphetamine-type substances, cocaine, other or unspecified stimulants), as well as tobacco and cannabis, are often present but may be less apparent. Significant withdrawal has *not* been documented in humans after repeated use of phencyclidine, other hallucinogens, and inhalants; therefore, this criterion is not included for these substances. Neither tolerance nor withdrawal is necessary for a diagnosis of a substance use disorder. However, for most classes of substances, a past history of withdrawal is associated with a

more severe clinical course (i.e., an earlier onset of a substance use disorder, higher levels of substance intake, and a greater number of substance-related problems).

Symptoms of tolerance and withdrawal occurring during appropriate use of prescribed medications given as part of medical treatment (e.g., opioid analgesics, sedatives, stimulants) are specifically *not* counted when diagnosing a substance use disorder. The appearance of normal, expected pharmacological tolerance and withdrawal during the course of medical treatment has been known to lead to an erroneous diagnosis of "addiction" even when these were the only symptoms present. Individuals whose *only* symptoms are those that occur as a result of medical treatment (i.e., tolerance and withdrawal as part of medical care when the medications are taken as prescribed) should not receive a diagnosis solely on the basis of these symptoms. However, prescription medications can be used inappropriately, and a substance use disorder can be correctly diagnosed when there are other symptoms of compulsive, drug-seeking behavior.

Severity and Specifiers

Substance use disorders occur in a broad range of severity, from mild to severe, with severity based on the number of diagnostic criteria that are met. As a general estimate of severity, a *mild* substance use disorder is suggested by the presence of two to three symptoms, *moderate* by four to five symptoms, and *severe* by six or more symptoms. Changing severity across time is also reflected by reductions or increases in the frequency and/or dose of substance use, as assessed by the individual's own report, report of knowledgeable others, clinician's observations, and biological testing. The following course specifiers and descriptive features specifiers are also available for substance use disorders: "in early remission," "in sustained remission," "on maintenance therapy," and "in a controlled environment." Definitions of each are provided within respective criteria sets.

Recording Procedures

The clinician should use the code that applies to the substance class but record the name of the *specific substance.* For example, the clinician should record F13.20 moderate alprazolam use disorder (rather than moderate sedative, hypnotic, or anxiolytic use disorder) or F15.10 mild methamphetamine use disorder (rather than mild amphetamine-type substance use disorder). For substances that do not fit into any of the classes (e.g., anabolic steroids), the ICD-10-CM code for other (or unknown) substance use disorder should be used and the specific substance indicated (e.g., F19.10 mild anabolic steroid use disorder). If the substance taken by the individual is unknown, the same ICD-10-CM code (i.e., for "other [or unknown] substance use disorder") should be used (e.g., F19.20 severe unknown substance use disorder). If criteria are met for more than one substance use disorder, each should be diagnosed (e.g., F11.20 severe heroin use disorder; F14.20 moderate cocaine use disorder).

The appropriate ICD-10-CM code for a substance use disorder depends on whether there is a comorbid substance-induced disorder (including substance intoxication and substance withdrawal). In the first example in the paragraph above, the diagnostic code for moderate alprazolam use disorder, F13.20, reflects the absence of a comorbid alprazolam-induced mental disorder. Because ICD-10-CM codes for substance-induced disorders indicate both the presence (or absence) and the severity of the substance use disorder, ICD-10-CM codes for substance use disorders can be used only in the absence of a substance-induced disorder. See the individual substance-specific sections for additional coding information.

Substance-Induced Disorders

The overall category of substance-induced disorders includes substance intoxication, substance withdrawal, and substance/medication-induced mental disorders (e.g., substance-induced psychotic disorder, substance-induced depressive disorder). While substance intoxication and substance withdrawal are recognized as mental disorders, for purposes of clarity of reference in discussions across this chapter, the term *substance/medication-induced mental disorder* (e.g., alcohol-induced depressive disorder, methamphetamine-induced anxiety disorder) is used to distinguish these disorders from substance intoxication and substance withdrawal.

Substance Intoxication and Substance Withdrawal

Criteria for the substance-specific intoxication syndromes are included within the substance-specific sections of this chapter. The essential feature is the development of a reversible substance-specific syndrome due to the recent ingestion of a substance (Criterion A). The clinically significant problematic behavioral or psychological changes associated with intoxication (e.g., belligerence, mood lability, impaired judgment) are attributable to the physiological effects of the substance on the central nervous system (CNS) and develop during or shortly after use of the substance (Criterion B) and are accompanied by substance-specific signs and symptoms (Criterion C). The symptoms are not attributable to another medical condition and are not better explained by another mental disorder (Criterion D). Substance intoxication is common among individuals with a substance use disorder but also occurs frequently in persons who use substances but do not have a substance use disorder. This category does *not* apply to tobacco.

The most common changes in substance intoxication involve disturbances of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior. Short-term, or "acute," substance intoxications may have different signs and symptoms from sustained, or "chronic," substance intoxications. For example, moderate cocaine doses may initially produce gregariousness, but social withdrawal may develop if such doses are frequently repeated over days or weeks.

When used in the physiological sense, the term *intoxication* is broader than the diagnosis of substance intoxication as defined in this manual. Many substances may produce physiological or psychological changes that are not necessarily problematic. For example, an individual with tachycardia from substance use is experiencing a physiological effect from the substance, but if this is the only symptom in the absence of problematic behavior, the diagnosis of substance intoxication would not apply. Intoxication may sometimes persist beyond the time when the substance is detectable in the body. This may be attributable to enduring CNS effects, from which the recovery takes longer than the time for elimination of the substance. These longer-term effects of intoxication must be distinguished from *withdrawal* (i.e., symptoms initiated by a decline in blood or tissue concentrations of a substance).

Criteria for substance withdrawal are also included within the substance-specific sections of this chapter. The essential feature is the development of a substance-specific problematic behavioral change, with physiological and cognitive concomitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use (Criterion A). The substance-specific syndrome (Criterion B) causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The symptoms are not due to another medical condition and are not better explained by another mental disorder (Criterion D). Withdrawal is usually, but not always, associated with a substance use disorder. Also, it is important to emphasize that symptoms of withdrawal occurring during appropriate use of medications given as part of medical treatment with

prescribed medications (e.g., opioid analgesics, sedatives, stimulants) are specifically *not* counted when diagnosing a substance use disorder. Most individuals with withdrawal have an urge to readminister the substance to reduce the symptoms.

Route of Administration and Speed of Substance Effects

Routes of administration that produce more rapid and efficient absorption into the bloodstream (e.g., intravenous, smoking, intranasal "snorting") tend to result in a more intense intoxication and an increased likelihood of an escalating pattern of substance use leading to withdrawal. Similarly, rapidly acting substances are more likely than slower-acting substances to produce immediate intoxication.

Duration of Effects

Within the same drug category, relatively short-acting substances tend to have a higher potential for the development of withdrawal than do those with a longer duration of action. However, longer-acting substances tend to have longer duration of withdrawal symptoms. The half-life of the substance parallels aspects of withdrawal: the longer the duration of action, the longer the time between cessation and the onset of withdrawal symptoms and the longer the withdrawal duration. In general, the longer the acute withdrawal period, the less intense the syndrome tends to be.

Use of Multiple Substances

Substance intoxication and withdrawal often involve several substances used simultaneously or sequentially. In these cases, each diagnosis should be recorded separately.

Associated Laboratory Findings

Laboratory analyses of blood and urine samples can help determine recent use and the specific substances involved. However, a positive laboratory test result does not by itself indicate that the individual has a pattern of substance use that meets criteria for a substance-induced or substance use disorder, and a negative test result does not by itself rule out a diagnosis.

Laboratory tests can be useful in identifying withdrawal. If the individual presents with withdrawal from an unknown substance, laboratory tests may help identify the substance and may also be helpful in differentiating withdrawal from other mental disorders. In addition, normal functioning in the presence of high blood levels of a substance suggests considerable tolerance.

Development and Course

Individuals ages 18–24 years have relatively high prevalence rates for the use of virtually every substance. Intoxication is usually the initial substance-related disorder and often begins in the teens. Withdrawal can occur at any age as long as the relevant drug has been taken in sufficient doses over an extended period of time.

Recording Procedures for Substance Intoxication and Substance Withdrawal

The clinician should use the code that applies to the class of substances but record the name of the *specific substance.* For example, the clinician should record F13.230 secobarbital withdrawal (rather than sedative, hypnotic, or anxiolytic withdrawal) or F15.120 methamphetamine intoxication (rather than amphetamine-type substance intoxication). Note that

the appropriate ICD-10-CM diagnostic codes for substance intoxication and substance withdrawal depend on whether there is a comorbid substance use disorder. In this case, the F15.120 code for methamphetamine intoxication indicates the presence of a comorbid mild methamphetamine use disorder. If there had been no comorbid methamphetamine use disorder (and no perceptual disturbances), the diagnostic code would have been F15.920. See the coding note for the substance-specific intoxication and withdrawal syndromes for the actual coding options.

For substances that do not fit into any of the classes (e.g., anabolic steroids), the ICD-10-CM code for other (or unknown) substance intoxication or other (or unknown) substance withdrawal should be used and the specific substance indicated (e.g., F19.920 anabolic steroid intoxication). If the substance taken by the individual is unknown, the same code (i.e., for the class "other [or unknown] substance") should be used (e.g., F19.920 unknown substance intoxication). If there are symptoms or problems associated with a particular substance but criteria are not met for any of the substance-specific disorders, the unspecified category can be used (e.g., F12.99 unspecified cannabis-related disorder).

As noted above, the substance-related codes in ICD-10-CM combine the substance use disorder aspect of the clinical picture and the substance-induced aspect into a single combined code. Thus, if both heroin withdrawal and moderate heroin use disorder are present, the single code F11.23 for heroin withdrawal is given to cover both presentations. See the individual substance-specific sections for additional coding information.

Substance/Medication-Induced Mental Disorders

The substance/medication-induced mental disorders are potentially severe, usually temporary, but sometimes persisting CNS syndromes that develop in the context of the effects of substances of abuse, medications, and some toxins. They are distinguished from the substance use disorders, in which a cluster of cognitive, behavioral, and physiological symptoms contribute to the continued use of a substance despite significant substance-related problems. The substance/medication-induced mental disorders may be induced by any of the 10 classes of substances that produce substance use disorders, or by a great variety of other medications used in medical treatment. Each substance/medication-induced mental disorder is described in the relevant chapter (e.g., substance/medication-induced depressive disorder is located in "Depressive Disorders"), and therefore, only a brief description is offered here. All substance/medication-induced disorders share common characteristics. It is important to recognize these common features to aid in the detection of these disorders. These features are described as follows:

A. A clinically significant presentation of symptoms characteristic of disorders in the relevant diagnostic class predominates in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings of both of the following:
    1. The symptoms in Criterion A developed during or soon after substance intoxication, substance withdrawal, or exposure to or withdrawal from a medication; and
    2. The involved substance/medication is capable of producing the symptoms in Criterion A.
C. The disturbance is not better explained by an independent mental disorder (i.e., one that is not substance- or medication-induced). Such evidence of an independent mental disorder could include the following:
    1. The disturbance preceded the onset of severe intoxication or withdrawal or exposure to the medication; or
    2. The disturbance persisted for a substantial period of time (e.g., at least 1 month) after the cessation of acute withdrawal or severe intoxication or taking the medica-

tion. This criterion does not apply to substance-induced neurocognitive disorders or hallucinogen persisting perception disorder, which persist beyond the cessation of acute intoxication or withdrawal.

D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic and Associated Features

Some generalizations can be made regarding the categories of substances capable of producing clinically relevant substance-induced mental disorders. In general, the more sedating drugs (sedative, hypnotics, or anxiolytics, and alcohol) can produce prominent and clinically significant depressive disorders during intoxication, while anxiety conditions are likely to be observed during withdrawal syndromes from these substances. Also, during intoxication, the more stimulating substances (e.g., amphetamines and cocaine) are likely to be associated with substance-induced psychotic disorders and substance-induced anxiety disorders, and with substance-induced major depressive episodes observed during withdrawal. Both the more sedating and the more stimulating drugs are likely to produce significant but temporary sleep and sexual disturbances. An overview of the relationship between specific categories of substances and specific psychiatric syndromes is presented in Table 1.

The medication-induced conditions include what are often idiosyncratic CNS reactions or relatively extreme examples of side effects for a wide range of medications taken for a variety of medical concerns. These include neurocognitive complications of anesthetics, antihistamines, antihypertensives, and a variety of other medications and toxins (e.g., organophosphates, insecticides, carbon monoxide), as described in the chapter on neurocognitive disorders. Psychotic syndromes may be temporarily experienced in the context of anticholinergic, cardiovascular, and steroid drugs, as well as during use of stimulant-like and depressant-like prescription or over-the-counter drugs. Temporary but severe mood disturbances can be observed with a wide range of medications, including steroids, antihypertensives, disulfiram, and any prescription or over-the-counter depressant or stimulant-like substances. A similar range of medications can be associated with temporary anxiety syndromes, sexual dysfunctions, and conditions of disturbed sleep.

In general, to be considered a substance/medication-induced mental disorder, there must be evidence that the symptoms being observed are not likely to be better explained by an independent mental disorder. The latter is more likely to be the case if the symptoms were present before the severe intoxication or withdrawal or medication administration, or, with the exception of several substance-induced persisting disorders listed in Table 1, continued more than 1 month after cessation of acute withdrawal, severe intoxication, or use of the medications. When symptoms are only observed during a substance-induced delirium (e.g., alcohol withdrawal delirium), only the delirium should be diagnosed, and other psychiatric symptoms occurring during the delirium should not also be diagnosed separately, as many of these symptoms (e.g., disturbances in mood, anxiety, reality testing) are commonly seen during agitated, confused states. The features associated with each relevant major mental disorder are similar whether observed with independent or substance/medication-induced mental disorders. However, individuals with substance/medication-induced mental disorders are likely to also demonstrate the associated features seen with the specific category of substance or medication, as listed in other subsections of this chapter.

Development and Course

Substance-induced mental disorders develop in the context of intoxication with or withdrawal from substances of abuse, whereas medication-induced mental disorders can be seen with prescribed or over-the-counter medications that are taken at the suggested doses.

Both conditions are usually temporary and likely to disappear within 1 month or so of cessation of acute withdrawal, severe intoxication, or use of the medication. Exceptions to these generalizations occur for certain long-duration substance-induced disorders: substance-associated neurocognitive disorders that relate to conditions such as alcohol-induced neurocognitive disorder, inhalant-induced neurocognitive disorder, and sedative-, hypnotic-, or anxiolytic-induced neurocognitive disorder; and hallucinogen persisting perception disorder ("flashbacks"; see the section "Hallucinogen-Related Disorders" later in this chapter). However, most substance/medication-induced mental disorders, regardless of the severity of the symptoms, are likely to improve relatively quickly with abstinence and unlikely to remain clinically relevant for more than 1 month after complete cessation of use.

As is true of many consequences of heavy substance use, some individuals are more and others less prone toward developing specific substance-induced disorders. Similar types of predispositions may make some individuals more likely to develop psychiatric side effects of some types of medications, but not others. However, it is unclear whether individuals with family histories or personal prior histories of independent psychiatric syndromes are more likely to develop the induced syndrome once the consideration is made as to whether the quantity and frequency of the substance were sufficient to lead to the development of a substance-induced syndrome.

There are indications that the intake of substances of abuse or some medications with psychiatric side effects in the context of a preexisting mental disorder is likely to result in an intensification of the symptoms of the preexisting mental disorder. The risk for substance/medication-induced mental disorders is likely to increase with both the quantity and the frequency of consumption of the relevant substance.

The symptom profiles for the substance/medication-induced mental disorders resemble independent mental disorders. While the symptoms of substance/medication-induced mental disorders can be identical to those of independent mental disorders (e.g., delusions, hallucinations, psychoses, major depressive episodes, anxiety syndromes), and although they can have the same severe consequences (e.g., suicide), most induced mental disorders are likely to improve in a matter of days to weeks of abstinence.

The substance/medication-induced mental disorders are an important part of the differential diagnoses for the independent psychiatric conditions. The importance of recognizing an induced mental disorder is similar to the relevance of identifying the possible role of some medical conditions and medication reactions before diagnosing an independent mental disorder. Symptoms of substance- and medication-induced mental disorders may be identical cross-sectionally to those of independent mental disorders but have different treatments and prognoses from the independent condition.

Functional Consequences of Substance/Medication-Induced Mental Disorders

The same consequences related to the relevant independent mental disorder (e.g., suicide attempts) are likely to apply to the substance/medication-induced mental disorders, but these are likely to disappear within 1 month after abstinence. Similarly, the same functional consequences associated with the relevant substance use disorder are likely to be seen for the substance-induced mental disorders.

Recording Procedures for Substance/Medication-Induced Mental Disorders

Diagnostic criteria, coding notes, and recording procedures for the specific substance/medication-induced mental disorders are provided in chapters of the manual corresponding with disorders of shared phenomenology (see the substance/medication-induced