

function test results are common, either as a result of resolving hepatitis or from toxic injury to the liver due to contaminants that have been mixed with the injected opioid. HIV is also prevalent in injection opioid users. Subtle changes in cortisol secretion patterns and body temperature regulation have been observed for up to 6 months following opioid withdrawal.

Association With Suicidal Thoughts or Behavior

Opioid use disorder is associated with a heightened risk for suicide attempts and suicide. Some suicide risk factors overlap with risk factors for an opioid use disorder. In addition, repeated opioid intoxication or withdrawal may be associated with severe depressions that although temporary can be intense enough to lead to suicide attempts and suicide. Nonfatal accidental opioid overdose and attempted suicide are distinct phenomena that can be difficult to differentiate but should not be mistaken for each other, if possible.

Findings from the Global Burden of Disease Study 2010 showed that among drugs of abuse, suicide is a common cause of death among regular users of opioids. Evidence suggests that suicides are undercounted or often misclassified in opioid-poisoning data. In a study of the Veterans Health Administration (VHA) national medical records, after adjustment for psychiatric comorbidity, opioid use disorder elevated the risk for suicide mortality, with greater increase in risk among women than among men. In another study also using VHA national medical records, among veterans prescribed opioids for chronic pain, suicide mortality increased with higher opioid doses, even after demographic and clinical factors were taken into account. A follow-up of a U.S. national cohort of adults with a history of an opioid overdose found that the standardized mortality ratio (SMR; the ratio between the observed number of deaths in a study population and the number of deaths that would be expected) was 25.9 for suicide, with a higher SMR for women than for men. A review posited that the reasons for the increased risk for suicide among opioid users were related to shared risk factors, namely, comorbid mental disorders and pain.

Functional Consequences of Opioid Use Disorder

Physiologically, opioid use is associated with a lack of mucous membrane secretions, causing dry mouth and nose. Slowing of gastrointestinal activity and a decrease in gut motility can produce severe constipation. Visual acuity may be impaired as a result of pupillary constriction with acute administration. In individuals who inject opioids, sclerosed veins (“tracks”) and puncture marks on the lower portions of the upper extremities are common. Veins sometimes become so severely sclerosed that peripheral edema develops, and individuals switch to injecting in veins in the legs, neck, or groin. When these veins become unusable, individuals often inject directly into their subcutaneous tissue (“skin-popping”), resulting in cellulitis, abscesses, and circular-appearing scars from healed skin lesions. Tetanus and *Clostridium botulinum* infections are rare but serious consequences of injecting opioids, especially with contaminated needles. Infections may also occur in other organs and include bacterial endocarditis, hepatitis, and HIV infection. Hepatitis C infections, for example, may occur in up to 90% of individuals who inject opioids. In addition, the prevalence of HIV infection is high among individuals who inject drugs, a large proportion of whom are individuals with opioid use disorder. For example, HIV infection rates are as high as 60% among heroin users in some areas of the United States and the Russian Federation. However, the incidence may be much lower in areas where access to clean injection material and paraphernalia is facilitated.

Tuberculosis is a particularly serious problem among individuals who use drugs intravenously, especially those who are dependent on heroin; infection is usually asymptomatic and evident only by the presence of a positive tuberculin skin test or tuberculosis blood test (interferon gamma release assay). However, many cases of active tuberculosis have been found, especially among those who are infected with HIV. These individuals of-

ten have a newly acquired infection but also are likely to experience reactivation of a prior infection because of impaired immune function.

Individuals who sniff heroin or other opioids into the nose (insufflation, or “snorting”) often develop irritation of the nasal mucosa, sometimes accompanied by perforation of the nasal septum. Difficulties in sexual functioning are common. Males often experience erectile dysfunction during intoxication or chronic use. Females commonly have disturbances of reproductive function and irregular menses.

Although acute opioid use produces analgesia, chronic use can produce hyperalgesia (opioid-induced hyperalgesia), a condition characterized by increased sensitivity to pain. Physiological dependence on opioids may occur in about half of the infants born to females with opioid use disorder. This can produce a severe withdrawal syndrome in the neonate requiring medical treatment and has increased markedly in prevalence.

The mortality rate in individuals with opioid use disorder is 6–20 times greater than in the general population. Fatal overdoses due to prescription opioids increased dramatically in the United States since 1999, with almost 400,000 such deaths occurring since then, and the rate of such overdoses is now five times higher than in 1999. Fatal overdoses due to heroin began a sharp increase in 2010, and since 2013, fatal overdoses due to synthetic opioids (e.g., fentanyl) increased so sharply that these rates were almost double the rates for prescription opioid or heroin overdoses by 2017. Nonfatal opioid overdoses resulting in hospitalization and emergency department visits have increased as well. Although not all risk factors for opioid use disorder and opioid overdose are the same, substantial overlap exists, making the risk for overdose one of the most serious potential consequences of opioid use disorder. Individuals with opioid use disorder are also at increased risk for mortality from many medical conditions (e.g., hepatitis, HIV infection, tuberculosis, cardiovascular disease). Death can also result from accidents, injuries, or other general medical complications.

Differential Diagnosis

Opioid intoxication, opioid withdrawal, and opioid-induced mental disorders. Opioid use disorder is differentiated from opioid intoxication, opioid withdrawal, and opioid-induced mental disorders (e.g., opioid-induced depressive disorder) in that opioid use disorder describes a problematic pattern of opioid use that involves impaired control over opioid use, social impairment attributable to opioid use, risky opioid use (e.g., continued opioid use despite medical complications), and pharmacological symptoms (the development of tolerance or withdrawal), whereas opioid intoxication, opioid withdrawal, and opioid-induced mental disorders describe psychiatric syndromes that occur in the context of heavy use. Opioid intoxication, opioid withdrawal, and opioid-induced mental disorders occur frequently in individuals with opioid use disorder. In such cases, a diagnosis of opioid intoxication, opioid withdrawal, or opioid-induced mental disorder should be given in addition to a diagnosis of opioid use disorder, the presence of which is indicated in the diagnostic code.

Other substance intoxication. Alcohol intoxication and sedative, hypnotic, or anxiolytic intoxication can cause a clinical picture that resembles that of opioid intoxication. A diagnosis of alcohol or sedative, hypnotic, or anxiolytic intoxication can usually be made based on the absence of pupillary constriction or the lack of a response to naloxone challenge. In some cases, intoxication may be due both to opioids and to alcohol or other sedatives. In these cases, the naloxone challenge will not reverse all of the sedative effects.

Other withdrawal disorders. The anxiety and restlessness associated with opioid withdrawal resemble symptoms seen in sedative-hypnotic withdrawal. However, opioid withdrawal is also accompanied by rhinorrhea, lacrimation, and pupillary dilation, which are not seen in sedative-type withdrawal. Dilated pupils are also seen in hallucinogen intoxication and stimulant intoxication. However, other signs or symptoms of opioid

withdrawal, such as nausea, vomiting, diarrhea, abdominal cramps, rhinorrhea, or lacrimation, are not present.

Independent mental disorders. Some of the effects of opioid use may resemble symptoms (e.g., depressed mood) of an independent mental disorder (e.g., persistent depressive disorder). Opioids are less likely to produce symptoms of mental disturbance than are most other drugs of abuse.

Comorbidity

Other than overdose, the most common medical comorbidities associated with opioid use disorder are viral (e.g., HIV, hepatitis C virus) and bacterial infections, particularly among injection heroin users. These infections are less common in prescription opioid use disorder.

Research with nationally representative samples of the U.S. population has found that opioid use disorder is often associated with other substance use disorders, especially those involving tobacco, alcohol, cannabis, stimulants, and benzodiazepines. Individuals with opioid use disorder are at risk for the development of persistent depressive disorder or major depressive disorder. These symptoms may represent an opioid-induced depressive disorder or an exacerbation of a preexisting independent depressive disorder. Periods of depression are especially common during chronic intoxication or in association with physical or psychosocial stressors related to the opioid use disorder. Insomnia is also common, especially during withdrawal. Opioid use disorder is also associated with bipolar I disorder, posttraumatic stress disorder, and antisocial, borderline, and schizotypal personality disorders. A history of conduct disorder in childhood or adolescence has also been identified as a significant risk factor for substance-related disorders, especially opioid use disorder. Further, prescription opioid use disorder and heroin use disorder are generally associated with *serious mental illness*, defined as a mental disorder other than a substance use disorder that results in serious functional impairment substantially limiting or interfering with major life activities.

Opioid Intoxication

Diagnostic Criteria

- A. Recent use of an opioid.
- B. Clinically significant problematic behavioral or psychological changes (e.g., initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment) that developed during, or shortly after, opioid use.
- C. Pupillary constriction (or pupillary dilation due to anoxia from severe overdose) and one (or more) of the following signs or symptoms developing during, or shortly after, opioid use:
 1. Drowsiness or coma.
 2. Slurred speech.
 3. Impairment in attention or memory.
- D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Specify if:

With perceptual disturbances: This specifier may be noted in the rare instance in which hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium.

Coding note: The ICD-10-CM code depends on whether or not there is a comorbid opioid use disorder and whether or not there are perceptual disturbances.

For opioid intoxication, without perceptual disturbances: If a mild opioid use disorder is comorbid, the ICD-10-CM code is **F11.120**, and if a moderate or severe opioid use disorder is comorbid, the ICD-10-CM code is **F11.220**. If there is no comorbid opioid use disorder, then the ICD-10-CM code is **F11.920**.

For opioid intoxication, with perceptual disturbances: If a mild opioid use disorder is comorbid, the ICD-10-CM code is **F11.122**, and if a moderate or severe opioid use disorder is comorbid, the ICD-10-CM code is **F11.222**. If there is no comorbid opioid use disorder, then the ICD-10-CM code is **F11.922**.

Diagnostic Features

The essential feature of opioid intoxication is the presence of clinically significant problematic behavioral or psychological changes (e.g., initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment) that develop during, or shortly after, opioid use (Criteria A and B). Intoxication is accompanied by pupillary constriction (unless there has been a severe overdose with consequent anoxia and pupillary dilation) and one or more of the following signs: drowsiness (described as being “on the nod”), slurred speech, and impairment in attention or memory (Criterion C); drowsiness may progress to coma. Individuals with opioid intoxication may demonstrate inattention to the environment, even to the point of ignoring potentially harmful events. The signs or symptoms of opioid intoxication must not be attributable to another medical condition and are not better explained by another mental disorder (Criterion D).

Up to 2009, opioid overdoses were mainly due to prescribed opioids, but starting in 2010, overdoses due to heroin began a sharp rise, and additionally, since 2015, fatal overdoses due to synthetic opioids other than methadone (generally fentanyl) have outnumbered overdoses due to prescribed opioids.

Associated Features

Opioid intoxication can include decreases in respiratory rate and blood pressure, and mild hypothermia. The duration of opioid intoxication can vary as a function of the pharmacokinetics of the opioid ingested. Opioid intoxication may result in fatal or nonfatal opioid overdose. Opioid overdose is characterized by unconsciousness, respiratory depression, and pinpoint pupils. Fatal opioid overdoses have increased exponentially in the United States since 1999.

Development and Course

Opioid intoxication can occur in an individual who is opioid naïve, an individual who uses opioids sporadically, and an individual who is physically dependent on opioids. The dose of opioid consumed relative to the likelihood of experiencing opioid intoxication will vary as a function of the status and history of the individual’s opioid exposure (i.e., tolerance). Individuals often report that the qualitative pleasurable experience of opioid intoxication diminishes after repeated use of an opioid.

Differential Diagnosis

Other substance intoxication. Alcohol intoxication and sedative-hypnotic intoxication can cause a clinical picture that resembles opioid intoxication. A diagnosis of alcohol or sedative-hypnotic intoxication can usually be made based on the absence of pupillary constriction or the lack of a response to a naloxone challenge. In some cases, intoxication may be due both to opioids and to alcohol or other sedatives. In these cases, naloxone administration will not reverse all of the sedative effects. While response to administration of nal-

oxone can support the diagnosis of opioid intoxication, nonresponse may be due to the co-ingestion of an opioid with another drug (e.g., a benzodiazepine, alcohol) or to ingestion of a higher dose of and/or higher-potency opioid (e.g., fentanyl).

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

Comorbidity

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

Opioid Withdrawal

Diagnostic Criteria

- A. Presence of either of the following:
 1. Cessation of (or reduction in) opioid use that has been heavy and prolonged (i.e., several weeks or longer).
 2. Administration of an opioid antagonist after a period of opioid use.
- B. Three (or more) of the following developing within minutes to several days after Criterion A:
 1. Dysphoric mood.
 2. Nausea or vomiting.
 3. Muscle aches.
 4. Lacrimation or rhinorrhea.
 5. Pupillary dilation, piloerection, or sweating.
 6. Diarrhea.
 7. Yawning.
 8. Fever.
 9. 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 attributable 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 depends on whether or not there is a comorbid opioid use disorder. If a mild opioid use disorder is comorbid, the ICD-10-CM code is **F11.13**, and if a moderate or severe opioid use disorder is comorbid, the ICD-10-CM code is **F11.23**. For opioid withdrawal occurring in the absence of an opioid use disorder (e.g., in a patient taking opioids solely under appropriate medical supervision), the ICD-10-CM code is **F11.93**.

Diagnostic Features

The essential feature of opioid withdrawal is the presence of a characteristic withdrawal syndrome that develops after the cessation of (or reduction in) prolonged opioid use (Cri-

terion A1). The opioids used may be illicit or licitly obtained drugs prescribed to treat pain. A withdrawal syndrome can also be precipitated by administration of an opioid antagonist (e.g., naloxone, naltrexone, nalmefene) after a period of opioid use (Criterion A2); it can also occur after administration of an opioid partial agonist (e.g., buprenorphine) to an individual currently using a full opioid agonist.

Opioid withdrawal has a characteristic pattern of signs and symptoms. The first of these are subjective and consist of complaints of anxiety, restlessness, and an “achy feeling” that is often located in the back and legs, along with irritability and increased sensitivity to pain. Three or more of the following must be present to make a diagnosis of opioid withdrawal: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection, or increased sweating; diarrhea; yawning; fever; and insomnia (Criterion B). Piloerection and fever are associated with more severe withdrawal and are not often seen in routine clinical practice because individuals with opioid use disorder usually obtain substances before withdrawal becomes that far advanced. These symptoms of opioid withdrawal must 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). Having symptoms that meet diagnostic criteria for opioid withdrawal alone is not sufficient for a diagnosis of opioid use disorder, but concurrent symptoms of craving and drug-seeking behavior are suggestive of comorbid opioid use disorder.

Associated Features

Opioid withdrawal may occur in any individual after cessation of repeated use of an opioid, whether in the setting of medical management of pain, during opioid agonist therapy for opioid use disorder, in the context of illicit use, or following attempts to self-treat symptoms of mental disorders with opioids. Opioid withdrawal is a distinct condition from opioid addiction or opioid use disorder and does not necessarily require the drug-seeking behaviors associated with opioid use disorder to be diagnosed. Thus, opioid withdrawal may occur in individuals without opioid use disorder and should not be confused with it. Males with opioid withdrawal may experience piloerection, sweating, and spontaneous ejaculations while awake.

Prevalence

Among individuals from various U.S. clinical settings, opioid withdrawal occurred in 60% of individuals who had used heroin at least once in the prior 12 months. Individuals regularly using opioids (e.g., prescription opioids for pain, illicit opioids) for a period of time are at risk for developing physical dependence, including withdrawal, on cessation or marked reduction in use.

Development and Course

The speed and severity of withdrawal associated with opioids depend on the half-life of the opioid used. Most individuals who are physiologically dependent on short-acting drugs such as heroin begin to have withdrawal symptoms within 6–12 hours after the last dose. Symptoms may take 2–4 days to emerge in the case of longer-acting drugs such as methadone or buprenorphine. Acute withdrawal symptoms for a short-acting opioid such as heroin usually peak within 1–3 days and gradually subside over a period of 5–7 days. More chronic symptoms (e.g., anxiety, dysphoria, anhedonia, craving, insomnia) can last for weeks to months. The severity of opioid withdrawal also varies depending on the duration of opioid use. Opioid withdrawal symptoms among individuals receiving long-term prescription opioid treatment for pain can be minimized by tapering the drug slowly.

Among those with an opioid use disorder, opioid withdrawal and attempts to relieve withdrawal are typical. The course of withdrawal can be part of an escalating pattern in which an opioid is used to reduce withdrawal symptoms, in turn leading to recurrent episodes of withdrawal at a later time.

Differential Diagnosis

Other withdrawal disorders. The anxiety and restlessness associated with opioid withdrawal resemble symptoms seen in sedative-hypnotic withdrawal. However, opioid withdrawal is also accompanied by rhinorrhea, lacrimation, and pupillary dilation, which are not seen in sedative-type withdrawal.

Other substance intoxication. Dilated pupils are also seen in hallucinogen intoxication and stimulant intoxication. However, other signs or symptoms of opioid withdrawal, such as nausea, vomiting, diarrhea, abdominal cramps, rhinorrhea, and lacrimation, are not present.

Opioid-induced mental disorders. Opioid withdrawal is distinguished from opioid-induced mental disorders (e.g., opioid-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 opioid withdrawal, predominate in the clinical presentation, and are severe enough to warrant clinical attention.

Comorbidity

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

Opioid-Induced Mental Disorders

The following opioid-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): opioid-induced depressive disorder (“Depressive Disorders”); opioid-induced anxiety disorder (“Anxiety Disorders”); opioid-induced sleep disorder (“Sleep-Wake Disorders”); and opioid-induced sexual dysfunction (“Sexual Dysfunctions”). For opioid intoxication delirium, opioid withdrawal delirium, and delirium induced by opioids taken as prescribed, see the criteria and discussion of delirium in the chapter “Neurocognitive Disorders.” These opioid-induced mental disorders are diagnosed instead of opioid intoxication or opioid withdrawal only when the symptoms are sufficiently severe to warrant independent clinical attention.

Unspecified Opioid-Related Disorder

F11.99

This category applies to presentations in which symptoms characteristic of an opioid-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 opioid-related disorder or any of the disorders in the substance-related and addictive disorders diagnostic class.

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

Sedative, Hypnotic, or Anxiolytic Use Disorder
 Sedative, Hypnotic, or Anxiolytic Intoxication
 Sedative, Hypnotic, or Anxiolytic Withdrawal
 Sedative-, Hypnotic-, or Anxiolytic-Induced Mental Disorders
 Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder

Sedative, Hypnotic, or Anxiolytic Use Disorder

Diagnostic Criteria

- A. A problematic pattern of sedative, hypnotic, or anxiolytic use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
1. Sedatives, hypnotics, or anxiolytics are 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 sedative, hypnotic, or anxiolytic use.
 3. A great deal of time is spent in activities necessary to obtain the sedative, hypnotic, or anxiolytic; use the sedative, hypnotic, or anxiolytic; or recover from its effects.
 4. Craving, or a strong desire or urge to use the sedative, hypnotic, or anxiolytic.
 5. Recurrent sedative, hypnotic, or anxiolytic use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences from work or poor work performance related to sedative, hypnotic, or anxiolytic use; sedative-, hypnotic-, or anxiolytic-related absences, suspensions, or expulsions from school; neglect of children or household).
 6. Continued sedative, hypnotic, or anxiolytic use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of sedatives, hypnotics, or anxiolytics (e.g., arguments with a spouse about consequences of intoxication; physical fights).
 7. Important social, occupational, or recreational activities are given up or reduced because of sedative, hypnotic, or anxiolytic use.
 8. Recurrent sedative, hypnotic, or anxiolytic use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by sedative, hypnotic, or anxiolytic use).
 9. Sedative, hypnotic, or anxiolytic 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 the sedative, hypnotic, or anxiolytic.
 10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the sedative, hypnotic, or anxiolytic to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of the sedative, hypnotic, or anxiolytic.

Note: This criterion is not considered to be met for individuals taking sedatives, hypnotics, or anxiolytics under medical supervision.

11. Withdrawal, as manifested by either of the following:
- a. The characteristic withdrawal syndrome for sedatives, hypnotics, or anxiolytics (refer to Criteria A and B of the criteria set for sedative, hypnotic, or anxiolytic withdrawal).
 - b. Sedatives, hypnotics, or anxiolytics (or a closely related substance, such as alcohol) are taken to relieve or avoid withdrawal symptoms.

Note: This criterion is not considered to be met for individuals taking sedatives, hypnotics, or anxiolytics under medical supervision.

Specify if:

In early remission: After full criteria for sedative, hypnotic, or anxiolytic use disorder were previously met, none of the criteria for sedative, hypnotic, or anxiolytic 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 the sedative, hypnotic, or anxiolytic,” may be met).

In sustained remission: After full criteria for sedative, hypnotic, or anxiolytic use disorder were previously met, none of the criteria for sedative, hypnotic, or anxiolytic 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 the sedative, hypnotic, or anxiolytic,” may be met).

Specify if:

In a controlled environment: This additional specifier is used if the individual is in an environment where access to sedatives, hypnotics, or anxiolytics is restricted.

Code based on current severity/remission: If a sedative, hypnotic, or anxiolytic intoxication; sedative, hypnotic, or anxiolytic withdrawal; or another sedative-, hypnotic-, or anxiolytic-induced mental disorder is also present, do not use the codes below for sedative, hypnotic, or anxiolytic use disorder. Instead, the comorbid sedative, hypnotic, or anxiolytic use disorder is indicated in the 4th character of the sedative-, hypnotic-, or anxiolytic-induced disorder (see the coding note for sedative, hypnotic, or anxiolytic intoxication; sedative, hypnotic, or anxiolytic withdrawal; or specific sedative-, hypnotic-, or anxiolytic-induced mental disorder). For example, if there is comorbid sedative-, hypnotic-, or anxiolytic-induced depressive disorder and sedative, hypnotic, or anxiolytic use disorder, only the sedative-, hypnotic-, or anxiolytic-induced depressive disorder code is given, with the 4th character indicating whether the comorbid sedative, hypnotic, or anxiolytic use disorder is mild, moderate, or severe: F13.14 for mild sedative, hypnotic, or anxiolytic use disorder with sedative-, hypnotic-, or anxiolytic-induced depressive disorder or F13.24 for a moderate or severe sedative, hypnotic, or anxiolytic use disorder with sedative-, hypnotic-, or anxiolytic-induced depressive disorder.

Specify current severity/remission:

F13.10 Mild: Presence of 2–3 symptoms.

F13.11 Mild, In early remission

F13.11 Mild, In sustained remission

F13.20 Moderate: Presence of 4–5 symptoms.

F13.21 Moderate, In early remission

F13.21 Moderate, In sustained remission

F13.20 Severe: Presence of 6 or more symptoms.

F13.21 Severe, In early remission

F13.21 Severe, In sustained remission

Specifiers

“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

Sedative, hypnotic, or anxiolytic substances include benzodiazepines, benzodiazepine-like drugs (e.g., zolpidem, zaleplon), carbamates (e.g., glutethimide, meprobamate), barbiturates (e.g., secobarbital), and barbiturate-like hypnotics (e.g., glutethimide, methaqualone, propofol). This class of substances includes most prescription sleeping medications and most prescription antianxiety medications. Nonbenzodiazepine antianxiety agents (e.g., buspirone, gepirone) are not included in this class because they do not appear to be associated with significant misuse.

Like alcohol, these agents are brain depressants and can produce similar substance/medication-induced and substance use disorders. Sedative, hypnotic, or anxiolytic substances are available both by prescription and illegally. Some individuals who obtain these substances by prescription will develop a sedative, hypnotic, or anxiolytic use disorder, while others who misuse these substances or use them for intoxication will not develop a use disorder. In particular, sedatives, hypnotics, or anxiolytics with rapid onset or short to intermediate lengths of action may be taken for intoxication purposes, although longer-acting substances in this class may be taken for intoxication as well.

Craving (Criterion A4), either during periods of active use or during periods of abstinence, is a typical feature of sedative, hypnotic, or anxiolytic use disorder. Misuse of substances from this class may occur in conjunction with use of other substances. For example, individuals may use intoxicating doses of sedatives or benzodiazepines to “come down” from cocaine or amphetamines or use high doses of benzodiazepines in combination with methadone to “boost” its effects.

Repeated absences or poor work performance, school absences, suspensions or expulsions, and neglect of children or household (Criterion A5) may be related to sedative, hypnotic, or anxiolytic use disorder; the continued use of the substances despite arguments with a spouse about consequences of intoxication or despite physical fights (Criterion A6) may also occur. Limiting contact with family or friends, avoiding work or school, or stopping participation in hobbies, sports, or games (Criterion A7) and recurrent sedative, hypnotic, or anxiolytic use when driving an automobile or operating machinery when impaired by such use (Criterion A8) are also seen in sedative, hypnotic, or anxiolytic use disorder.

Very significant levels of tolerance and withdrawal can develop to sedative, hypnotic, or anxiolytic substances. There may be evidence of tolerance and withdrawal in the absence of a diagnosis of a sedative, hypnotic, or anxiolytic use disorder in an individual who has abruptly discontinued use of benzodiazepines that were taken for long periods of time at prescribed and therapeutic doses. In these cases, an additional diagnosis of sedative, hypnotic, or anxiolytic use disorder is made only if other criteria are met. That is, sedative, hypnotic, or anxiolytic medications may be prescribed for appropriate medical purposes, and depending on the dose regimen, these drugs may then produce tolerance and withdrawal. If these drugs are prescribed or recommended for appropriate medical purposes, and if they are used as prescribed, the resulting tolerance or withdrawal does not count toward the diagnosis of a substance use disorder. However, it is necessary to determine whether the drugs were inappropriately prescribed and used (e.g., falsifying medical symptoms to obtain the medication; using more medication than prescribed; obtaining the medication from several doctors without informing them).

Given the unidimensional nature of the symptoms of sedative, hypnotic, or anxiolytic use disorder, severity is based on the number of diagnostic criteria that are met.